PRINTED: 09/09/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C 07/25/2019	
NAME OF PE	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO 901 BETHESDA ROAD WINSTON SALEM, NC 27103	ODE	3.720.23.10	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIA		
E 000	Initial Comments		E 0	00			
F 000		3.73, Emergency ID # HKLT11.	F 0	00			
F 550 SS=D	survey was conducte of the 32 complaint a	g in deficiencies F550, d F686. cise of Rights	F 5:	50		8/22/19	
33-0	§483.10(a) Resident The resident has a rig self-determination, ar access to persons an	Rights. ght to a dignified existence, nd communication with and					
	with respect and dign resident in a manner promotes maintenand	and in an environment that be or enhancement of his or ognizing each resident's lity must protect and					
ADODATODY	access to quality care severity of condition, must establish and m practices regarding tr provision of services residents regardless	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.	5	TITLE		(X6) DATE	

Electronically Signed 08/19/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345284	B. WING _		07	C //25/2019		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 901 BETHESDA ROAD WINSTON SALEM, NC 27103		720,2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		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 550	rights as a resident of or resident of the Unit \$483.10(b)(1) The fact resident can exercise interference, coercion from the facility. \$483.10(b)(2) The resident of interference, coercion from the facility. \$483.10(b)(2) The resident of interference, coercise of interference, coercise of interference, coercise of his or her subparts. This REQUIREMENT by: Based on observation	of Rights. right to exercise his or her f the facility and as a citizen	F 5	,	s Plan of			
	provide care in a mar dignity by not providir urinary catheter drain (Resident #263) review Findings included: Resident #263 was a 7/11/19 with diagnose neuromuscular dysfuretention of urine. A review of the comp Set (MDS) assessment	dmitted to the facility on es that included, in part, nction of bladder and ent dated 7/18/19 revealed ognitively intact and had an heter.		not constitute an agreement of alleged deficiencies. To rema compliance with all Federal and Regulations the facility has that take the actions set forth in the Correction. The Plan of Correctionstitutes the facility's allegated compliance such that all allegated deficiencies cited have been corrected by the date or date. F550 Resident Rights/Exeres Rights Corrective Action: Resident #263. A privacy covurinary catheter drainage bag provided to maintain resident privacy on 7/23/19. Resident	with the in in nd State aken or will nis Plan of ection ation of ged or will be s indicated. rcise of rer for the g was 's dignity and			

		DATE SURVEY COMPLETED				
		345284	B. WING			C 07/25/2019
NAME OF PE	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	'	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	Continued From pag	ge 2 an indwelling suprapubic	F 55	discharged 8/3/19.		
	catheter with an inte bag covered adequa	rvention to "keep catheter tely to promote dignity."		Identification of other residents be involved with this practice: All residents requiring the use of	of a urinary	
	Resident #263 revea room. The door to the opened to the hallwat catheter drainage ba	PM an observation of aled she was in bed in her ne resident's room was ay. The resident's urinary ag was uncovered, contained ide of the bed and was visible		catheter drainage bag, have the to be affected by this practice. A audit of all residents requiring a catheter drainage bag was done that resident's dignity and prival maintained by providing a prival for the urinary catheter drainage Director of Nursing and Registe	e potential A complete urinary e to ensure cy was cy cover e bag. The	
	Resident #263 reveation. The door to the opened to the hallwar catheter drainage bases.	PM an observation of aled she was in bed in her the resident's room was ay. The resident's urinary ag was uncovered, contained ide of the bed and was visible		Unit Managers completed this a 8/16/19 for all nursing stations. residents were identified requiriprivacy cover for the urinary cat drainage bag. All six residents in privacy cover for the urinary cat drainage bag to maintain their deprivacy.	audit on Six ng a theter nave a theter	
	Resident #263 reveation. The door to the opened to the hallwar catheter drainage bases.	PM an observation of aled she was in bed in her the resident's room was ay. The resident's urinary ag was uncovered, contained ide of the bed and was visible		Systemic Changes: All Full Time and Part Time and (Registered Nurses, Licensed F Nurses, Medication Tech's, Nur Assistants) will be educated on following by the Director of Nurs Education began on 8/19/19. Al who require a urinary catheter of	Practical sing the sing. If residents	
