PRINTED: 07/30/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345284	B. WING			C 06/08/2018
NAME OF PROVIDER OR SUPPLIER THE OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	, ,	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
self-determination, ar access to persons an outside the facility, in this section. §483.10(a)(1) A facility with respect and dignoresident in a manner promotes maintenancher quality of life, recindividuality. The faci promote the rights of §483.10(a)(2) The facaccess to quality care severity of condition, must establish and material provision of services residents regardless §483.10(b) Exercise The resident has the rights as a resident of the United Services and the United Services (and the United Services) interference, coercion from the facility.	Rights. ght to a dignified existence, and communication with and and services inside and cluding those specified in ty must treat each resident with and and services inside and cluding those specified in ty must treat each resident with and in an environment that the corenhancement of his or cognizing each resident's with a side of the resident. cility must provide equal the resident. cility must provide equal the regardless of diagnosis, or payment source. A facility maintain identical policies and the under the State plan for all of payment source. of Rights. right to exercise his or her of the facility and as a citizen ted States. cility must ensure that the ensure th	F 550	TITLE		7/5/18 (X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

06/29/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C 06/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER	1 1 1		STREET ADDRESS, CITY, STATE, ZIP CODE	I	00/00/2010	
				901 BETHESDA ROAD			
THE OAK	S			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 550	Continued From page	e 1	F 55	0			
	subpart. This REQUIREMENT by:	rights as required under this is not met as evidenced ons, record review, staff and		The statements made on this	Plan of		
	provide care to maint providing incontinent	iews, the facility failed to ain a residents dignity by not care before feeding a 60) for 1 of 7 residents		Correction are not an admission not constitute an agreement walleged deficiencies. To remain compliance with all Federal ar	rith the n in		
	(Resident #60) reviewed for Activities of Daily Living (ADLs).			Regulations the facility has tak take the actions set forth in thi Correction. The Plan of Corre	s Plan of ction		
	The findings included			constitutes the facility's allegated	ed		
		admitted to the facility on es, in part, of Alzheimer's.		deficiencies cited have been corrected by the date or dates F550 RESIDENT RIGHTS	indicated.		
	(MDS) assessment d resident had severely required extensive as	erly Minimum Data Set ated 4/10/18 revealed the impaired cognition and esistance of two people for		OF RIGHTS. The plan of correcting the spe deficiency. The plan should ac processes that lead to the defi	dress the		
	always incontinent of	and hygiene and was bladder.		cited; The facility failed to provide ca maintain a residents dignity by			
	A review of the care plan dated 4/20/18 revealed a problem of incontinence with an intervention of "I need assistance with incontinent care."			providing incontinent care before a resident (Resident #60) for residents (Resident #60) revidence of Daily Living. C N	ore feeding 1 of 7 ewed for		
	4:15PM revealed the	4/18 at approximately resident lying in bed. A urine the resident had a large, a noted to the pad		provide incontinence care here resident became combative at assistance. Resident #60: Incontinence caprovided per plan of care and	self because and needed are was also		
	resident lying in bed. present in the hallway	5/18 at 8:34 AM revealed the A strong urine odor was y and, upon entering the ge, circular brownish area erneath him.		provided prior to being assiste meals. The procedure for implementing acceptable plan of correction to specific deficiency cited; On 6/28/2018, the Director of	ng the for the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345284	B. WING _		 	o	6/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	-		STR	REET ADDRESS, CITY, STATE, ZIP CODE			
	_			901	BETHESDA ROAD			
THE OAK	5			WIN	NSTON SALEM, NC 27103			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 550	Continued From page	ge 2	F 5	550				
					Quality Assurance Nurse Consultant a	nd		
	An observation on 6	6/5/18 at 8:45 AM revealed			Unit Manager began in-servicing the			
	Nurse Aide (NA) #1	in Resident #60's room			nursing staff (Registered nurses and			
	feeding him breakfa	st. Incontinent care had not			Nurse Aides: Full time, Part time and			
	been provided and t	the urine odor remained.			PRN) that the resident has a right to a			
					dignified existence, self-determination,	J		
		ition was conducted on 6/5/18			and communication with and access to)		
		10:30 AM. There were no			persons and services inside and outside	et		
	incontinent care pro	vided during that time.			the facility. A facility must treat each			
					resident with respect and dignity and o			
		:30 AM on 6/5/18, Hospice			for each resident in a manner and in a			
NA #1 entered the room. An observation at that				environment that promotes maintenan				
		ospice NA pull the top sheet			or enhancement of his or her quality of	i		
		state "he's soaked". The			life, recognizing each resident's	and .		
		, brief, pad and bottom sheet The resident's t-shirt was wet			individuality. The facility must protect a promote the rights of the resident. The			
		d a brownish colored stain			facility must provide equal access to			
		ended. A strong urine odor			quality care regardless of diagnosis,			
		bservation of resident's skin			severity of condition, or payment source	;e		
		redness or open areas.			A facility must establish and maintain			
					identical policies and practices regardi	na		
	An interview with N	A #1 on 6/5/18 at			transfer, discharge, and the provision of			
	approximately 11:30) AM revealed she knew the			services under the State plan for all			
	resident was inconti	nent when she was feeding			residents regardless of payment source	e.		
	him, but couldn't do	it herself because the			The facility must ensure that the reside	∍nt		
	resident became co	mbative so she told NA #2,			can exercise his or her rights without			
	who was assigned t	o Resident #60.			interference, coercion, discrimination of	r		
					reprisal from the facility.			
	An interview with N				The facility must ensure to provide car			
		5 AM revealed he checks the			maintain a resident's dignity by providi	ng		
		nence every 2 hours. He			incontinence care before feeding a			
	stated he did not kn				resident			
	_	reakfast and did not answer			As of 7/E/2019 no pursing staff			
		1 had told him the resident			As of 7/5/2018 no nursing staff (Registered nurses and Nurse Aides: I	=ull		
		ing breakfast. He stated he			time, Part time and PRN) will be allowed			
	_	nt at 6:00 AM and 9:00 AM it was revealed the resident			to work until the training has been	5 U		
	_	st at 9:00 AM, he stated that			completed. Effective 7/5/2018, this			
	he changed him at 6				training is incorporated into the new			
	no onangeu min at t	2.00 / MVI.	1	1	adming is incorporated into the flew		1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345284	B. WING			C 06/08/2018	
NAME OF PR	ROVIDER OR SUPPLIER	0.10201		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/0	00/2010
					01 BETHESDA ROAD		
THE OAKS	S				VINSTON SALEM, NC 27103		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	`	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 550	Continued From page	e 3	F t	550			
					employee orientation program. This		
		Corporate Nurse Consultant			information has been integrated into th		
		revealed incontinent care is			standard orientation training and in the		
	provided per the care				required in-service refresher courses fo		
		t was incontinent, she would eck the resident frequently to			all employees and will be reviewed by a Quality Assurance Process to verify that		
		e was needed. She further			the change has been sustained.	11	
		ot expect staff to continue			the change has been sustained.		
		hey were aware the resident			The monitoring procedure to ensure the	at	
	needed to be change	-			the plan of correction is effective and the		
	_				specific deficiency cited remains correct	ted	
	An interview with the	residents' wife on 6/7/18 at			and/or in compliance with the regulator	y	
		ne frequently finds him wet			requirements; The Director of Nursing	or	
	•	e visits. She stated Resident			Unit Manager will observe 5 residents		
		set if he knew he was left			each week to include the weekend duri	ng	
	wet because he was	always such a neat person.			meals to ensure that they have had		
					incontinence care provided before bein	-	
					assisted with feeding by using a quality		
					assurance survey tool This will be done weekly for 4 weeks then monthly for 3	;	
					months.		
					Reports will be presented to the weekly	,	
					Quality Assurance committee by the		
					Director of Nursing to ensure corrective	ا د	
					action for trends or ongoing concerns is		
					initiated as appropriate. The weekly		
					Quality Assurance Meeting is attended	by	
					the Director of Nursing, Wound Nurse,		
					Minimum Data Set Coordinator, Unit		
					Manager, Therapy, Health Information		
					Manager, Dietary Manager and the		
					Administrator.		
					The title of the person responsible for		
					implementing the acceptable plan of		
					correction;		
					Administrator and /or Director of Nursir	ıg.	
F 577	Right to Survey Resu	Its/Advocate Agency Info	F t	577		•	7/5/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345284	B. WING _				C /08/2018	
NAME OF PE	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 BETHESDA ROAD VINSTON SALEM, NC 27103	1 00/	00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 577 SS=C	Continued From pag CFR(s): 483.10(g)(10		F 5	577				
	(i) Examine the resul of the facility conduct surveyors and any placement to the facility (ii) Receive informatic client advocates, and to contact these agei	on from agencies acting as does not be afforded the opportunity notes.						
	and family members residents, the results the facility. (ii) Have reports with certifications, and co respecting the facility years, and any plan or respect to the facility to review upon reque (iii) Post notice of the areas of the facility the accessible to the public (iv) The facility shall information about co. This REQUIREMENT	adily accessible to residents, and legal representatives of of the most recent survey of respect to any surveys, mplaint investigations made of during the 3 preceding of correction in effect with a available for any individual est; and a availability of such reports in the state of the stat						
	interviews, the facility location and availabil results. Findings included: During a tour of the fan observation was results.	ons and resident and staff of failed to post the notice of lity of the facility's survey acility on 6/3/18 at 7:00 AM made that survey results lebook binder on a table near			The statements made on this Plan of Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or w take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged	d do ill		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY,	STATE ZIP CODE	1 00/0	30/2010
				901 BETHESDA ROAD	,,		
THE OAK	3				C 27402		
				WINSTON SALEM, NO	C 2/103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 577	Continued From page	e 5	F 5	77			
	the reception desk in	the front lobby.		deficiencies cited	d have been or will be		
		,			date or dates indicate	d.	
	An observation on 6/3	3/18 at 10:00 AM revealed			TO SURVEY		
	there was no notice p	oosted in the facility		RESULTS/ADVC	OCATE AGENCY INFO).	
	regarding the availab	ility and location of recent		The plan of corre	ecting the specific		
	survey results.			deficiency. The p	plan should address th	е	
				processes that le	ead to the deficiency		
	An observation on 6/-	4/18 at 2:00 PM revealed		cited;			
	there was no notice p	<u>-</u>			d to post the notice of		
		ility and location of recent			ilability of the facility's		
	survey results.			,	Facility had renovation		
	0 0/F/40 1000 PM	D : 1 . 0			th survey result posting	js	
		I the Resident Council			aced in a different		
		eted. During the meeting,			enovation the posting of		
		members stated they had location of the survey results		were not placed	ts location and availabi	iiity	
	_	ew with the Resident Council			tice was posted in the		
		meeting revealed she didn't			the availability and		
		y results were, where they			nt survey results in area	as	
		d not seen any signage that			ent and accessible to the		
	directed residents to			public, resident a			
				1 -	or implementing the		
	An observation on 6/	5/18 at 4:14 PM revealed		acceptable plan	of correction for the		
	there was no notice p			specific deficiend	-		
		ility and location of recent			Administrator ensured		
	survey results.			· '	as posted in the facility		
					ailability and location o	of	
	An interview was con	•			sults in areas that are		
		18 at 2:48 PM. She stated		·	ccessible to the public		
	_	was posted in the facility and			milies. Resident Counc	CII	
		bulletin boards located			lembers were verbally		
	throughout the facility			notified about the	e posting.		
		ing renovations. She said e be posted that directed		On 6/8/2018 tha	Quality Assurance Nu	rea	
		s to the location of the			rviced the Administrate		
		anned to have the notice			has the right to: Exam		
	posted in the facility.	annea to have the notice			e most recent survey of		
	posted in the idelity.				icted by Federal or Sta		
					ny plan of correction in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _		00	C 6/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 901 BETHESDA ROAD WINSTON SALEM, NC 27103		5/00/2010
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 577	Continued From page	e 6	F 5	effect with respect to the respective information from as client advocates, and lead opportunity to contact the The facility must; Post in accessible to residents/ amembers and legal representations, the results of the survey of the facility. Have respect to any surveys, of complaint investigations of the facility during the 3 per and any plan of correction respect to the facility, avaindividual to review upon facility must. Post notice of the availab reports in areas of the facility shall not make identifying information about residents. Resident Council Meeting for 6/25/2018. On 6/25/2018 during the leading the Resident Council Meeting for 6/25/2018. On 6/25/2018, the Resident Council Meeting the Resident Council Meeting for 6/25/2018. Effective 7/5/2018, this traincorporated into the locate book. Effective 7/5/2018, this traincorporated into the new orientation program. This been integrated into the side integrated into the	a agencies acting be afforded the ese agencies. a place readily and family esentative of the most recent we reports with the ertifications and made respecting receding years, in in effect with eallable for any request. The collity of such collity that are to the public. The count complainants of the was scheduled as we scheduled as we scheduled as we wait to of the survey results ocated and that facility that tion of the survey realing is wemployee in information has a place of the survey results or and the survey results or and that facility that the survey results or and the survey results or and that facility that the survey results or and that facility that the survey results or and the survey results or and that facility that the survey results or and that facility that the survey results or and the survey results or and that facility that the survey results or and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	L IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	((X3) DATE SURVEY COMPLETED	
	345284	B. WING			C 06/08/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/00/2010	
			901 BETHESDA ROAD			
THE OAKS			WINSTON SALEM, NC 27103			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 636 SS=D Continued From page 7 Continued From page 7 Comprehensive Assess CFR(s): 483.20(b)(1)(2)	sments & Timing	F 6	orientation training and in the rein-service refresher courses for employees and will be reviewed Quality Assurance Process to withe change has been sustained. The monitoring procedure to enthe plan of correction is effective specific deficiency cited remains and/or in compliance with the rerequirements; The Administrat weekly facility rounds, will ensure notice is posted in the facility rethe availability and location of resurvey results in areas that are and accessible to the public, resund families. This will be done usurvey tool. This will be done usurvey tool. This will be done weeks then monthly for 3 month Reports will be presented to the Quality Assurance committee by Director of Nursing to ensure condition for trends or ongoing conditiated as appropriate. The week Quality Assurance Meeting is at the Director of Nursing, Wound Minimum Data Set Coordinator, Manager, Therapy, Health Informanager, Dietary Manager and Administrator. The title of the person responsite implementing the acceptable placorrection; Administrator and /or Director or definition of the place of the person responsite implementing the acceptable place or the place of the person responsite implementing the acceptable place or the place of the person responsite implementing the acceptable place or the place of the person responsite implementing the acceptable place or the place of the person responsite implementation.	all d by the erify that l. esure that e and that s correcte egulatory tor, during re that a garding ecent prominer sidents using a reekly for ns. e weekly y the orrective ncerns is eekly ttended b Nurse, , Unit rmation the ble for an of	t at ed g	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345284	B. WING _			C 06/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		00/00/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 636	§483.20 Resident As The facility must con- a comprehensive, ac reproducible assessr functional capacity. §483.20(b) Compreh §483.20(b)(1) Resid A facility must make assessment of a resi goals, life history and resident assessment by CMS. The assess the following: (i) Identification and of (ii) Customary routine (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behav (vii) Psychological wo (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutriti (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatmer (xvii) Discharge plant (xvii) Documentation regarding the additio on the care areas trig the Minimum Data So (xviiii) Documentation assessment. The as include direct observ	sessment duct initially and periodically curate, standardized nent of each resident's ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, I preferences, using the instrument (RAI) specified sment must include at least demographic information e. s. or patterns. ell-being. ning and structural problems. s and health conditions. onal status. ats and procedures. hing. of summary information nal assessment performed tigered by the completion of et (MDS).	F 6	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			(C	
		345284	B. WING			06/	08/2018	
NAME OF P	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 11 BETHESDA ROAD TINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 636	licensed and nonlicer members on all shifts §483.20(b)(2) When timeframes prescribe chapter, a facility musassessment of a resistimeframes specified through (iii) of this seprescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmission significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii) Not less than once This REQUIREMENT by: Based on record revinterviews the facility assess a resident recresidents reviewed for #80). Findings include: Resident #80 was ad 4/20/18 with diagnoshypertension (high bl Renal Disease (ESR) hyperlipidemia (high Minimum Data Set (Nother esident had integretion of care.	required. Subject to the d in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 43(b) of this chapter do not r days after admission, as in which there is no the resident's physical or repurposes of this section, a a return to the facility absence for hospitalization be every 12 months.	F	536	The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or wil take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F636 COMPREHENSIVE ASSESSMENTS & TIMING. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	II f		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			l	C 08/2018
NAME OF PI	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 BETHESDA ROAD FINSTON SALEM, NC 27103	1 00/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636	stated the resident retimes a week. A Phyfor dialysis on Mondathe dialysis facility. Review of Section Of for 4/27/18 did not spreceiving dialysis ser During an interview veet of 8/18 at 10:35 AM sthe resident received admission MDS from that she must have of the assessment. During an interview veet of the assessment of the assessment of the state of the assessment.	eceived hemodialysis three visician 's order was placed ay, Wednesday and Friday at of the admission MDS dated pecify that resident #80 was vices. With the MDS Coordinator on the stated that not indicating a dialysis services on her a 4/27/18 was an error and everlooked it while completing with the Administrator and the regional Nurse Consultant on ey stated that it was their	F	636	cited; The facility failed to comprehensively assess a resident receiving dialysis for of 3 residents reviewed for dialysis services. (Resident #80). MDS Coordinator omitted to code dialysis or the comprehensive assessment dated 4/27/18. Resident #80: Resident Minimum Data Set Assessment (Admission Comprehensive Assessment) with Assessment Reference Date (ARD) of 4/27/2018 was modified with a Correct Attestation Date of 6/8/2018. The assessment was submitted to the state QIES system on 6/11/2018 and was accepted on 6/11/2018. Submission ID 14914790 The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 6/25/2018 through 6/27/2018 the Director of Nursing, Quality Assurance Nurse Consultant and Mini Data Set (MDS) Coordinators reviewed the most current Mini Data Set (MDS) for the last months to ensure that Section O0100J Dialysis was coded appropriately. On 6/26/2017 the Quality Assurance Nurse Consultant in serviced the Director Nursing, Dietary Manager, and Mini	ive	
					Data Set (MDS) Coordinator's on the importance of accurately coding the Mi Data Set assessments for Dialysis. Code peritoneal or renal dialysis which occurs at the nursing home or at anoth facility, record		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ULL PREFIX (EACH CORRECTIVE ACTION SHOULD		VE ACTION SHOULD BE ED TO THE APPROPRIAT		
F 636	Continued From pag	e 11	F 6	Treatments of hemofi Continuous Ultrafiltrat Continuous Arteriover (CAVH), and Continuous Peritoneal Dialysis (Citem.IVs, IV medication transfusions administrate considered part of procedure and are not items K0510A (Paren (IVmedications), or Othis item may be code performs his/her own As of 7/3/2018 notem involved with coding Story Dialysis (that is Direct Data Set (MDS) Coortal allowed to work until the completed. Effective 7/3/2018, the incorporated into the orientation program. Deen integrated into the orientation training and in-service refresher contents and inservice refresher contents. The monitoring proces the plan of correction specific deficiency cite and/or in compliance requirements; The Eland/or Mini Data Set will review 5 resident records Mini Data Set	tion (SCUF), hous Hemofiltration ous Ambulatory tAPD) in this on, and blood ered during dialysis of the dialysis of the dialysis of the dialysis of the training the training the training has been the training the training the training the training has been the training the training the training that the	s er s). i en as	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345284	B. WING		C 06/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 636 F 656 SS=D	CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The con describe the following (i) The services that a	comprehensive Care Plan ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial ied in the comprehensive nprehensive care plan must	F 630	this could be either one of the following assessments that is Comprehensive/ Quarterly / PPS Mini Data Set (Assessments) per week to ensure that Section O0100J, Dialysis was coded appropriately. This will be done on week basis to include the weekend for 4 week then monthly for 3 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends of ongoing concerns is initiated as appropriate. The weekly QA Meeting if attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HII Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	t ekly eks y ng r s

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C 06/08/2018
NAME OF PI	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	00/00/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 656	required under §483.24, §483. provided due to the re under §483.10, includ treatment under §483.30 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation wit resident's representar (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's community was assessed to cal contact agencie entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on observation and staff interviews, to implement the compression of the part of the compression of the purpor of the compression of the purpor	psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 3.10(c)(6). Bervices or specialized at the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-bals for admission and efference and potential for sillities must document a desire to return to the seed and any referrals to be and/or other appropriate see. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced ans, record reviews, resident the facility failed to ehensive care plans for 2 of Residents #34 and #87) is and for 1 of 6 sampled	F 656	The statements made on this Plan of Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State	
	also failed to develop for 1 of 6 sampled res	r limited range of Resident #87). The facility a comprehensive care plan sidents reviewed with a ontractures (Resident #114)		Regulations the facility has taken or w take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility sallegation of compliance such that all alleged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION		X3) DATE SURVEY COMPLETED	
						1	С	
		345284	B. WING _			06/	/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAK	2			90	01 BETHESDA ROAD			
IIIL OAK	•			V	VINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From pag	je 14	F 6	356				
	and failed to follow t	he care plan to provide			deficiencies cited have been or will be			
	application of a brac				corrected by the date or dates indicate	d.		
	••	f 27 residents' care plans			,			
	reviewed (Resident				F656 DEVELOP/IMPLEMENT			
	,	,			COMPREHENSIVE CARE PLAN.			
	Findings included:				The plan of correcting the specific			
					deficiency. The plan should address th	е		
	1. Resident #69 was	s admitted to the facility on			processes that lead to the deficiency			
		es that included, in part,			cited,			
	hemiplegia and cont	racture, unspecified joint.			The facility failed to implement the			
		114:			comprehensive care plans for 2 of 4			
		al Minimum Data Set (MDS)			sampled residents (Residents #34 and			
		/7/17 revealed Resident #69			#87) reviewed for accidents and for 1 c			
		ed decision making skills and both sides of her upper			sampled residents reviewed for limited range of motion/contractures (Resider			
	extremity.	our sides of fiel apper			#87). The facility also failed to develop			
	CAUCHILLY.				comprehensive care plan for 1 of 6	u		
	A review of the care	plan updated 5/2/18 revealed			sampled residents reviewed with a			
		upper extremity contracture."			splinting device for contractures (
		tion included, "Apply splint to			Resident #114) and failed to follow the			
	right hand daily and	remove at night."			care plan to provide application of a brifor contracture management for 1 of 27			
	A review of a physic	ian order dated 2/21/18			resident⊡s care plans reviewed (
	revealed, "Nursing to	o put brace on right hand in			Resident #69). Resident #34 and #87			
		at evening. Diagnosis:			care plan was not implemented by staf			
	contracture right har	nd."			Resident #87, #114, and #69 care plar			
					was not implemented by staff due to la	ck		
		cation Administration Record			of knowledge.			
	` ′	3 revealed the brace was to			Resident #34: Care plan meeting with			
		ent #69's right hand at 8:00			interdisciplinary team (Social worker,			
	AM and removed at	9.00 PIVI.			Minimum Data Set Coordinators, Unit manager, Hall Nurse, Nurse Aide,			
	On 6/3/18 at 10:16 /	AM an observation of			Administrator, Therapy,) and Resident			
		room revealed her right hand			representative held. Reviewed current			
		hand brace was not in place.			interventions per care plan, resident ha			
		able to verbally answer			not had a fall, but is at risk for falls. Fal			
		her head "no" when asked if			mat discontinued as not an appropriate			
	· ·	nand. Further observation			intervention for resident. All other			
		ce was on top of Resident			interventions are active and appropriat	e.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345284	B. WING		C 06/08/2018
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010
				901 BETHESDA ROAD	
THE OAK	5			WINSTON SALEM, NC 27103	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	
F 656	Continued From pag	ge 15	F 656	3	
	#69's dresser.			Resident #87: Care plan meeting v	with
				interdisciplinary team (Social work	er,
	On 6/4/18 at 10:45 A	AM an observation was made		Minimum Data Set Coordinators, U	Jnit
		ne day room. The brace was		manager, Hall Nurse, Nurse Aide,	
	not on her right hand	d.		Administrator, Therapy,) and Residual	dent
				representative held. Reviewed cur	
		M an observation was made		interventions per care plan, reside	
		er room. The brace was not		not had a fall, but is at risk for falls	
	on her right hand.			mat discontinued as not an approp	oriate
	O 0/5/40 -+ 0-50 DI	M it i		intervention for resident. All other	
		M an interview was completed		interventions are active and appro	-
		Family Member. He stated ie right hand contracture		Splint / Brace applied per plan of cas indicated on the Medication	care and
		nitted to the facility. The		Administration Record per physicia	an
		orted that when he visited on		orders.	all
		e resident's brace was not on		Resident #114: Splint / Brace appl	ied ner
		o he applied the brace both		plan of care and as indicated on the	-
	_	pically visited Resident #69		Medication Administration Record	
		and often, when he visited, the		physician orders.	
	brace was not on the			Resident #69: Splint / Brace applie	ed per
				plan of care and as indicated on th	ne
	On 6/6/18 at 11:11 A	AM an observation was made		Medication Administration Record	per
	of Resident #69 in the	ne day room. The brace was		physician orders.	
	not on her right hand	d.		The procedure for implementing the	
				acceptable plan of correction for the	ne
	On 6/6/18 at 11:20 A			specific deficiency cited;	
		se #1. She stated the nurse		On 6/18/2018 through 6/27/2018 th	
		the braces/splints for		Director of Nursing, Quality Assura	
		ment. She said Resident		Nurse Consultant, Therapy Directo	or, Unit
	_	a contracture and that		Manager and Minimum Data Set	
		needed the nurse's help		Coordinators reviewed all current	and that
		ne brace. Nurse #1 said she		residents with care plan intervention	
		got to put the brace on		required the use of a fall mat. They reviewed all current residents with	-
	_	hand for the last couple of esident's Family Member had		splinting / brace devices for contra	
	_	the past that when he visited		management to ensure that a	เงเนเซิง
		and brace was not on.		comprehensive care plan was dev	reloned
	1 CONCORT #00 HOLHO	and brade was not on.		and plan of care was followed by r	•
	On 6/6/18 at 11:25 A	AM an interview was		department (Registered nurses RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		0.0	C 5/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.020.		STREET ADDRESS, CITY, STATE, ZIP		0/00/2016	
TVAIVIL OF T	TOVIDER OR OUT FEILIN				OODL		
THE OAKS	3			901 BETHESDA ROAD			
				WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From page	e 16	F 6	56			
	seen Resident #69 w	 She stated she had never ith a hand brace and didn't sed to apply the hand brace 		Licensed Practical Nurses Aides) for splints/braces u contracture management.	ised for		
	On 6/6/18 at 2:22 PM with the Administrato that staff follow the cabe applied daily to Re	I an interview was completed r. She stated she expected are plan and that the brace esident #69's right hand.		On 6/26/2017 through 7/5 Quality Assurance Nurse Unit Manager in serviced and LPN) and Nurse Aide time, and PRN) that the fa develop and implement a person-centered care plar resident, consistent with th	Consultant and the Nurses (RN s (Full time, Part acility must comprehensive n for each		
	5/1/11 with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, dementia with behavioral disturbance, and a history of falling.			rights set forth and that in- measurable objectives an meet a resident s medica mental psychosocial need identified in the comprehe	d timeframes to al, nursing and Is that are		
	dated 3/20/18 indicat severely, cognitively assistance of two sta transfers; had impair	rly Minimum Data Set (MDS) ed Resident #34 was impaired; required extensive ff for bed mobility and ed range of motion on one had no falls since the ssment.		orders will be placed in the health record for the resid Administration Record. A care plan will be develope implemented for residents	ssessment. Splints/ Braces: Physician orders will be placed in the electronic ealth record for the resident under the administration Record. A comprehensive are plan will be developed and explemented for residents who use splints/Braces and who use fall mats.		