	protocol for catheter were kept covered we their room. Nurse #1 said when the drainage bag did cover. On 7/23/19 at 3:13 F	te #1. She stated the drainage bags was that they when a resident was not in a resident was in their room I not necessarily need a		bag, must have a privacy cover maintain their dignity and privacy times. Resident Rights. The res a right to a dignified existence, self-determination, and commun with and access to persons and inside and outside the facility, ir those specified in this section. A must treat each resident with redignity and care for each reside manner and in an environment.	to cy at all cident has nication d services ncluding A facility espect and ent in a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED:		PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		0,	C 7/ 25/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1723/2013	
				901 BETHESDA ROAD			
THE OAKS	3			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE	
IAG			IAG	DEFICIENCY)			
F 550	Continued From page	e 3	F 55	50			
	resident stated she d the drainage bag from	idn't care if other people saw n the hallway.		promotes maintenance or enhator of his or her quality of life, reconstant resident's individuality. The	gnizing		
	On 7/24/19 at 10:44			must protect and promote the	rights of the		
	He stated since the re	lent #263's family member. esident had been		resident. The facility must prov access to quality care regardle	•		
	•	admitted to the facility he		diagnosis, severity of condition			
		e issues with her memory		payment source. A facility mus			
	member said when R	ognitive baseline. The family		and maintain identical policies practices regarding transfer, di			
	baseline with cognitic			and the provision of services u	_		
		e bag be covered in order to		State plan for all residents rega			
	protect her dignity and privacy.			payment source. The facility m	ust ensure		
	O 7/00/40 -+ 0-00 D	NA intoniono		that the resident can exercise I			
	On 7/23/19 at 3:08 Pl			rights without interference, coe			
		irector of Nursing (DON). bags were supposed to be		discrimination, or reprisal from The resident has the right to be			
	_	rivacy and dignity, particularly		interference, coercion, discrimi			
		ag faced the doorway where		reprisal from the facility in exer			
	_	others who walked by the		or her rights and to be support	-		
	-	I she had educated staff in		facility in the exercise of his or	-		
	the past about cathet	er care and the education		as required under this subpart.			
	included covering the	drainage bags. She		of Rights. The resident has the			
	further stated the nur	se went into the resident's		exercise his or her rights as a	resident of		
	• •	med catheter care. The		the facility and as a citizen or r	esident of		
		ted catheter drainage bags		the United States.			
	be covered at all time	es.		This in service will be complete	-		
				8/22/2019. Any nurses, nursin	-		
				assistants, med tech's (full time	e, part time,		
				and PRN) and member of the	not ropoivo		
				interdisciplinary team who did in-service training will not be al			
				work until training is completed			
				information has been integrate			
				standard orientation training ar			
				required in-service refresher co			
				all employees and will be revie			
				Quality Assurance Process to	•		
				the change has been sustained	•		

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
	345284	B. WING			C 07/25/2019
			STREET ADDRESS, CITY, STATE, ZIF 901 BETHESDA ROAD WINSTON SALEM, NC 27103	CODE	07/25/2019
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BI O THE APPROPRIA	DATE
Continued From page	4	F 5	Monitoring: To ensure compliance, T Nursing and or Unit Mana 5 residents who require a drainage bag to ensure the dignity and privacy is ma providing a privacy cover catheter drainage bag. T audit will be reviewed at a Quality Assurance Team be done on weekly basis monthly for 3 months. Re- presented to the Weekly Life/Quality Assurance C Director of Nursing and/o Set (MDS) Coordinators corrective action initiated Any immediate concerns the Director of Nursing or for appropriate action. Co monitored and ongoing a reviewed at the Weekly C Meeting. Weekly Quality Committee meeting is att Administrator, Director of Minimum Data Set Coord Manager, Support Nurse (Health Information Mana	ager will obser a urinary cather hat resident's intained by for the urinary. The results of the the weekly Meeting. This for 4 weeks the ports will be Quality of ommittee by the or Minimum Date to ensure as appropriate will be brough Administrator ompliance will auditing progra Quality of Life Assurance tended by Nursing, dinator, Unit , Therapy, HIM agement), Dief	y his will nen ne ata e. at to be m