	#34 was susceptible physical harm related her cerebrovascular awas non-weight bear Interventions include risks of throwing her a blue fall mat to the the bed was in the local physical harmonic factorial was susceptible.	4/5/18 revealed Resident to falling which may cause if to hemiplegia secondary to accident; and the resident ing of bilateral extremities. It is remind the resident of the legs over the side of the bed; right side of the; and ensure west position at all times.		Effective 7/5/2018, this traincorporated into the new orientation program. This been integrated into the straining and in in-service refresher coursemployees and will be revenuality Assurance Process the change has been sust	employee information has tandard the required es for all riewed by the s to verify that ained.		
	1:18 p.m., and 6/7/18 Resident #34 was in	8/18 at 9:05 a.m., 6/6/18 at 8 at 1:15 p.m., revealed her bed which was raised at ximately 3-feet from floor).		The monitoring procedure the plan of correction is ef specific deficiency cited re and/or in compliance with	fective and that emains corrected		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUR COMPLETE				
		345284	B. WING _				C 6/08/2018
NAME OF PE	ROVIDER OR SUPPLIER			901	REET ADDRESS, CITY, STATE, ZIP CODE BETHESDA ROAD NSTON SALEM, NC 27103	1 0	0/00/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE		
F 656	The gray fall mat was upright against the wabed. There was no fanext to either side of an ext to either side of the scoop mattress resident had no recer and and halp legia and hemiplegia and hemiplegia and hemiplegia and hemiplegia and hemiplegia and Alzheimer's disease Review of the annual 5/1/18 indicated Resicognitively intact, required five staff for bed motion of upper and I side, and had no falls. The Care Plan reveal	af folded and positioned all on the right side of the ll mat on the floor positioned the bed. In 6/7/18 at 3:32 p.m., MDS dent #34 had right side ealed the resident was was able to move her body at throw her leg over the side s. She stated that the nt falls. Is admitted to the facility on sees which included: paresis following cerebral at non-dominant side, the behavioral disturbance, ase. Minimum Data Set dated dent #87 was moderately, uired extensive assistance obility, was totally dependent ers, had impaired range of ower extremities on one.	F		requirements; The Director of Nursing and/or Minimum Data Set Coordinator will review 5 residents with orders for splints/braces to ensure that it is implemented as ordered and that is it planned. The Director of Nursing and/of Minimum Data Set Coordinators will review 5 residents with care plan interventions to have a fall mat beside their bed while in bed to ensure that the plan of care is being implemented. Thi will be done on weekly basis to include weekend for 4 weeks then monthly for months. Reports will be presented to the weekl Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concernsinitiated as appropriate. The weekly Quality Assurance Meeting is attended the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursi	e s e the 3 y e s l by	
	physical harm related secondary to cerebro hemiplegia, and was left lower extremity. In cushioned fall mat at position.	ity to falling that may cause I to unsteady balance vascular disease with left non-weight bearing of her nterventions included: a bedside; and, bed in low 18 at 8:06 a.m. and on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		C 06/08/2018	
NAME OF PROV	/IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	06/08/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION	
6/ th w file w D (r n n th th or 3. 12 he in v a de re or Ti re In sp re	the low position near as not next to the beauting as not next to the beauting as not next to the beauting an interview of the next to the beauting assistant) states as a several properties of the latest properties as a latest properties and had not be latest properties as a latest properties as a latest properties as a latest properties and had not be latest properties as a latest properties and had not be latest properties and had not be latest properties as a latest propertie	Resident #87 was in bed in the door, but the fall mat ed. The fall mat was on the fall mat was on the fall the room, beneath the set. The fall mat was on the fall mat was a would often wiggle down in ed when the resident was in was to be placed on the floor e bed. Admitted to the facility on sees which included: be bed. Admitted to the facility on sees which included: be bed. Admitted to the facility on sees which included: be bed. Admitted to the facility on sees which included: be bed. Admitted to the facility on sees which included: be bed. Admitted to the facility on sees which included: be bed. Admitted to the facility on sees which included: be bed. Admitted to the facility on sees which included: be bed. Admitted to the facility on sees which included: be seed the facility near the facility on the schedule. Admitted to the facility on sees which included: believe and lower extremities on falls. Between the facility on sees which included: believe application of the schedule; and assist with according to the schedule. Between the fall mat was on the fall mate was in was	F 65	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 06/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	_	00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page Interventions include and off at bedtime.	ge 19 ed: hand splint on in morning	F 6	56		
	a.m., 6/6/18 at 1:28 revealed the resider	p.m., and 6/7/18 at 10:55 p.m., and 6/7/18 at 9:44 a.m., nt without a splinting device on land. There was no splinting resident's room.				
	NA#5 (nursing assis apply the hand splir left hand at the begi	on 6/06/18 at 1:36 p.m., stant) revealed that she would at to Resident #87's contracted inning of her shift for four he time the resident would rd it in the bed.				
	Administrator stated should have reported #87 frequently removed.	on 6/7/18 at 10:15 a.m., the distribution that the nursing assistants and to the nurse that Resident oved the hand splint then the MDS nurse so the resident's updated/revised.				
	11/1/16 with diagnormellitus with neurop	as admitted to the facility on ses which included: diabetes pathy, and a history of attack and cerebral infarction s.				
	Summary dated 12/ was to receive resto	pational Therapy Discharge 16/16 revealed Resident #114 orative nursing for the t, resting hand splint.				
	indicated Resident required extensive a	m Data Set dated 5/15/18 #114 was cognitively intact; assistance of two staff with nsfers; had impaired range of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		C 06/08/2018
NAME OF PROVIDE	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
mo sid: The reverse of correct of	e; and had no fall e review of the Ca ealed Resident # ated to the inabilit daily living) satisfa ebrovascular acc akness and contr nd. Interventions e-position and tu arter side rails for e. ere was no Care ge of motion serve Resident #114's ring an observation e fingers of the re ard the palm of the nt was observed ated to the right of the Resident #114 applied to her ha family applied it. ring an observation sident #114 was a self lunch. The b on a stack of other 6/7/18 at 2:00 p. served sitting uprint on her right ha	and lower extremities on one is. are Plan dated 5/30/18 are plan da	F 65		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY PLETED
			7 56.25				С
		345284	B. WING _			06/	08/2018
THE OAK	ROVIDER OR SUPPLIER			STREET ADDRESS, CI 901 BETHESDA ROA WINSTON SALEM,	ND.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	notice the resident's ricidid not observe a split the nursing assistant nursing assistant) did had a splint. At this por Nurse#2 excused her an observation of the returning to the intervishe observed a hand nightstand and the received that if the resident had a split the care plan. Care Plan Timing and CFR(s): 483.21(b)(2)(2)(2)(3)(4)(2)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	ent#114 during care, she did ight hand contracture, but nting device in the room and (could not recall which not indicate the resident bint of the interview MDS is left from the room to make resident in her room. Upon iew, MDS Nurse#2 revealed splint on Resident#114's sident informed her that she want the splint applied. MDS is she had been made aware lint, it would have been on It Revision (i)-(iii) Pensive Care Plans or been sive care plan must it days after completion of its essessment. It is endicated to-resician. It is with responsibility for the it is and nutrition services staff. It is and nutrition services staff. It is included in a resident's conticipation of the resident resentative is determined	F				7/5/18

OVIDER OR SUPPLIER	345284			
OVIDER OR SUPPLIER		B. WING		C 06/08/2018
THE OAKS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 00/00/2018
(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
(F) Other appropriate disciplines as detern or as requested by the disciplines as detern or as requested by the disciplines as detern after each assect of the assessments. This REQUIREMEN by: Based on observation interviews, the facility care plan to reflect of (Resident #81) resided daily living (ADLs). The findings included Resident #81 was as 8/16/17 with diagnost fracture. A review of the admit (MDS) assessment of presence of a fracture of the quark not indicate the presence.	e staff or professionals in nined by the resident's needs he resident. vised by the interdisciplinary essment, including both the quarterly review T is not met as evidenced ons, record review and staff y failed to update a resident's ast removal for 1 of 7 ents reviewed for activities of d: dmitted to the facility on ses, in part, of left ankle ssion Minimum Data Set dated 8/23/17 revealed the re. terly MDS dated 2/11/18 did ence of a fracture.	F 65	The statements made on this Plan or Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or watake the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F657 CARE PLAN TIMING AND REVISION. The plan of correcting the specific deficiency. The plan should address processes that lead to the deficiency cited,	nd do e vill of e ted.
related to limited bed from left ankle fractu An observation on 6, resident sitting up in observation of a cas	d mobility secondary to pain re and presence of cast." /3/18 at 10:37 AM revealed her wheelchair with no to her left ankle.		7(Resident #81) residents reviewed f activities of daily living. (ADLs). Minimodal Data Set Nurse did not resolve the caplan once cast was removed.	or mum are
	Continued From pag (F) Other appropriate disciplines as detern or as requested by the (iii)Reviewed and reviewed and assessments. This REQUIREMEN by: Based on observation interviews, the facility care plan to reflect to (Resident #81) resided aily living (ADLs). The findings included Resident #81 was as 8/16/17 with diagnost fracture. A review of the admit (MDS) assessment to presence of a fracture of the quart not indicate the president approblem of "risk for related to limited bed from left ankle fracture. An observation on 6 resident sitting up in observation of a cas. An interview with ME	This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update a resident's care plan to reflect cast removal for 1 of 7 (Resident #81) residents reviewed for activities of daily living (ADLs). The findings included: Resident #81 was admitted to the facility on 8/16/17 with diagnoses, in part, of left ankle	Continued From page 22 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update a resident's care plan to reflect cast removal for 1 of 7 (Resident #81) residents reviewed for activities of daily living (ADLs). The findings included: Resident #81 was admitted to the facility on 8/16/17 with diagnoses, in part, of left ankle fracture. A review of the admission Minimum Data Set (MDS) assessment dated 8/23/17 revealed the presence of a fracture. A review of the quarterly MDS dated 2/11/18 did not indicate the presence of a fracture. A review of the care plan dated 4/27/18 revealed a problem of "risk for impaired skin integrity related to limited bed mobility secondary to pain from left ankle fracture and presence of cast." An observation on 6/3/18 at 10:37 AM revealed resident sitting up in her wheelchair with no observation of a cast to her left ankle. An interview with MDS nurse #1 on 6/7/18 at 1:44	Continued From page 22 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update a resident's care plan to reflect cast removal for 1 of 7 (Resident #81) residents reviewed for activities of daily living (ADLs). The findings included: The statements made on this Plan of Correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or vertice that the actions set forth in this Plan of Correction. The Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated the presence of a fracture. A review of the admission Minimum Data Set (MDS) assessment dated 8/23/17 revealed the presence of a fracture. A review of the quarterly MDS dated 2/11/18 did not indicate the presence of a fracture. A review of the care plan dated 4/27/18 revealed a problem of "risk for impaired skin integrity related to limited bed mobility secondary to pain from left ankle fracture and presence of cast." An observation on 6/3/18 at 10:37 AM revealed resident sitting up in her wheelchair with no observation of a cast to her left ankle. An interview with MDS nurse #1 on 6/7/18 at 1:44

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING COMPLI			X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 06/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 901 BETHESDA ROAD WINSTON SALEM, NC 2710		00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIAT EIENCY)	(X5) COMPLETION DATE
F 657	clinical meeting. All c quarterly. MDS nurse have removed the ca plan but she missed An interview with the 3:15 PM revealed he	receives during the daily if the care plans are updated #1 revealed she should st from Resident #81's care	F	On 6/18/2018 through 6 Quality Assurance Nurs Minimum Data Set Coo all current residents wit interventions with the p No current resident in the cast and no intervention of cast. On 6/26/2017 through 7 Quality Assurance Nurs serviced the Minimum If Coordinator that the fact and implement a complete corresident and it has to be 7 days after completion comprehensive assess interdisciplinary team we not limited to the attenda registered nurse with resident, a nurse aide of the resident, a mem nutrition services staff, practicable, the particip resident and the reside (s). An explanation mus resident's medical reconstruction of the resident representative practicable for the deveresident's care plan. When a cast is remove must be updated to reflee the feeting of the resident of the resident of the resident of the resident of the deveresident's care plan. When a cast is remove must be updated to reflee the feeting of the resident of the resident of the resident of the resident of the deveresident's care plan. When a cast is remove must be updated to reflee the feeting of the resident of the resident of the resident of the resident of the deveresident's care plan.	se Consultant and ordinators reviewed h care plan resence of cast. The facility has a noreflects presence of the cast of the se Consultant in Data Set collity must develop rehensive plan for each the developed withing physician, a responsibility for the with responsibility for the	ed ce

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C 06/08/2048
NAME OF PE	ROVIDER OR SUPPLIER	040204		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	06/08/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 657	Continued From pag	e 24	F 65	been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify the the change has been sustained. The monitoring procedure to ensure the plan of correction is effective and to specific deficiency cited remains corrected and/or in compliance with the regulator requirements; The Director of Nursin and/or Minimum Data Set Coordinator will review 5 residents to ensure that a comprehensive care plan is developed within 7days after completion of the comprehensive assessment and it is revised timely. This will be done on we basis to include the weekend for 4 we then monthly for 3 months. Reports will be presented to the weekend Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns initiated as appropriate. The weekly Quality Assurance Meeting is attended the Director of Nursing, Wound Nurse Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator.	e aat nat that that totted bry g s a d d eekly eks ly re is
F 658 SS=D	CFR(s): 483.21(b)(3) §483.21(b)(3) Complete Services provide	eet Professional Standards (i) rehensive Care Plans d or arranged by the facility, mprehensive care plan,	F 65	8	7/5/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
TO THE OT THE	TO VIDER OR OUT FEET						
THE OAKS	3				THESDA ROAD		
				WINST	ON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	e 25	F 6	58			
	by:	standards of quality. is not met as evidenced ns, record review, and staff		Th	e statements made on this Plan of		
	and resident interview physician orders to ol	vs the facility failed to follow btain daily weights and		Cor not	rrection are not an admission to and constitute an agreement with the	l do	
	report changes to the				eged deficiencies. To remain in		
	residents (Resident #	,			npliance with all Federal and State		
	condition with shortness of breath and chest discomfort.			1 7	gulations the facility has taken or wi		
	discomfort.			I	e the actions set forth in this Plan of rrection. The Plan of Correction	í	
	Findings include:			I	rection. The Plan of Correction is its titutes the facility's allegation of		
	Findings include.			I	npliance such that all alleged		
	Resident #117 was a	dmitted to the facility on		I	iciencies cited have been or will be		
		es that included chronic atrial		I	rected by the date or dates indicate	d.	