CFR(s): 483.10(c)(7) §483.10(c)(7) The rig medications if the inte defined by §483.21(b this practice is clinica This REQUIREMENT	ht to self-administer erdisciplinary team, as)(2)(ii), has determined that lly appropriate.	F 5.	_		8/22/19
	ROVIDER OR SUPPLIER S SUMMARY ST, (EACH DEFICIENC) REGULATORY OR L Continued From page Continued From page Resident Self-Admin CFR(s): 483.10(c)(7) \$483.10(c)(7) The rig medications if the inte defined by \$483.21(b this practice is clinica	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) \$483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by \$483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced	Resident Self-Admin Meds-Clinically Approp Continued From page 4 Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by \$483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced	ROVIDER OR SUPPLIER S SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 4 F 550 Continued From page 4 F 550 Monitoring: To ensure compliance, T Nursing and or Unit Mans 5 residents who require a drainage bag to ensure t dignity and privacy is ma providing a privacy cover catheter drainage bag. 1 audit will be reviewed at Quality Assurance Team be done on weekly basis monthly for 3 months. Re presented to the Weekly Life/Quality Assurance To Director of Nursing and/C Set (MDS) Coordinators Coordinators Coordinators the Director of Nursing on for appropriate action. Committee meeting is at Administrator, Director Minimum Data Set Coor Manager, Support Nurse (Health Information Man Manager, Wound Nurse.) F 554 Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) \$483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by \$483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced	ROWIDER OR SUPPLIER 345284 B WIND SITREET ADDRESS, CITY, STATE, ZIP CODE 91 BETHESDA ROAD WINSTON SALEM, N. C 27103 SUMMARY STATEMENT OF DETICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LS: IDENTIFYING INFORMATION) COntinued From page 4 F 550 Monitoring: To ensure compliance, The Director of Nursing and or Unit Manager will obset of residents who require a urinary cathe drainage bag to ensure that resident's dignity and privacy is maintained by providing a privacy cover for the uninar catheter drainage bag. The results of a udit will be reviewed at the weekly Quality Assurance Team Meeting. This be done on weekly Dasis for 4 weeks the monthly for 3 months. Reports will be presented to the Weekly Quality of Life/Quality Assurance Team Meeting. This be done on weekly Dasis for 4 weeks the monthly for 3 months. Reports will be presented to the Weekly Quality of Life/Quality Assurance Commettee by the Director of Nursing and/or Minimum Daset (MDS) Coordinators to ensure corrective action initiated as appropriat Any immediate concerns will be brough the Director of Nursing or Administrator for appropriate action. Compliance will monitored and ongoing auditing progragar reviewed at the Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting is attended by Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Diet Manager, Wound Nurse. Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) The right to self-administer meedications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(c l	
		345284	B. WING _			07/	25/2019	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
	_			90	11 BETHESDA ROAD			
THE OAK	5			W	INSTON SALEM, NC 27103			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 554	Continued From pa	F t	554					
	Based on observat	tions, resident and staff			The statements made on this Plan of			
	interviews, and reco	ord review, the facility failed to			Correction are not an admission to an	d do		
	determine whether	the self-administration of			not constitute an agreement with the			
	medications was cl	inically appropriate for 1 of 1			alleged deficiencies. To remain in			
	sample resident (R	esident #44) who was			compliance with all Federal and State			
	observed to have a	medication at bedside.			Regulations the facility has taken or w			
					take the actions set forth in this Plan of	f		
	The findings include	ed:			Correction. The Plan of Correction			
	D :: 1 #44	. 1. 20. 1. 0. 6. 22			constitutes the facility's allegation of			
		admitted to the facility on			compliance such that all alleged			
	8/23/16. His cumulative diagnoses included chronic obstructive pulmonary disease (COPD).				deficiencies cited have been or will be corrected by the date or dates indicate			
	Cilionic obstructive	pullionary disease (COPD).			corrected by the date of dates indicate	:u.		