	_	on (high blood pressure),		F65	-		
		ers, and chronic systolic		PR	OFESSIONAL STANDARDS.		
	congestive heart failu	-		The	e plan of correcting the specific		
	-			def	iciency. The plan should address th	е	
	The admission Minim	um Data Set (MDS) dated		pro	cesses that lead to the deficiency		
	5/21/18 specified the	resident had intact		cite	ed,		
	cognition, no behavio	rs or rejection of care.		The	e facility failed to follow physician		
		ed two person extensive			ers to obtain daily weights and repo	rt	
		obility, transfers, toilet use,			anges to the physician for 1 of 1		
		uired one person extensive		I	idents (Resident #117) with change		
		notion on/off unit, dressing,		I	ndition with shortness of breath and		
		hygiene. The resident was		I	est discomfort. Nurse did not		
	_	owel movements, had an		I	cument daily weight obtained by nur	se	
		heter, and was administered		I	e in the electronic health record.		
	_	during that assessment			sident #117: Daily Weight was		
	period.				ained, Medical Doctor was notified,		
	Dovious of the residen	atta aara nian datad far			v orders implemented per physician	1	
		nt's care plan dated for			ers, Care plan revised.		
		sident #117 had Congestive			e procedure for implementing the ceptable plan of correction for the		
		with goals to be free of		I	•		
		velling) and for his body			ecific deficiency cited;		
	_	in normal limits through the			6/18/2018 through 6/27/2018 the	nd	
		ations to be in place were to and monitor/document for			ality Assurance Nurse Consultant a it Manager reviewed all current	iu	
	CHECK DIEATH SOUTIUS	and monitor/document for	1	UIII	it ivianayer reviewed all current		

PRINTED: 07/30/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			5 4//40			С
		345284	B. WING			6/08/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS				901 BETHESDA ROAD		
THE UAK	•			WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	Continued From page	e 26	F 65	8		
	and to monitor/docun needed of any signs dependent edema of edema, shortness of skin, dry cough, diste weight gain unrelated wheezes upon auscu	and/or fatigue, increased		residents with daily weights to daily weights were obtained as physician orders and that physician orders. On 6/26/2017 through 7/5/2018 Quality Assurance Nurse Consisterviced the all nurses (Registruciense Practical Nurses) and Aide that the facility must ensure services provided or arranged.	s per ician was lition 8 the sultant in ered Nurse, Medication re that the	
	placed on 6/4/2018 to obtained every eveni	ng shift.		facility as outlined by the comp care plan meet professional sta quality. Daily weights have to daily per physician orders, phy orders have to be followed and	orehensive andards of be obtained sician I to	
	6/2/18) 6/3/2018 5:47 PM - 2	236.8 pounds (Lbs) - 236.8 Lbs 237.2 Lbs 235.9 Lbs 236.3 Lbs 234.0 Lbs rained from 5/25/18 through		immediately notify physician of change of condition. Effective 7/5/2018, this training incorporated into the new emp orientation program. This infor been integrated into the standard orientation training and in the rein-service refresher courses for employees and will be reviewed Quality Assurance Process to the change has been sustained.	is loyee mation has ard equired r all d by the verify that d.	
	8:39 AM the resident oriented, and was ea that he had just been speech therapy but w continuous feeding the resident did not exhibit	nrough his PEG tube. The bit any signs or symptoms of as unlabored, no obvious		The monitoring procedure to end the plan of correction is effective specific deficiency cited remains and/or in compliance with their requirements; The Director of and/or Unit Manager will review including the weekend, 5 resid daily weights ordered to ensure weights are obtained per physicand that physician has been not specific to the plant of the plant	ve and that ns corrected regulatory Thursing v weekly, ents with e that daily cian orders	

Facility ID: 923497

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _		٠,	C 6/ 08/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 901 BETHESDA ROAD WINSTON SALEM, NC 27103	•	3/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	resident #117 was shortness of breath The resident stated discomfort, was ov couldn't catch his be was flushed and pe around eyes) was obtained his daily withey had not weighthat it was not done that he had not refund that he had not refund that she noticed thin not been obtained. She stated that wei according to the rewere not ordered to hadn't realized the surveyor informed observed (shortness the resident had strouldn't catch his bewere aware and that soon as possible During an interview Regional Nurse Coshe stated that it we follow physician or to obtain daily weights were	tion on 6/07/18 9:41 AM in bed and presented with in and was holding his chest. If he was having chest erall very uncomfortable and breath. The resident's face eriorbital edema (swelling moted. When asked if they had weight that morning, he stated led him yet, and also stated led daily, only on occasion, and used at any time. If with Nurse #50 on 6/07/18 ked about weights and stated les morning that a weight had When shown the weight log ghts were not done daily cords and stated that they be done on her shift, so she of weren't being done. This Nurse #50 of the symptoms so of breath, holding chest, and lated he felt uncomfortable and lated he felt uncomfortable and lated he self thought would be obtained	F6	any change of condition. This on weekly basis to include the for 4 weeks then monthly for Reports will be presented to Quality Assurance Committed Director of Nursing to ensure action for trends or ongoing initiated as appropriate. The Quality Assurance Meeting if the Director of Nursing, Wood Minimum Data Set Coordinated Manager, Therapy, Health It Manager, Dietary Manager and Administrator.	ne weekend r 3 months. the weekly ee by the e corrective concerns is e weekly s attended by und Nurse, ator, Unit information		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345284	B. WING _			C 06/08/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		5070072010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	Continued From pag for residents with CH tube feedings.	e 28 F, especially with continuous	F 6	58		
	2:23 PM she stated spound weight gain" by provider at that time. she felt it was import pound weight gain when stated she did not because it was the finhad restarted daily weight gain when the stated she did not because it was the finhad restarted daily weight gain.	with Nurse #50 on 6/07/18 at the was aware of the "10 out had not called to notify the When this surveyor asked if ant to notify providers of a 10 out to someone who has CHF out feel it was necessary rest one obtained since they eights, but that she was the provider for the resident's in and cough.				
	stated that the Nurse and notified about we New orders were pla	Note from 6/7/2018 2:42 PM Practitioner (NP) was called eight gain and congestion. ced for chest x-ray and one 20mg tablet by mouth. NP w up in the morning.				
F 677 SS=D	facility's MD stated the report a 10 pound we well as the shortness other signs or symptodepending on the co-could possibly required hospital for further expenses.	or Dependent Residents	F 6	77		7/5/18
	out activities of daily services to maintain personal and oral hy	dent who is unable to carry living receives the necessary good nutrition, grooming, and giene; Γ is not met as evidenced				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		C	
NAME OF D	DOVIDED OD CUDDUED	343204		STREET ADDRESS, CITY, STATE, ZIP CODE	06/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER					
THE OAKS	3			901 BETHESDA ROAD		
				WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 677	Continued From page	29	F 677	7		
	by:			The state of the s	,	
		ns, record review, staff and		The statements made on this Plan o		
		ews, the facility failed to		Correction are not an admission to a	nd do	
	· •	are for 1 of 7 residents		not constitute an agreement with the		
	· · ·	ing assistance with Activities		alleged deficiencies. To remain in		
	of Daily Living (ADLs)).		compliance with all Federal and State		
	The fire discussion aloude of	_		Regulations the facility has taken or v		
	The findings included	:		take the actions set forth in this Plan	OT	
	1 Decident #60 was	admitted to the facility on		Correction. The Plan of Correction		
		_		constitutes the facility's allegation of compliance such that all alleged		
	ZIZZI I I With diagnose	es, in part, of Alzheimer's.		deficiencies cited have been or will b		
	A ravious of the guarte	orly Minimum Data Sot		corrected by the date or dates indica		
	A review of the quarterly Minimum Data Set (MDS) assessment dated 4/10/18 revealed the			corrected by the date of dates indica	leu.	
	, ,	impaired cognition and		F677 ADL CARE PROVIDED FO		
	_	sistance of two people for		DEPENDENT RESIDENTS.		
	-	and hygiene and was		The plan of correcting the specific		
	always incontinent of			deficiency. The plan should address	the	
	always incontinent of	bidder.		processes that lead to the deficiency		
	A review of the care r	plan dated 4/20/18 revealed		cited:		
		ence with an intervention of		The facility failed to failed to provide		
	needing assistance w			incontinent care for 1 of 7 residents		
				(Resident #60) requiring assistance v	vith	
	An observation on 6/4	1/18 at approximately 4:15		Activities of Daily Living (ADLs). Nurs		
		lying in bed. A urine odor		aide did not provide incontinent care		
		resident had a large, circular		resident was combative and was wai		
	-	to the pad underneath him.		for assistance.		
		·		Resident #60: Incontinence care was		
	An observation on 6/5	5/18 at 8:34 AM revealed the		provided per plan of care.		
		A strong urine odor was		The procedure for implementing the		
		and, upon entering the		acceptable plan of correction for the		
	resident's room, a lar	ge, circular brownish area		specific deficiency cited;		
	noted to the pad unde	erneath him.		On 6/25/2018, the Director of Nursing	g and	
				Unit Manager began in-servicing the		
	An observation on 6/5	5/18 at 8:45 AM revealed		nursing staff (Registered nurses and		
	Nurse Aide (NA) #1 ir	n Resident #60's room		Nurse Aides: Full time, Part time and		
	feeding him breakfast	. Incontinent care had not		PRN) that a resident who is unable to)	
	been provided and th	e urine odor remained.		carryout activities of daily living recei-		
				the necessary services to maintain g	boc	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		0.4500.4	D. MING		С
		345284	B. WING		06/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE OAKS	2			901 BETHESDA ROAD	
THE OAK	•			WINSTON SALEM, NC 27103	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 677	Continued From page	÷ 30	F 67	7	
	Continuous observati	on was conducted on 6/5/18		nutrition, grooming, and personal ar	id oral
		10:30 AM. There were no		hygiene; The facility must ensure to	
	staff observed enterin	g the resident's room.		provide incontinence care per plan of	of
				care.	
	At approximately 10:3	30 AM on 6/5/18, Hospice			
	NA #1 entered the roo	om. An observation at that		As of 7/5/2018 no nursing staff	
	time revealed the Hos	spice NA pull the top sheet		(Registered nurses and Nurse Aides	s: Full
	off the resident and st	ate "he's soaked". The		time, Part time and PRN) will be allo	wed
	resident's top sheet, b	orief, pad and bottom sheet		to work until the training has been	
		he resident's t-shirt was wet		completed. Effective 7/5/2018, this	
	•	a brownish colored stain		training is incorporated into the new	
		nded. A strong urine odor		employee orientation program. This	
	was present. An observation of resident's skin did			information has been integrated into	
	not indicate any redne	ess or open areas.		standard orientation training and in t	
				required in-service refresher course	
	An interview with NA			all employees and will be reviewed I	
		AM revealed she knew the		Quality Assurance Process to verify	that
		ent when she was feeding		the change has been sustained.	
	him, but couldn't do it			The man it will be a second on the second	414
		bative so she told NA #2,		The monitoring procedure to ensure	
	who was assigned to	Resident #60.		the plan of correction is effective and	
	An intonvious with NIA	#2 on 6/5/19 of		specific deficiency cited remains cor	
	An interview with NA	AM revealed he checks the		and/or in compliance with the regula requirements; The Director of Nurs	, I
		ence every 2 hours. He		Unit Manager will observe 5 residen	_
	stated he did not know			each week to include the weekend v	
		akfast and did not answer		are unable to carry out Activities of I	
	_	had told him the resident		Living to ensure that they had	Jany
		g breakfast. He stated he		incontinence care provided per plan	of
		at 6:00 AM and 9:00 AM		care by using a quality assurance (C	
		was revealed the resident		survey tool This will be done weekly	-
	_	at 9:00 AM, he stated that		weeks then monthly for 3 months.	
	he changed him at 6:			Reports will be presented to the wee	ekly
	G			Quality Assurance Committee by the	
	An interview with the	Corporate Nurse Consultant		Director of Nursing to ensure correc	
		revealed incontinent care is		action for trends or ongoing concern	
	provided per the care	plan. If the care plan		initiated as appropriate. The weekly	,
	indicated the resident	was incontinent and		Quality Assurance Meeting is attend	ed by
	needed assistance wi	th incontinent care, she		the Director of Nursing, Wound Nurs	se,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.4500.4				l	С
		345284	B. WING _			06/	08/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	3		901 BETHESDA ROAD				
0/			WINSTON SALEM, NC 27103		VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	frequently to see if income She further revealed s	f to check the resident continent care was needed. she would not expect staff to sident if they were aware the	F	677	Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursin	ια	
F 686 SS=D	CFR(s): 483.25(b)(1)(§483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre	rity re ulcers. hensive assessment of a	F (686		3	7/5/18
	professional standard pressure ulcers and dulcers unless the individemonstrates that the (ii) A resident with prenecessary treatment with professional stan promote healing, prevnew ulcers from deve This REQUIREMENT by:	care, consistent with s of practice, to prevent loes not develop pressure vidual's clinical condition by were unavoidable; and essure ulcers receives and services, consistent dards of practice, to rent infection and prevent loping.			The statements made on this Plan of		
	facility failed to compl assessments that incl wound for 1 of 3 resid reviewed for pressure Findings included: Resident #67 was add				The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or wil take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged	I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			1	C 08/2018
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	00.20.0
				g	901 BETHESDA ROAD		
THE OAKS	3			٧	WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	e 32	F6	386			
	peripheral vascular di	isease, end stage renal			deficiencies cited have been or will be		
	disease and non-Alzh				corrected by the date or dates indicate	d.	