	A review of Resider	A review of Resident #44 's most recent			F554 Resident Self-Admin			
	Minimum Data Set	(MDS) was an annual			Meds-Clinically Approp			
	assessment dated	5/16/19. The MDS			Corrective Action:			
		ed the resident had intact			Resident #44. Resident was offered a	ก		
		laily decision making. He			opportunity to self-administer his			
		n only for eating, limited			medication during assessment. Reside	ent		
		motion on the unit and for			indicated no desire to self-administer			
		sive assistance from staff for			medications, this was documented in t	he		
	· ·	ers, locomotion off the unit,			appropriate place in the resident's			
	dressing, and perso	onai nygiene.			electronic medical record, and the resident was deemed to have deferred	1		
	A review of the reci	dent 's current Care Plan (not			this right to the facility.	1		
		ted. Resident #44's care			Identification of other residents who m	21/		
		s the self-administration of			be involved with this practice:	ау		
	medications.	o the sen dammetation of			All cognitively intact residents with a B	IMS		
					of 13 or greater, have the potential to			
	A review of Resider	nt #44 ' s current physician			affected by this practice. Each cognitive			
	orders included a m				intact resident was offered an opportu	-		
	100-62.5-25 microg	grams per inhalation of Trelegy			to self-administer his or her medication	าร		
		as one inhalation orally one			during review by the facility's			
		D. The medication order			interdisciplinary team (Director of Nurs			
		to rinse mouth after use and			Unit Managers, Minimum Data Set [M	DS]		
		ipta is a dry powder inhaler			Coordinators, and Staff Nurses) on			
	_	nation of three active			8/16/2019. If the cognitively intact resi	dent		
		sone, a corticosteroid;			indicated no desire to self-administer			
	∣ umeclidinium, a typ	e of bronchodilator to open			medications, this was documented in t	.he		

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		345284	B. WING			C 7/ 25/2019	
NAME OF P	ROVIDER OR SUPPLIER	0.020.	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		1125/2019	
TVAIVIL OF T	TOVIDER OR OUT FILE						
THE OAKS	3			901 BETHESDA ROAD			
				WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE			
F 554	Continued From page	e 6	F 5	54			
F 554	the airways; and, vilated bronchodilator). The not include an order of self-administer any order of self-administer any order of self-administer and or the self-administra. An observation was of 10:47 AM as Resider watching his television was observed on the bed and within reach #44 was asked if the permission was giver was identified as a Trinquiry, the resident of the table after he was the inhaler was alway auxiliary label placed mouth after use." Additional observation Ellipta inhaler placed 's bedside on 7/21/11	nterol, a long-acting current physician orders did for the resident to f his medications. #44 's electronic medical assessments were completed	F 5	appropriate place in the reside electronic medical record, and resident was deemed to have of this right to the facility. If the contract resident desired to self-amedications an assessment was conducted by the interdisciplina determine the resident's ability self-administer medications. The of the interdisciplinary team as are recorded on the Medication Administration Assessment, where the ability to safely self-administer medication, the physician was a further assessment of the same bedside medication storage was conducted. This was complete 8/16/2019. The Director of Nur Manager and MDS Coordinator observed all residents room to there were no medications four bedside storage. No an aut medications were observed in	the deferred ognitively administer as ary team to to he results asessment hich is in ecord. If the onstrated ster notified and fety of as d by using, Unit ors ensure that nd at the authorized the		
		ducted on 7/21/19 at 3:15 4. The Trelegy Ellipta inhaler		resident's room or bed side. The observation was completed on Systemic Changes: All Full Time and Part Time and	8/16/2019.		