					F686 TREATMENT/SVCS TO		
	A review of the annua	al Minimum Data Set (MDS)			PREVENT/HEAL PRESSURE ULCER		
	assessment dated 4/	16/18 revealed Resident #67			The plan of correcting the specific		
	had severely impaired	d cognition. She had an			deficiency. The plan should address th	е	
		sue injury pressure ulcer and			processes that lead to the deficiency		
	received pressure uld	cer care.			cited;		
					The facility failed to complete weekly		
	A review of the care p				pressure ulcer assessments that include	led	
	revealed a problem of, "Currently has susped deep tissue injury (SDTI) to left heel related to immobility." Care plan interventions included				measurement of the wound for 1 of 3		
					residents. (Resident #67) reviewed for pressure ulcers.		
	•	ts as ordered and monitor			Resident #67: Weekly pressure ulcers		
		ep pillows beneath calves to			assessment that included measurement		
		Observe/document/report to			of the wound was completed weekly.		
		skin status: appearance,			Wound documentation was completed	by	
	color, wound healing,				the physician and the treatment nurse	-	
	infection, wound size	, stage."			in training. Treatment nurse had not completed facility required wound		
	A review of physician	(MD) order dated 3/23/18			documentation.		
	revealed, "Skin prep t	to left heel daily every day			The procedure for implementing the		
	shift for wound care."				acceptable plan of correction for the		
					specific deficiency cited;		
		y pressure ulcer review			On 6/27/2018-6/29/2018 weekly press		
		ed an onset date of 3/22/18.			ulcers assessments were completed b	-	
		community acquired and was			Wound Nurse for all residents who have	е	
	unstageable. The wo	ound was not measured.			pressure ulcers.		
	A review of the weekl	y pressure ulcer review			On 6/25/2018, the Director of Nursing	and	
	dated 4/2/18 revealed	T - T			Unit Manager began in-servicing the	2110	
	measured.				nurses (Registered nurses and License	Э	
					Practical Nurse: Full time, Part time an		
	A review of the weekl	y pressure ulcer review			PRN) that the facility must ensure that		
	dated 4/9/18 revealed	the assessment had not			resident receives care, consistent with		
	been completed and	was "in progress."			professional standards of practice, to		
					prevent pressure ulcers and does not		
		rogress note dated 4/25/18			develop pressure ulcers unless the		
	revealed a wound to	the back of the left heel that			individual's clinical condition demonstra	ates	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345284	B. WING _			06	/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE			
	_			901	1 BETHESDA ROAD			
THE OAK	5			WI	NSTON SALEM, NC 27103			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F 686	Continued From pa	ge 33	F 6	686				
	measured 1.5 centil	meters (cm) by 1 cm.			that they were unavoidable. The facilit	y		
	Diagnosis included,	"SDTI of unknown depth of			must ensure that a resident with press	ure		
		pply skin prep to the back of			ulcers receives necessary treatment a	nd		
	the heel daily."				services, consistent with professional			
					standards of practice, to promote heal	-		
		kly pressure ulcer review			prevent infection and prevent new ulce	ers		
		aled a measurement of 1.5cm			from developing. The facility must			
	by 1.0 cm.			complete weekly pressure ulcers				
	A manufactured the a manage	lical record revealed re-			assessments that include measureme			
		lical record revealed no			of the wounds weekly for residents wh			
		ews or measurements were reeks of 4/16/18, 4/30/18,			have pressure ulcers. Weekly pressur ulcer assessments will be completed	е		
	5/7/18, 5/14/18, or \$				weekly by the wound nurse and or Un	iŧ		
	3///10, 3/14/10, 0/ 3	5/20/10.			Manager.			
	On 6/6/18 at 8:51 A	M an interview was completed			Managor.			
		A) #4. He stated while the new			As of 7/5/2018 no nursing staff			
	I	s in orientation he helped			(Registered nurses and License Pract	ical		
		tments. He said Resident #67			Nurse: Full time, Part time and PRN) v			
	had the wound on h	er left heel "for a while" and			be allowed to work until the training ha	as		
	that the Medical Dir	ector staged the wound each			been completed. Effective 7/5/2018, the	าis		
	week.				training is incorporated into the new			
					employee orientation program. This			
		M an interview was completed			information has been integrated into the			
		sultant. She said wound			standard orientation training and in the			
		ne as ordered and a weekly			required in-service refresher courses f			
		impleted to measure the			all employees and will be reviewed by			
	-	the location and type of tissue.			Quality Assurance Process to verify th	at		
		ical Director completed his			the change has been sustained.			
		of the wound and that unless			The manitoring procedure to enquire th	a o t		
	_	in the wound the Medical rite a new pressure ulcer note.			The monitoring procedure to ensure the plan of correction is effective and the plan of correction is effective.			
	Director wouldn't Wi	ite a new pressure dicer note.			specific deficiency cited remains corre			
	On 6/6/18 at 2:15 P	M an interview was completed			and/or in compliance with the regulato			
		or. She stated the previous			requirements; The Director of Nursin			
		in April and the Director of			Unit Manager will review 5 residents e	•		
		Supervisor had rounded with			week, who have pressure ulcers to en			
	_	r when he assessed wounds.			that a weekly pressure ulcer assessme			
		id not answer as to why the			that included measurement of the wou			
		er reports and measurements			has been completed by using a quality			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345284	B. WING _				08/2018
NAME OF PI	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 BETHESDA ROAD VINSTON SALEM, NC 27103	1 00/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	with the Medical Direct #67's wound to her let had improved and "Wasaid the facility had the nurses in the past year turnover they had los wound documentation wound reviews and make weekly.	an interview was completed ctor. He stated Resident ft heel started at the facility, where expected here out today." He are different treatment for and because of the treatment in completing in but stated he expected heasurements be completed expected heasurements be completed.		6886	assurance (QA) survey tool This will be done for 4 weeks then monthly for 3 months. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing Months.	/ ess by	7/5/18
SS=D	resident who enters the range of motion does range of motion unless condition demonstrate of motion is unavoidal §483.25(c)(2) A reside motion receives appropriate §483.25(c)(3) A reside receives appropriate of the receives appropriate of the receives appropriate of the range of motion receives appropriate of the receives appropriate of the range of motion demonstrates of the range of the ran	cility must ensure that a ne facility without limited not experience reduction in as the resident's clinical es that a reduction in range ble; and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION		PLETED
		345284	B. WING _			1	C 08/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
THE 041/	_			90	01 BETHESDA ROAD		
THE OAKS	5			W	VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 688	Continued From page	e 35	F 6	888			
	reduction in mobility i This REQUIREMENT by:	able independence unless a s demonstrably unavoidable. is not met as evidenced					
	and staff interviews, t application of a splint management for 3 of	6 sampled residents , and #69) reviewed for			The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or with the patients and forth in this Plan.	II	
	Findings included:				take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility sallegation of compliance such that all alleged	Ī	
	12/10/14 with diagnor hemiplegia and hemi infarction affecting lef	paresis following cerebral t non-dominant side, th behavioral disturbance,			deficiencies cited have been or will be corrected by the date or dates indicate F688 INCREASE PREVENT DECREASE IN ROM MOBILITY. The plan of correcting the specific		
	dated 5/1/18 indicate moderately, cognitive assistance of two star dependent of two star	ly intact, required extensive ff for bed mobility, was totally ff for transfers, had impaired per and lower extremities on			deficiency. The plan should address the processes that lead to the deficiency cited, The facility failed to provide application a splint/brace for contracture management for 3 of 6 sampled reside (Resident #87, #114, #69) reviewed fo limited range of motion. Resident #87: Splint / Brace applied per second processes that lead to the processes that lead to the deficiency as the processes that lead to the deficiency as the processes that lead to the deficiency are the processes that lead to the deficiency are the processes that lead to the deficiency are the processes that lead to the deficiency as the processes that lead to the deficiency are the processes that lead to the processes the processes that lead to the processes the processes that lead to the processes the processes that lead to	n of ents r	
	restorative nursing fo Interventions included splint according to the removal of the brace The Care Plan also re impaired physical mo	ed Resident #87 received r splinting/brace application. d: assist with application of e schedule; and assist with according to the schedule. evealed Resident #87 had bility related to left sided alance, and coordination due by ascular accident.			plan of care and as indicated on the Medication Administration Record per physician orders. Resident #114: Splint / Brace applied plan of care and as indicated on the Medication Administration Record per physician orders. Resident #69: Splint / Brace applied per plan of care and as indicated on the Medication Administration Record per	per	

PRINTED: 07/30/2018 FORM APPROVED OMB NO. 0938-0391

I ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		345284	B. WING _			06	08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	,			901 BET	THESDA ROAD		
THE OAK	•			WINST	ON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page		F 6	88			
	and off at bedtime.	d: hand splint on in morning		Car	vsician orders. re plan was not implemented by sta resident #87, #114, #69 due to lack		
		entation Survey Reports of			owledge.		
	completed tasks by the assistants included: F	PROM (passive range of		I	e procedure for implementing the ceptable plan of correction for the		
		or 15 minutes daily. Apply			ecific deficiency cited;		
	splint during day, leav	e on for 4-6 hours. Observe		On	6/18/2018 through 6/27/2018 the		
	skin around splint dai		I	ector of Nursing, Quality Assurance			
	increased swelling ar		I	rse Consultant, Therapy Director, U	nit		
		g and after splint removal.			nager and Minimum Data Set		
	The May 2018 and June 2018 survey reports indicated Resident#87 did not receive PROM			1	ordinators reviewed all current	. f	
		d splint was not applied for			idents with splinting / brace devices ntractures management to ensure the		
		and on June 3, 2018.		I	y were applied per physician orders		
	14 days iii way 2010	and on build 5, 2016.			sing department (Registered nurse	-	
	Observations of Resi	dent #87 on 6/5/18 at 10:55			, Licensed Practical Nurses LPN ar		
		.m., and 6/7/18 at 9:44 a.m.,			rse Aides).		
		without a splinting device on			,		
	her contracted left ha	nd. There was no splinting		On	6/26/2017 through 7/5/2018 the		
	device visible in the r	esident's room.		I	ality Assurance Nurse Consultant a it Manager in serviced the Nurses (
	During an interview o	n 6/06/18 at 1:36 p.m.,		I	LPN) and Nurse Aides (Full time,		
		ant) revealed that she would			e, and PRN) that The facility must		
		to Resident #87's contracted		I .	sure that a resident who enters the		
		ning of the 7:00 a.m. shift for		faci	ility without limited range of motion		
		of the time the resident		doe	es not experience reduction in range	e of	
	would remove it and	discard it in the bed. The NA		mot	tion unless the resident□s clinical		
	stated she ensured p	alm of the resident's		con	ndition demonstrates that a reductio	n in	
		washed during her showers			ge of motion is unavoidable and A		
		ays and Thursdays. During			ident with limited range of motion		
		vas observed removing the			eives appropriate treatment and		
		ack hand roll with finger			vices to increase range of motion a		
		awer in the resident's room.			to prevent further decrease in range		
		olint to the resident's left			tion. A resident with limited mobility		
		ted the resident's hand had			eives appropriate services, equipm		
	small dirt particles an	u nau an ouor.			d assistance to maintain or improve bility with maximum practicable		
	During a closer obser	vation of Resident #87's			ependence unless a reduction in		
	During a closer observation of Resident #87's			Inde	spondonoo unicos a reduction in		1

Facility ID: 923497

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER	1 1 1		STREET ADDRESS, CITY, STATE, ZIP	CODE	1 00/0	70/2010
TO THE OT THE	TO VIDER OR GOTT EIER				0002		
THE OAKS	3			901 BETHESDA ROAD			
				WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 688			F6	88			
	unpleasant odor emit	_		mobility is demonstrably u Splints/Braces have to be physician orders.			
	Administrator stated in nursing was incorport provided to residents assistants should have Resident #87 frequer then the nurse should resident's Care Plan 2. Resident #114 was 11/1/16 with diagnose mellitus with neuropat transient ischemic att with residual deficits. Review of the Occup Discharge Summary Resident #114 was to for the application of The annual Minimum indicated Resident #1 required extensive as bed mobility and transitation of the required extensive as bed mobility and transitations.	ack and cerebral infarction ational Therapy (OT) dated 12/16/16 revealed be receive restorative nursing a right, resting hand splint. Data Set dated 5/15/18 and the set of two staff with sets; had impaired range of		Effective 7/5/2018, this traincorporated into the new orientation program. This been integrated into the st orientation training and in in-service refresher course employees and will be rev Quality Assurance Proces the change has been sust. The monitoring procedure the plan of correction is ef specific deficiency cited re and/or in compliance with requirements; The Direct and/or Minimum Data Set will review 5 residents were the weekend, with orders splints/braces to ensure the implemented /applied as on the done on a weekly basis weekend for 4 weeks them months. Reports will be presented	employee information I andard the required es for all iewed by the s to verify the ained. to ensure the fective and the mains correct the regulator or of Nursing Coordinators ekly including for nat it is ordered This is to include the monthly for to the weekly	at nat cted y y y s s y will ne 3	
	The review of the Carevealed Resident #1 related to the inability of daily living) satisfacerebrovascular accieweakness and contra hand. Interventions in	re Plan dated 5/30/18 14 had a self-care deficit to perform ADLs (activities ctorily, secondary to old dent with residual right side ction to fingers on her right acluded: one staff assistance in bed; and, the use of		Quality Assurance Commi Director of Nursing to ensu action for trends or ongoin initiated as appropriate. T Quality Assurance Meeting the Director of Nursing, W Minimum Data Set Coordi Manager, Therapy, Health Manager, Dietary Manage Administrator.	ure corrective g concerns in the weekly g is attended found Nurse, nator, Unit	s by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C 06/08/2018
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 688 Continued From page 38		ne 38	F 68	38		
F 000	quarter side rails for care. During an observation 11:05 a.m., Resident The fingers of the retoward the palm of the splint was observed located to the right obed. Resident #114 not applied to her hather family applied it. During an observation Resident #114 was sherself lunch. The blowith a stack of other on 6/6/18 at 3:30 p.inursing assistants to medication administration adm	on and interview on 6/4/18 at t #114 was sitting up in bed. sident's right hand were bent he hand. A stained, blue hand hanging from the nightstand of the resident's head of the revealed the hand splint was and every day and only when on 6/6/18 at 1:16 p.m., sitting up in bed feeding ue hand splint was in a chair items. m., after reviewing of the asks records and the retion records of Resident confirmed ble documentation indicating int was applied by facility staff oot. m., Resident#114 was ght in bed with a blue hand	F 68	The title of the person responsimplementing the acceptable correction; Administrator and /or Director	plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 06/08/2018
NAME OF PROV	/IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
3. 5/he A as ha ha ex A a A rig A re th cc A (M be AI OI Re to Tr qu sh re #6 Oi of no	and contractive of the annual seessment dated 8/7 and severely impaired and impairment on booktremity. The view of the care problem of, "right up care plan intervention of the management of the problem of and impairment on the care plan intervention of the management of the manage	admitted to the facility on that included, in part, acture, unspecified joint. I Minimum Data Set (MDS) 7/17 revealed Resident #69 I decision making skills and th sides of her upper Ilan updated 5/2/18 revealed oper extremity contracture." on included, "Apply splint to emove at night." In order dated 2/21/18 put brace on right hand in the evening. Diagnosis: I." In ation Administration Record revealed the brace was to the #69's right hand at 8:00 income.	F6	588		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C 06/08/2018	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 901 BETHESDA ROAD WINSTON SALEM, NC 27103		J 6 /06/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 688	of Resident #69 in he on her right hand. On 6/5/18 at 3:52 PM with Resident #69's F Resident #69 had the before she was admit Family Member report 6/4/18 and 6/5/18 the her right hand and so days. He said he typ five days per week arbrace was not on the On 6/6/18 at 11:11 Al of Resident #69 in the not on her right hand. On 6/6/18 at 11:20 Al completed with Nurse aides (NAs) applied to contracture managen #69's right hand had sometimes the NAs right when they applied the thought the NAs forgon Resident #69's right had sometimes the has forgon Resident #69's right had sometimes the NAs forgon Resident #69's right had sometimed to her in the Resident #69 her har on 6/6/18 at 11:25 Al completed with NA #3 seen Resident #69 w	an interview was completed amily Member. He stated right hand contracture ted to the facility. The red that when he visited on a resident's brace was not on the applied the brace both ically visited Resident #69 and often, when he visited, the resident's hand. Man observation was made a day room. The brace was the braces/splints for the braces/splints for the braces/splints for the last couple of sident's Family Member had the past that when he visited and brace was not on.	F 6	88			
		I an interview was completed r. She stated she expected					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		C 06/08/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 33/05/23/13
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 688	Continued From page	· 41	F 68	88	
	that staff follow the physician order and that the brace be applied daily to Resident #69's right hand.				
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)			9	7/5/18
	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to position fall mats on the floor, next to the beds of 2 of 4 sampled residents (Residents #34 and #87) reviewed for accidents.				
				The statements made on this Plan of Correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and Stat Regulations the facility has taken or	nd do e
	Findings included: 1. Resident #34 was	admitted to the facility on		take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged	of
	and hemiparesis follo affecting the right don	which included: hemiplegia wing cerebral infarction ninant side, dementia with		deficiencies cited have been or will be corrected by the date or dates indicated.	
	Review of the quarter dated 3/20/18 indicate severely, cognitively i assistance of two staf	mpaired; required extensive if for bed mobility and ad range of motion on one had no falls since the		F689 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The plan of correcting the specific deficiency. The plan should address processes that lead to the deficiency cited, The facility failed to position fall mats the floor, next to the beds of 2 of 4 sampled residents (Residents #34 a	the s on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		١ , ,	(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	0.020.		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	5/08/2018	
NAME OF FI	NOVIDER OR SUFFLIER						
THE OAKS	3			901 BETHESDA ROAD			
				WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 689	Continued From pag	e 42	F 68	9			
F 689	The Care Plan dated #34 was susceptible physical harm related her cerebrovascular was non-weight bear Interventions include risks of throwing her a blue fall mat to the the bed was in the lo Observations on 6/03 1:18 p.m., and 6/7/18 Resident #34 in her bregular height (approting The gray fall mat was upright against the word bed. There was no fanext to either side of observations. During an interview of Nurse #1 stated Reshemiparesis. She revnon-ambulatory, but and would sometime of the scoop mattress resident had no received. Resident #87 was 12/10/14 with diagnohemiplegia and hemininfarction affecting less was non-affecting less was susceptible and hemininfarction affecting less was non-ampless and hemininf	4/5/18 revealed Resident to falling which may cause of to hemiplegia secondary to accident; and the resident ing of bilateral extremities. d: remind the resident of the legs over the side of the bed; right side of the; and ensure west position at all times. 3/18 at 9:05 a.m., 6/6/18 at 3 at 1:15 p.m., revealed bed which was raised at eximately 3-feet from floor). It is folded and positioned all on the right side of the latter and the bed during each of the latter at 3.32 p.m., MDS ident #34 had right side was able to move her body is throw her leg over the side is. She stated that the int falls.	F 68	#87) reviewed for accidents. Resident #34: Care plan meeting interdisciplinary team (Social Wo Minimum Data Set Coordinators manager, Hall Nurse, Nurse Aide Administrator, Therapy,) and Re representative held. Reviewed conterventions per care plan, resident had a fall, but is at risk for falmat discontinued as not an approximater intervention for resident. All other interventions are active and approximater #87: Care plan meeting interdisciplinary team (Social Wo Minimum Data Set Coordinators manager, Hall Nurse, Nurse Aide Administrator, Therapy,) and Re representative held. Reviewed conterventions per care plan, resident had a fall, but is at risk for falmat discontinued as not an approximater intervention for resident. All other interventions are active and approximater for implementing acceptable plan of correction for specific deficiency cited; On 6/18/2018 through 6/27/2018 Director of Nursing, Quality Assuntance Consultant, Therapy Direct Manager and Minimum Data Set Coordinators reviewed all current residents with care plan intervent required the use of a fall mat. Cameeting with interdisciplinary team Worker, Minimum Data Set Coordinators reviewed all current required the use of a fall mat. Cameeting with interdisciplinary team Worker, Minimum Data Set Coordinators Reviewed Set Coordinato	orker, , Unit e, sident urrent dent has lls. Fall opriate er ropriate. g with orker, , Unit e, sident urrent dent has lls. Fall opriate er tropriate. the		
		ase. I Minimum Data Set dated ident #87 was moderately,		Unit manager, Hall Nurse, Nurse Administrator, Therapy,) and Re representative held on 6/27/2018-6/29/2018. Reviewed	sident		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			l '	08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103			00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA		(X5) COMPLETION DATE
F 689	of two staff for bed m on two staff for transf motion of upper and I side, and had no falls The Care Plan reveal increased susceptibil physical harm related secondary to cerebro hemiplegia, and was left lower extremity. It cushioned fall mat at position. On 6/3/18 at 8:06 a.m a.m., Resident #87 w near the door, but the bed. The fall mat was of the room, beneath observations. During an interview of (nursing assistant) stanon-ambulatory, but the bed. NA#5 reveal.	uired extensive assistance obility, was totally dependent ers, had impaired range of ower extremities on one ed Resident #87 was at ity to falling that may cause to unsteady balance vascular disease with left non-weight bearing of her nterventions included: a bedside; and, bed in low a. and on 6/5/18 at 10:53 as observed in a low bed e fall mat was not next to the con the floor on the far side the window during both n 6/6/18 at 1:36 p.m., NA#5 ated Resident #87 was would often wiggle down in ed when the resident was in was to be placed on the floor	F	interventions per care plan to mat was an appropriate interveach resident. Care plans recurrent interventions are activappropriate. On 6/26/2017 through 7/5/20 Quality Assurance Nurse Corunit Manager in serviced the and LPN) and Nurse Aides (fime, and PRN) that the faciliensure that the resident environments as free of accident hipossible, and each resident radequate supervision and as devices to prevent accidents, will be implemented per plan. Effective 7/5/2018, this training incorporated into the new emorientation program. This infibeen integrated into the standorientation training and in the in-service refresher courses from the change has been sustain. The monitoring procedure to the plan of correction is effect specific deficiency cited remained/or in compliance with the requirements; The Director and/or Minimum Data Set Cowill observe 5 resident with conterventions to have a fall must be done on weekly basis	vention for vised and ve and v	nd RN Part is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/00/2010	
THE OAK				901 BETHESDA ROAD			
THE OAK	5			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 804 SS=D	CFR(s): 483.60(d)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	ar, Palatable/Prefer Temp (2) drink es and the facility provides- repared by methods that ue, flavor, and appearance; and drink that is palatable, and appetizing is not met as evidenced in, and resident and staff	F 6	weekend for 4 weeks then month months. Reports will be presented to the Quality Assurance Committee by Director of Nursing to ensure coraction for trends or ongoing condinitiated as appropriate. The wee Quality Assurance Meeting is att the Director of Nursing, Wound Minimum Data Set Coordinator, Manager, Therapy, Health Inform Manager, Dietary Manager and the Administrator. The title of the person responsibe implementing the acceptable placorrection; Administrator and /or Director of	weekly the rective cerns is ekly ended by Nurse, Unit nation the le for n of Nursing.	7/5/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION IILDING		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _				08/2018
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
				90	01 BETHESDA ROAD		
THE OAKS	8				/INSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804 Continued From page 45		⇒ 45	F 8	804	or will take the actions set forth in this		
		admitted to the facility on			plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged	on	
	4/20/18 with diagnose hypertension (high blokenal Disease (ESRI			deficiencies cited have been or will be corrected by the dates indicated.			
	hyperlipidemia (high of Minimum Data Set (Minimum Data Set) the resident had intactive of the resident had interested to the resident had been set to the r			F804 NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP The plan for correcting the specific			
	rejection of care, and independent for eatin			deficiency. The plan should address processes that lead to the deficiency cited.			
	stated the resident re	Area Analysis from 4/27/18 ceived hemodialysis three as ordered a liberalized renal			The facility failed to maintain appropriatemperatures and ensure palatability of food items transported with dialysis		
	diet for management order was placed for	of ESRD. A Physician's			residents to the dialysis facility. Reside #80. Food items transported to the dialysis center for resident #80 were	nt	
	#80 on 6/4/18 9:15 Albag was observed in	n and interview with resident M, a large plastic resealable the resident's bag hanging			placed in zip lock bags. The Corporate Dietitian with the Contra Food Management Company purchase		
	wrapped sandwich, a two packs of saltine of	neelchair containing a plastic container of apple sauce, crackers, and a small can of ked about the meal in her			insulated cooler bags on Wednesday, June 6, 2018, which were put into use Friday, June 8, 2018. Dietary staff will place appropriate dialysis meal in coole		
	bag, the resident stat given to take with her dialysis facility, and the	ed that this was the meal to eat for lunch at the nat it is brought to her on the			bag with freezer (ice) pack and deliver resident with breakfast tray. Dietary Management will monitor compliance w	to	
	plastic bag each day stated that the sandw of sandwich meat or p	roximately 8:00 AM in the she went for dialysis. She vich was usually some kind peanut butter and jelly. She of usually eat her meal			The procedure for implementing the acceptable plan of correction for the specific deficiency cited;		
	because it didn't taste temperature by the tire	-			An in-service on Preparing Dialysis Bag was conducted for all Dietary staff on June 6, 2018 by the Corporate Dietitiar with the Contract Food Management	_	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDIN				、
		345284	B. WING			1) 08/2018
NAME OF PI	ROVIDER OR SUPPLIER	I		STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 00/1	70,2010
				901 BE	THESDA ROAD		
THE OAK	8				TON SALEM, NC 27103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 804	Continued From page	e 46	F 8	04			
				Co	ompany. Topics covered included		
	During an interview w	ith the Dietician and			propriate items to be placed in dialy	sis	
	_	ager on 6/07/18 at 1:38 PM,			g, review of updated list of residents		
	when asked about ho	w meals are prepared prior		dia	alysis and their respective diet order	and	
	to transport to the dia	lysis facility for the three		pro	ocedure for packing meal in insulate	d	
	_	iding in the facility, she			oler bag with freezer (ice) pack. An		
		h is wrapped in plastic			dit tool was put into place to monitor		
	separately, a soda, fruit, and crackers were			co	mpliance with this policy on 6/29/18.		
	placed in a large rese						
		ent's on their breakfast trays.			e monitoring procedure to ensure th		
The sandwich was usually some kind of meat				e plan of correction is effective and the			
	such as ham or turkey, or peanut butter and jelly. She stated that the facility had been asked to				ecific deficiency cited remains corre	ctea	
		with insulated bags but that		l l	d/or in compliance with regulatory quirements.		
	it had not been done.	_		100	quirements.		