	was observed on the the time of the intervi #44 reiterated the inh bedside and reported medication himself. I resident stated he us morning. Resident # the inhaler in the mor	TV table next to the bed at ew. Upon inquiry, Resident aler was always kept by his		(Registered Nurses, Licensed Nurses, Medication Tech's, and Assistants) will be educated or following by the Director of Nur Education began on 8/19/19. A and aides are required to reporcharge nurse on duty any med found at the bedside not autho bedside storage and to give ur	Practical d Nursing n the rsing. All nurses rt to the lications rized for		

Facility ID: 923497

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245004	B. WING					
		345284	B. WING _			07/	25/2019	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
THE OAK	s			90	1 BETHESDA ROAD			
07				W	INSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 554	Continued From page after using the inhale When asked if he rins the water after using the resident stated he resident noted that "s some water to drink a Additional observatio Ellipta inhaler placed 's bedside on 7/22/19 at 8:20 AM. Accompanied by the (DON), an observatio 8:25 AM of the Treleg #44 's bedside table the resident. The DO explained to the resident to the resident to the resident this physician have this medication. An interview was con AM with the DON. D	r, he stated he did not. sed his mouth and spit out the Trelegy Ellipta inhaler, e did not, but "could." The cometimes" he would have after using the inhaler. Ins were made of the Trelegy on the table at Resident #44 9 at 9:12 AM and on 7/23/19 facility 's Director of Nursing on was made on 7/23/19 at the sy Ellipta inhaler on Resident and placed within reach of DN picked up the inhaler and lent she would need to to get approval for him to by his bedside. ducted on 7/23/19 at 8:27 uring the interview,	F 5	554	medications to the charge nurse for ret to the family or responsible party. Family or responsible party. Family or responsible parties are reminded of procedure and related policy when necessary. Each cognitively intact (BIM of 13 or greater) resident is offered an opportunity to self-administer his or her medications on admission /readmission and during quarterly review by the facily interdisciplinary team (Director of Nursis Unit Managers, Minimum Data Set [ME Coordinators, and Staff Nurses). If the cognitively intact resident indicates no desire to self-administer medications, it is documented in the appropriate places the resident's electronic medical record and the resident is deemed to have deferred this right to the facility. If the cognitively intact resident desires to self-administer medications an assessment is conducted by the interdisciplinary team to determine the resident's ability to self-administer	urn lies this IS ity's ng, IS]		
	the resident 's bedsic with information obtain conducted with the resident An interview was comply with the resident During the interview, Trelegy Ellipta inhale and his reported self-medication were disconverted by the resident whether he had been appropriate for the resident Trelegy Ellipta inhale	ducted on 7/23/19 at 1:29 's Medical Doctor (MD). the observations of the r at Resident #44 's bedside administration of the ussed. Upon inquiry as to asked if it was clinically sident to self-administer the r, the physician stated he did MD stated he did not believe			medications. The results of the interdisciplinary team assessment are recorded on the Medication Self Administration Assessment, which is in the resident electronic health record. If cognitively intact resident demonstrates the ability to safely self-administer medication, the physician is notified an further assessment of the safety of bedside medication storage is conducted bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer using the conditions set forth in the policy and procedures. When	the d a ed. d		

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	_			901 BETHESDA ROAD			
THE OAK	5			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 OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 554	Continued From page	e 8	F 55	54			