				Th	e Director of Dining & Nutrition		
	During an interview w	rith Transport on 6/07/18			ervices or designee will monitor pack	ing	
	1:58 PM, she stated t	hat there was no cooler on		of	dialysis bags to ensure that appropr	iate	
	the bus, and that the	residents kept their food		me	eal is in cooler bag(s) with freezer (ic	e)	
	bags with them during	g and after transport to the		pa	ck on dialysis days and delivered to		
		also stated that it took about			sident(s) with breakfast tray using th		
		e to the dialysis facility and		- 1	etary Quality Assurance Audit Tool.		
	that the van had air c	onditioning.			Il be done 5 days per week, including	-	
	D	itte the Administrator and			eekend days, for two months and the		
	_	vith the Administrator and		- 1	eekly for one additional month. Repo		
	-	egional Nurse Consultant on the Administrator stated that			II be presented to the weekly Quality surance meeting by the Administrate		
		aware of the issue and that		- 1	ensure corrective action initiated as	ار	
		to transport the food items		- 1	propriate. Compliance will be monitor	ored	
	_	receiving dialysis. She		1 -	d ongoing auditing program reviewe		
		expectation that staff follow			e weekly Quality Assurance Committ		
		e appropriate temperatures			ie weekly Quality Assurance Meeting		
	and palatability of foo				ended by The Administrator, Directo		
	, ,				ursing, Minimum Data Set Coordinate		
	2)Resident #101 was	admitted to the facility on			erapy, Health Information Manager		
	5/8/18 with diagnoses			the	e Director of Dining & Nutrition Servi	ces.	
		rtery disease, heart failure,					
		ood pressure), End Stage			e title of the person responsible for		
Renal Disease (ESRD), diabetes mellitus,		D), diabetes mellitus,		im	plementing the plan of correction.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 06/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 901 BETHESDA ROAD WINSTON SALEM, NC 27103		00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE
F 804	hyperlipidemia (high obstructive pulmonar Minimum Data Set (N specified the resident behaviors or rejection supervision for eating indicated that the restreatment and a physicallysis treatment through the stated that his breakfast tray in a a turkey sandwich, or ginger ale. He stated because he can't eat day, they weren't apphot soda, and that he three days a week. During an interview wassistant dietary man when asked about ho to transport to the diadialysis residents restated that a sandwick separately, a soda, freplaced in a large resedelivered to the resident's it had not been done. During an interview was us such as ham or turke She stated that the faprovide the resident's it had not been done. During an interview was 1:58 PM, she stated that the faprovide that the faprovide that the stated that the faprovide that the faprovide that a sandwick was us such as ham or turke She stated that the faprovide the resident's it had not been done.	cholesterol), and chronic y disease. The most recent MDS) dated for 6/6/18 thad intact cognition, no not of care, and required y meals. The MDS also ident received dialysis sician order was placed for ee days a week. With resident #101 on 6/07/18 at his food came to him on a plastic bag. It was usually rackers, applesauce, and a dithat he didn't eat his meals the same thing every other betizing, that he can't drink is went for dialysis treatments with the Dietician and larger on 6/07/18 at 1:38 PM, but meals are prepared prior alysis facility for the three iding in the facility, she is wrapped in plastic ruit, and crackers were ealable plastic bag and ent's on their breakfast trays. It is surally some kind of meat y, or peanut butter and jelly. It is with insulated bags but that	F8	The Administrator is respons implementation and completi acceptable plan of correction	ion of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C 06/08/2018	
		345284	B. WING _		0		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 901 BETHESDA ROAD WINSTON SALEM, NC 27103		0/00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 804	10-15 minutes to drive that the van had air that she noticed that meals sent with him would still have the back to the facility. During an interview Quality Assurance of 6/8/2018 at 1:25 PM she had been made coolers were bought for the three resides stated that it was he facility policy to ensure and palatability of for the three resides stated that it was he facility policy to ensure and palatability of for the three resides stated that it was he facility policy to ensure and palatability of for the three resides stated that it was he facility policy to ensure and palatability of for the three resides and hyperlipidemia recent Minimum Dasspecified the resides behaviors or rejection independent for earlindicated that the retreatment and a phydialysis treatment the several attempts when asked about the transport to the control of the	e also stated that it took about rive to the dialysis facility and conditioning. She also stated at resident #101 never ate his in to dialysis, and the bag food in it during transport. I with the Administrator and Regional Nurse Consultant on M, the Administrator stated that e aware of the issue and that in to transport the food items intreceiving dialysis. She er expectation that staff follow sure appropriate temperatures admitted to the facility on ses that included anemia, heart in (high blood pressure), End se (ESRD), diabetes mellitus, (high cholesterol). The most ata Set (MDS) dated for 6/6/18 ent had intact cognition, no on of care, and was ting meals. The MDS also esident received dialysis ysician order was placed for inree days a week.	F	304			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345284	B. WING		C 06/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 06/	06/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 804	stated that a sandwice separately, a soda, freplaced in a large reserved elivered to the reside. The sandwich was us such as ham or turke. She stated that the farm provide the resident's it had not been done. During an interview was 1:58 PM, she stated the bus, and that the bags with them during dialysis facility. She at 10-15 minutes to drive that the van had air controlled.	th is wrapped in plastic uit, and crackers were calable plastic bag and ent's on their breakfast trays. Sually some kind of meat by, or peanut butter and jelly cility had been asked to with insulated bags but that with Transport on 6/07/18 hat there was no cooler on residents kept their food g and after transport to the also stated that it took about the to the dialysis facility and conditioning.	F 80	4		
F 812 SS=F	Quality Assurance Re 6/8/2018 at 1:25 PM, she had been made a coolers were bought for the three resident stated that it was her facility policy to ensurand palatability of foo Food Procurement, St CFR(s): 483.60(i)(1)(3) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procurapproved or consider state or local authoriti (i) This may include for	ore/Prepare/Serve-Sanitary 2) by requirements. re food from sources ed satisfactory by federal,	F 81	2		7/5/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345284	B. WING		C 06/08/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 812	and local laws or reg (ii) This provision doe facilities from using p gardens, subject to o safe growing and foo (iii) This provision do from consuming food §483.60(i)(2) - Store, serve food in accord standards for food se This REQUIREMENT by: Based on observation interview, the facility conditions in the kitch food items were date to store food items of to ensure the kitchen free from soiled cloth equipment during me Findings included: 1. During the initial that 6:36 a.m., a mop in colored water was obtained. In the sink label was a small red buck stained cloths. There against a storage rac dishwashing room. The linen noted on the flot bottom of the closed to the dining room).	ulations. es not prohibit or prevent produce grown in facility compliance with applicable ad-handling practices. es not preclude residents als not procured by the facility. It prepare, distribute and ance with professional ervice safety. To is not met as evidenced one and dietary staff failed to maintain sanitary then by not ensuring resealed and labeled; and by failing for the floor; and by failing as was maintained clean and as/linens and cleaning eal preparation. Our of the kitchen on 6/3/18 in a bucket full of brown observed next to the "meat" led "meat sink only", there are to fwater containing two the was a broom leaning exit of clean dishware in the chere was a white, sheet of for aligned against the kitchen door (which opened Throughout these tary cook was preparing food	F 81	The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies. To remain in compliance with all feder and state regulations the facility has to or will take the actions set forth in this plan of correction. The plan of corrections to compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 FOOD PROCUREMENT, STORE/PREPARE/SSERVE-SANITA The plan for correcting the specific deficiency. The plan should address the processes that lead to deficiency cited. The facility failed to maintain sanitary conditions in the kitchen by not ensuring resealed food items were dated and labeled; and by failing to store food ite off of the floor; and by failing to ensure kitchen was maintained clean and free from soiled cloths/linens and cleaning equipment during meal preparation. Since the correction of the floor is and by failing to ensure kitchen was maintained clean and free from soiled cloths/linens and cleaning equipment during meal preparation. Since the correction of the floor; and by failing to ensure kitchen was maintained clean and free from soiled cloths/linens and cleaning equipment during meal preparation. Since the correction of the floor; and by failing to ensure kitchen was maintained clean and free from soiled cloths/linens and cleaning equipment during meal preparation.	d do ral aken tion RY he d. ring ems e the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284 B. WING			C 06/08/2018		
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COL	<u>_</u> DE	00/00/2010	
				901 BETHESDA ROAD			
THE OAKS			WINSTON SALEM, NC 27103				
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SI			
F 812	During an interview o dietary cook revealed staff currently on duty that the mop in the buin the kitchen by the coprevious night. She a why or who placed the against the bottom of	e 51 n 6/3/18 at 6:40 a.m., the she was the only dietary until 6:45 a.m. She stated licket of dirty water was left dietary staff who worked the liso stated she did not know e sheet of linen on the floor the kitchen door; but she rival to work that morning.	F 8	did not label and date resealed did not remove food items off Staff did not remove soiled cleaning equipment after continuous These observations were mainitial kitchen tour on June 3, were discussed with the Coomorning. The Director of Dini	if the floor. loths and impletion. ade during to 2018 and look on duty thing &	the hat	
	in the kitchen on 6/3/r tray of unlabeled and of red colored juices i The walk-in refrigerat not dated and not lab raw chicken and 1-ha There was 1-case of floor and multiple cas	ns of the refrigeration units 18 at 6:45 a.m., there was a not dated 6 ounce glasses in the reach-in refrigerator. or#2 contained resealed but eled raw meats (1-bag of lf roll of raw ground beef). frozen breadsticks on the es of frozen food items on a platform in the center eezer.		Nutrition Services with the Co Management Company was the findings by the Cook and were corrected immediately a by the Director of Dining & Ni Services on her initial walk the Monday, June 4, 2018. The procedure for implement acceptable plan of correction specific deficiency cited; An in-service on Sanitation a Food Storage was conducted Dietary staff on June 6, 2018 Corporate Dietitian with the Company of the find the Surveyor's initial tour of the surveyor's initial tour of the proper storage of items in all areas, proper labeling and date items in food storage areas, personal storage of mops and other cladepartment closing procedure appropriate use of designated preparation sinks. An audit to into place to monitor compliad policy on 6/29/18. The monitoring procedure to	informed of all areas and inspect utrition in a for the information and Proper d for all in a formation and book at the proper leaning of oper leaning tool was put ince with this ensure that	f ted od d gg ge en s, is	
				The monitoring procedure to the plan of correction is effect			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345284	B. WING		C 06/08/2018	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	30/00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 812	Continued From page	2.52	F8	specific deficiency cited remains correct and/or in compliance with regulatory requirements. The Director of Dining & Nutrition Services or designee will monitor sanital practices of the kitchen to include propostorage of cleaning tools; proper use of designated food preparation sinks; proplabeling, dating and storage of food in a food storage areas; and adherence to department closing procedures using the Dietary Quality Assurance Audit Tool. Twill be done 5 days per week, including weekend days, for two months and the weekly for one additional month. Repowill be presented to the weekly Quality Assurance meeting by the Administrato to ensure corrective action initiated as appropriate. Compliance will be monito and ongoing auditing program reviewed the weekly Quality Assurance Committee The weekly Quality Assurance Meeting attended by the Administrator, Director Nursing, Minimum Data Set Coordinated Therapy, Health Information Manager at the Director of Dining & Nutrition Service. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	ary er er er all ne ihis n rts red d at ee. is of or, and	
F 865 SS=F	QAPI Prgm/Plan, Disc CFR(s): 483.75(a)(2)	closure/Good Faith Attmpt (h)(i)	F 8	65	7/5/18	
	§483.75(a) Quality as	surance and performance				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		C 06/08/2018	
	NAME OF PROVIDER OR SUPPLIER THE OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 00/00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 865	Survey Agency no lat promulgation of this results of the Secretary of the recomposition of the secretary of the recomposition of the secretary of the recomposition of the recomposition of the secretary of the recomposition of the secretary of t	tits QAPI plan to the State er than 1 year after the egulation; e of information. ary may not require ords of such committee ch disclosure is related to ch committee with the section. by the committee to identify efficiencies will not be used as is not met as evidenced or is not met as evidenced or is not met as evidenced or is quality Assurance and the facility of identify the section of 5/25/17. Deficiencies in the ace following the of 5/25/17. Deficiencies in the section of its product of the facility's inability to in of the facility's inability to	F 86	·	n to and do in the in State n or will Plan of ion on of will be indicated.	
	Assessment program The findings included These tags are cross	:		The plan of correcting the specific deficiency. The plan should add processes that lead to the deficicited; The facility's Quality Assessment	ress the ency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			С	
		345284	B. WING			06/08/2018		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
THE OAK	•			90	1 BETHESDA ROAD			
THE OAK	5			W	INSTON SALEM, NC 27103			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG			PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F 865	Continued From pa	F 8	365					
				Assurance Committee failed to mainta	iin			
	F-550. Based on o	bservations, record review,			implemented procedures and monitor			
		mber interviews, the facility			interventions put in place following the			
	failed to provide ca			recertification survey of 5/25/2017. Th				
		ding incontinent care before			deficiency was in the areas of residen			
		(Resident #60) for 1 of 7			rights/exercise of rights, comprehensive			
	residents (Residen			assessments and timing, care plan tim	ııng			
	Daily Living (ADLs			and revision, free of accident				
	During the recentifi	action comment of E/OE/47 than			hazards/supervision/devices, and food			
	_	cation survey of 5/25/17 the			procurement store/prepare/serve- san	-		
		F-241 for failure to promote placing a wander-guard ankle			was recited on the recent recertification /complaint survey of 6/8/2018. The two			
		one alert and oriented			federal surveys of record show a patter			
	residents (Residen				of the facility's inability to sustain an	,,,,,,		
				effective Quality Assurance and				
	F-636. Based on re	ecord review and facility staff			Assessment program. F550-Nurse aid	de		
		ity failed to comprehensively			did not provide incontinence care as			
	assess a resident i	receiving dialysis for 1 of 3			resident was combative and was waiti	ng		
	residents reviewed	for dialysis services (Resident			for assistance. F636- Minimum Data S	3et		
	#80).				Nurse omitted to code dialysis on the			
					comprehensive assessment dated			
		cation survey of 5/25/17 the			4/27/18. F657- Minimum Data Set Nu	rse		
		F-272 for failure to			did not resolve the care plan upon			
		ssess the dental needs for 1 of			removal of the cast. F689- Care was r			
	· ·	ts (Resident #77) reviewed for			implemented by staff. F812- Staff did			
	dental status and s	services.			label and date resealed food, and did			
	E 657 Pasad on a	bservations, record review and			remove food items off the floor. Staff			
		e facility failed to update a			not remove soiled cloths and cleaning equipment after completion.			
		n to reflect cast removal for 1			equipment after completion.			