F 554	self-administration wi was in compliance w A telephone interview at 12:00 PM with the helped to care for Re interview, the observ inhaler at Resident # reported self-administ were discussed. The aware the resident w bedside for self-administration of PM with the DON in a self-administration of Ellipta inhaler kept at interview, the DON self-about the inhaler bein staff. The DON reports.	ithout a physician 's order ith the facility 's policy. It was conducted on 7/24/19 Nurse Practitioner (NP) who esident #44. During the ations of the Trelegy Ellipta 44 's bedside and his stration of the medication en NP stated she was not as keeping an inhaler at nistration. Inducted on 7/24/19 at 4:16 regards to the resident's medication and the Trelegy bedside. During the tated the resident was upseting taken away from him by	F 55	the interdisciplinary team deter bedside or in-room storage of r would be a safety risk to other the medications of residents perself-administer are stored in the medication cart or medication resident requests each dose from medication nurse, who provides medication to the resident in the unopened package for the resident and package for the resident in service was completed 8/19/2019. Any nurses, nursing assistants, med tech's (full time and PRN) and member of the interdisciplinary team who did r in-service training will not be all work until training is completed information has been integrated standard orientation training an required in-service refresher coall employees and will be revied Quality Assurance Process to whe change has been sustained Monitoring: To ensure compliance, The Dir Nursing and or Unit Manager was the sident's room or bed side. The of Nursing and or Unit Manage 5 cognitively intact (BIMS of 13)	medications residents, remitted to recentral room. The room the records record		
				residents (new admissions/rea electronic medical record and e documentation indicates that fa offered an opportunity to self-a his or her medication on admission/readmission per faci	idmissions) ensure that acility dminister		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	 	(X3) DATE :	
		345284	B. WING			07/	25/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, 901 BETHESDA RO WINSTON SALE		1 0772	29/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B -REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 554 F 561 SS=D	promote and facilitate through support of renot limited to the right (1) through (11) of thi §483.10(f)(1) The resactivities, schedules (waking times), health	(3)(8) mination. right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f) is section. ident has a right to choose (including sleeping and care and providers of health ent with his or her interests, an of care and other	F 5	and procedul weekly basis 3 months. The reviewed at Team Meeting to the weekly Committee of Neet (MDS) (Corrective at Any immediting the Director for appropriation monitored at reviewed at Meeting. We Committee of Administrate Minimum Data Manager, She (Health Info Manager, Weekly Director for appropriation of the Director for appropriation of	ures. This will be done on is for 4 weeks then monthly The results of this audit will is the weekly Quality Assuraring. Reports will be present by Quality Assurance (Quality of Life meeting by the Nursing and/or Minimum Date Coordinators to ensure action initiated as appropriate iate concerns will be brought of Nursing or Administrator in the Weekly Quality of Life deekly Quality Assurance meeting is attended by or, Director of Nursing, ata Set Coordinator, Unit Support Nurse, Therapy, HIM Dormation Management), Die Yound Nurse.	be nce nce nce nce nce nce nce nce nce nc	8/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		C 07/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 07/23/2019	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 561		ident has a right to make s of his or her life in the	F 56	1		
	with members of the	ident has a right to interact community and participate in both inside and outside the				
	religious, and commu interfere with the right facility. This REQUIREMENT by:	tivities, including social, nity activities that do not is of other residents in the is not met as evidenced and staff interviews and		The statements made on this Plan of Correction are not an admission to an		
	resident's choice and scheduled for 1 of 5 r reviewed for choices. Findings included:	provide showers as esidents (Resident #265)		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	vill	
		dmitted to the facility on that included, in part, pritis.		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 indicate		
	-	- ·		F561 Self-Determination Corrective Action: Resident #265: Resident was offered shower. Shower was provided to honor.		