) residents reviewed for			This tag is cross referenced to:			
	activities of daily liv				F550 The facility failed to failed to pro	vide		
		J (/-			care to maintain a residents dignity by			
	During the recertifi	cation survey of 5/25/17 the			providing incontinent care before feed			
		F-280 for failure to update a			a resident (Resident #60) for 1 of 7	J		
		or one of two sampled			residents (Resident #60) reviewed for	<u>-</u>		
	residents with falls	·			Activities of Daily Living (ADLs).			
					During the recertification survey of 5/2	5/17		
	F-689. Based on o	bservations, record reviews,			the facility was cited at F-241 for failur			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING			06/0) 08/2018
NAME OF PR	ROVIDER OR SUPPLIER	l	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	1 00/0	0.2010
				901 BETHESDA ROAD			
THE OAKS	3			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED			PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 865	Continued From page	e 55	F 8	65			
F 865	and staff interviews, the fall mats on the floor, sampled residents (Reviewed for accidents). During the recertificate facility was cited at Fewheelchair to the floot to manufacturer's instead on the resident restransportation, Reside the wheelchair with Resident land her head on the van from complained of right slincident. F-812. Based on obstinterview, the facility from the facility from the store food items were dated to store food items of to ensure the kitchen free from soiled clothed equipment during medium the recertificate facility was cited at Feitems and properly clean our shment refrigerate Refrigerator #3. An Interview was con Administrator and Quinterview	the facility failed to position next to the beds of 2 of 4 desidents #34 and #87) is. Ition survey of 5/25/17 the race of the facility van according tructions before transporting eviewed for van ent #54. During transport desident #54 fell backwards ling on her back and hitting floor. Resident #54 houlder pain after the revations and dietary staff failed to maintain sanitary then by not ensuring resealed d and labeled; and by failing was maintained clean and solinens and cleaning al preparation. Ition survey of 5/25/17 the race of the flood ean 1 of 3 residents'	F8	promote resident dignity be wander-guard ankle brace one alert and oriented res #35) F636 The facility failed comprehensively assess a receiving dialysis for 1 of 3 reviewed for dialysis servi #80). During the recertification is 5/25/2017 the facility was for failure to comprehensive dental needs for 1 of 3 sai (Resident #77) for dental services F-657 the facility failed to resident's care plan to refl for 1 of 7 (Resident #81) in reviewed for activities of dealth (ADLs). During the recertification is 5/25/2017 the facility was for failure to update a care for one of two sampled residents (Resident #87) reviewed for accident During the recertification is 5/25/2017 the facility was for failure to secure the whole floor of the facility was for failure to secure the whole floor of the facility van accomanufacturer's instruction transporting one of one re	elet on one of sidents (Residents (Residents a resident a resident a resident a resident a resident a resident at F-272 vely assess the mpled resident and update a lect cast removes a resident a resident a resident at F-280 e plan for falls a resident a resident at F-280 e plan for fall are resident at F-280 e plan for fall and resident at F-320 e resident at	ent 2 ne nts oval 0 s ats	
	of Life meeting and the	et every week for a Quality nat the QA meetings were ss problem areas and ministrator, DON, ADON,		for van transportation, Res During transport the whee Resident #54 fell backwar resident landing on her ba	elchair with ds with the	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	345284 B. WING		06	C 6/08/2018			
NAME OF P	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 865	well as all of the othe Quality of care was n audits, daily focus roi infection control, nutr were reviewed. Whe the facility's administration reoccurring problems was that changes wo	e 56 edical director attended, as a department heads nonitored by survey process, unds, and focus areas of ition, pressure ulcers, etc. an asked what expectations ration had for preventing s, they stated the expectation huld be made throughout the issues were resolved.	F	her head on the van floor complained of right shoul incident. F812 Based on observate staff interview, the facility maintain sanitary conditions by not ensuring resealed dated and labeled; and the food items off of the floor ensure the kitchen was and free from soiled cloth cleaning equipment during preparation. During the recertification 5/27/2017 the facility was for failure to label food it clean 1 of 3 residents' not refrigerators. Nourishmer #3. The procedure for implest acceptable plan of correst specific deficiency cited; This tag is cross referent F550. The facility failed care to maintain a resident care to maintain a resident (Resident #60). Activities of Daily Living. F636 the facility failed to assess a resident received of 3 residents reviewed services. (Resident #80). F-657 the facility failed to resident's care plan to refor 1 of 7(Resident #81) reviewed for activities of F689 the facility failed to on the floor, next to the light for the floor of the floor, next to the floor.	alder pain after the stion and dietary by failed to ions in the kitchen of food items were by failing to store or; and by failing to maintained clean the line and ing meal of survey on as cited at F-323 tems and properly ourishment ent Refrigerator ementing the action for the stiction for the county of the line and ing meal of the line and ing		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	CONSTRUCTION		
		345284	B. WING		С	
		343264	B. WING _			06/08/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
THE OAK	s			901 BETHESDA ROAD		
IIIE OAIN	•			WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE		
F 865	Continued From page	e 57	F 8		ents #34 and s. n and dietary ailed to s in the kitch ood items we failing to store and by failing intained clear liners and meal Assurance inistrator in sessment armaintain a surance minimum of:(vices;(ii) The designee;(iii) ers of the of who must aboard mem dership role; nt and tailed to ctivities such sect to which surance and (ii) Develop plans of act deficiencies: A State or the disclosure of ttee except in a related to the surance of the control	nen ere ere g to an (i) e i) be aber p tion ;;(h) e f in he

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
	345284 B. WING			C 06/08/2018			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 865	Continued From page	e 58	F8	requirements of this section. (i) Signor faith attempts by the commidentify and correct quality deficing not be used as a basis for sanct. Effective 7/5/2018, this training incorporated into the new employer orientation program. This inform been integrated into the standard orientation training and in the regin-service refresher courses for employees and will be reviewed Quality Assurance Process to we the change has been sustained. The monitoring procedure to ensure the plan of correction is effective specific deficiency cited remains and/or in compliance with the reguirements; This tag is cross reference to F550. The facility failed to failed care to maintain a residents digring providing incontinent care before a resident (Resident #60) for 1 residents (Resident #60) for 1 residents (Resident #60). F636 the facility failed to compressess a resident receiving dially of 3 residents reviewed for dially services. (Resident #80). F-657 the facility failed to update resident's care plan to reflect care for 1 of 7 (Resident #81) resident reviewed for activities of daily liv (ADLs). F689 the facility failed to position on the floor, next to the beds of sampled residents (Residents #50).	nittee to encies will ions. s yee nation has d quired all by the erify that sure that and that corrected gulatory to provide nity by not e feeding of 7 red for enersively risks for 1 sis erights at removal is ing. In fall mats 2 of 4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345284	B. WING _		_	C 06/08/2048	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)	I	(X5) COMPLETION DATE
F 865	Continued From page	e 59	F8	#87) reviewed for a F812 Based on obs staff interview, the f maintain sanitary or by not ensuring res dated and labeled; food items off of the ensure the kitchen and free from soiled cleaning equipment preparation To ensure complian Director of Nursing using a quality assu. Facility will monitor Assurance for F550 and F812. This will basis for 4 weeks th months by Administ monthly by the Qual Consultant to ensure will be presented to Assurance Committ Administrator or Dir assure corrective and appropriate. Any im be brought to the D Administrator for appropriate will be ongoing auditing provided by Admini Nursing, Minimum I Unit Manager, Ther Information Manage Wound Nurse. The title of the persimplementing the acceptance of the persimplementing the	servation and dietary facility failed to conditions in the kitch ealed food items we and by failing to sto a floor; and by failing was maintained clead cloths/linens and to during meal and reviewed and to during to during the weekly Quality the by the rector of Nursing to compliance and to during the mean and to during the during to during the mean and to during the mean and to during the	nen ere gre g to an r ue lity), se orts will r the y is	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345284	B. WING		C 06/08/2018		
NAME OF PROVIDER OR SUPPLIER THE OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		06/06/2016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION		
F 865	Continued From page 60		F 86	correction; Administrator and /or Director of	f Nursing.		
F 880 SS=D				0	7/5/18		
	infection prevention designed to provide comfortable environr development and tradiseases and infection §483.80(a) Infection program. The facility must esta	ablish and maintain an and control program a safe, sanitary and ment and to help prevent the nsmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at					
	reporting, investigati and communicable of staff, volunteers, visi providing services un arrangement based conducted according accepted national state §483.80(a)(2) Writte procedures for the p but are not limited to (i) A system of surve possible communical infections before the persons in the facility (ii) When and to who	upon the facility assessment to §483.70(e) and following andards; In standards, policies, and rogram, which must include, illance designed to identify ble diseases or y can spread to other					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345284 B. WING			C 06/08/2018			
NAME OF PROVIDER OR SUPPLIER THE OAKS			9	STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 00/00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475	
F 880	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 880	The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or witake the actions set forth in this Plan or	11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345284		B. WING			C 06/08/2018			
NAME OF PROVIDER OR SUPPLIER				S-	1 00/	06/2016		
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAKS				901 BETHESDA ROAD				
					/INSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880 Continued From page 62		e 62	F8	380				
F 880	Continued From page 62 A review of the facility's policy dated July 1, 2002 (revision date of May 2014) and titled "Contact Precautions" revealed "in addition to standard precautions use of contact precautions, or the equivalent, for specified residents known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident (hand or skin-to-skin contact that occurs when performing resident-care activities that require touching the resident dry skin) or indirect contact (touching) with environment surfaces or resident-care items in the residents' environment". Resident #55 was admitted to the facility 3/16/18 with diagnoses that included, in part, heart failure, hypertension, hyperlipidemia, diabetes mellitus, and chronic obstructive pulmonary disease. Review of active physician orders and assessments revealed the resident was being treated for Clostridium difficile (bacterial infection causing severe diarrhea) as of 6/4/18. An observation on 6/4/18 at 1:32 PM nurse assistant (NA) #6 was observed feeding resident #55's roommate without a gown or gloves on, a contact precautions sign was posted on the door, and personal protective equipment (PPE) and trashcan with lid was located outside the room door. During an observation on 6/4/18 NA #7 entered room at 1:35 PM without donning a gown or gloves, picked up resident #55's food tray, and		F 8			e s s. ion		
	walked out of the room. When asked what was the facility policy for resident's with contact precautions she stated that she was supposed to put on a gown, gloves, and wash her hands with				The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345284 B. WING			C 06/08/2018				
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
					01 BETHESDA ROAD		
THE OAKS	3				VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG			ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	880 Continued From page 63		F8	880			
	-	leaving the resident's room. n on 6/4/18 at 1:38PM			following elements; A system for preventing identifying, reporting, investigating and controlling infections	and	
		ered resident #55's room			communicable disease for all residents	,	
		vn and was wearing gloves.			staff , volunteers , visitors and other		
		e facility policy he stated he			individuals providing services under a		
	sign on the door but ju	r what was required per the			contractual arrangement based upon the facility assessment conducted according		
	sign on the door but j	ust riadir t seem it.			to And following accepted national	ig	
	During an interview w	ith NA #6 on 6/4/18 at 1:55			standards; written standards, policies, and		
	PM, she stated that it was the facility's policy that if she was working directly with the resident on isolation precautions she was required to wear				procedures for the program , which mu		
					include, but are not limited to: A system		
					surveillance designed to identify possib	le	
	gloves and a gown, but since she was working				communicable disease or infections		
	with her roommate, it wasn't required.				before they can spread to other person		
					in the facility; when and to whom possi	ble	
	_	ith the Quality Assurance			incidents of communicable disease or		
		ultant on 6/07/18 11:24 AM			infections should be reported, standard		
		pectation is that staff follow			and transmission-based precautions to		
		precautions, that they should			followed to prevent spread of infections when and how isolation should be used		
		owns and gloves while in the at staff were educated			for a resident; including but not limited		
	about the policy annu				The type and duration of the isolation,	ιο.	
	about the policy aims	any and as needed.			depending upon the infectious agent or		
					organism involved, and A requirement		
					the isolation should be the least restrict		
					possible for the resident under the		
					circumstances. The circumstances und	er	
					which the facility must prohibit employe	es	
					with a communicable disease or infected	ed	
					skin lesions from direct contact will		
					transmit the disease and the hand		
					hygiene procedures to be followed by s	staff	
					involved in direct resident contact. A	- J	
					system for recording incidents identified	J	
					under the facilities IPCP and the corrective actions taken by the facility.		
					Personnel must handle, store, process		
					and transport linens so as to prevent th		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
0.45004		D. WING				С	
345284 B. WII			B. WING _	/ING			08/2018
NAME OF PROVIDER OR SUPPLIER				STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	•			901 BI	ETHESDA ROAD		
THE OAK	3			WINS	STON SALEM, NC 27103		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION S		LD BE COMPL	
F 880	Continued From page	e 64	F8	At all control the real Q the second the sec	bread of infection. s of 7/5/2018 no employee will be lowed to work until the training has be ompleted. ffective 7/5/2018, this training is corporated into the new employee rientation program. his information has been integrated in the standard orientation training and in equired in-service refresher courses for lemployees and will be reviewed by the standard orientation training and in equired in-service refresher courses for lemployees and will be reviewed by the standard orientation training and in equired in-service refresher courses for lemployees and will be reviewed by the standard orientation is effective and the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and the plan of correction is	nto the or the at at nat cted ry ekly nis ks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
345284 B. WING				C 06/08/2018			
				STREET ADDRESS, CITY, STATE, ZIP CODE	0	6/08/2018	
NAME OF PROVIDER OR SUPPLIER							
THE OAKS				901 BETHESDA ROAD			
				WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORR REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERIORS.			OULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	e 65	F 88	implementing the acceptable plar correction; Administrator and /or Director of I			