	A review of the care prevealed a problem of (ADL) self-care perform intervention included personal hygiene.	f activities of daily living mance deficit. An		resident's choice. Identification of other residents who me be involved with this practice: All residents have the potential to be affected by this practice. On 8/15/201	nay	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING				C 7/25/2040	
NAME OF D	ROVIDER OR SUPPLIER	0.0201		STDE	EET ADDRESS, CITY, STATE, ZIP CODE	07	7/25/2019	
NAME OF T	NOVIDEN ON 3011 LIEN							
THE OAK	S				BETHESDA ROAD			
				WIN	STON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)) BE	(X5) COMPLETION DATE	
F 561	Continued From page	age 11	 F!	561				
	Continuou i ioni pe	.90	' `		2/16/2010 all Karday's (this is a			
	On 7/22/10 at 0:02	AM an interview was			3/16/2019 all Kardex's (this is a shortened version derived from the c	oro		
		sident #265 during which he ng them I want to take a			plan that identifies key care needs for			
		nly had one shower." Resident			esidents) were reviewed to ensure t shower schedule for each resident w			
		peen at the facility for			place and appropriate by Minimum D			
		weeks and had only received			Set Coordinators, Unit Manager and			
	one shower.	weeks and had only received			Director of Nursing. All resident's Ka			
	one snower.				are accurate and appropriate. On	ucx		
	A review of the me	dical record revealed Resident			3/19/2019 the Director of Nursing, U	nit		
		ed for showers on Tuesday and		- 1	Managers, Minimum Data Set			
		-11 PM shift). Further review			coordinators interviewed all alert and	l		
		ord documentation revealed		- 1	priented residents (BIMS of 13 or gr			
		eived a shower on 7/9/19			o ensure that they received a showe			
		2/19 (Friday). No shower was			schedule or as requested. All resider			
		ve been provided on 7/16/19 or			nterviewed indicated that they receiv			
	7/19/19.	·			shower per schedule or as requested			
					3/20/2019 the Director of Nursing, U			
	On 7/25/19 at 11:2	6 AM an interview was			Managers, Minimum Data Set			
	completed with Nu	rse Aide (NA) #3. She stated		0	coordinators observed all other resid	ents (
	she worked with Re	esident #265 on 7/16/19 and		E	BIMS of 12 or less) and reviewed			
	recalled that she g	ave him a shower. NA #3 said		6	electronic documentation for shower	s in		
		nented the shower in the		t	he electronic medical record to ens	ure		
	computer kiosk but	told the nurse that she gave a		t	hat they received a shower per sche	dule		
	shower to Residen	t #265.			or as required. All observed resident			
					vere noted to have received a show	-		
		AM an interview was		- 1	schedule or as requested. Any reside	ent		
		sident #265. He said he was		- 1	vho did not received a shower, had	_		
		not receive a shower on the			appropriate supporting documentation			
	prior evening (Tues	sday) as scheduled on 7/23/19.			he electronic medical record indicati	-		
	A	disal assessed assessed A.D. (1971)			why they did not shower and also the			
		dical record revealed Resident			esident representative was notified.			
	#265 refused a sho	ower on 7/23/19.			observation was completed on 8/21/2	2019.		
	On 7/04/40 at 0:00	DM on intensionary			Systemic Changes:	ı		
		PM an interview was			All Full Time and Part Time and PRN			
	· •	.#2. She stated she worked		,	Registered Nurses, Licensed Practic			
		5 on 7/23/19 from 3:00-11:00			Nurses, Medication Tech's, and Nurs	ing		
		resident was on the schedule			Assistants) will be educated on the			
	i ioi a shower but a	shower wasn't given. NA #2		T	ollowing by the Director of Nursing.		1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C 07/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	0.0201	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CC	DDE	07/25/2019	
				901 BETHESDA ROAD			
THE OAK	S			WINSTON SALEM, NC 27103			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 561	Continued From pag		F 5				
	said she thought she room and offered a stremember if the resi #2 reported she there and had not followed "really wanted one." On 7/25/19 at 11:11 completed with the I She said residents with showers twice a week had a wound with a maintain the dressin better idea to switch shift when he could wound care was dorexpected if a resider	e went in to Resident #265's shower but could not dent answered yes or no. NA n left Resident #265's room dup with him and asked if he AM an interview was Director of Nursing (DON). Were typically scheduled for ek. She said Resident #265 dressing on it and in order to g she thought it would be a his shower time to the day receive a shower before ne. The DON further said she int was scheduled for a offered to provide a shower		Education began on 8/19/19 resident has a right to choos schedules (including sleepin times), health care and provicare services consistent with interests, assessments, and and other applicable provision part. Each resident has a rigical choices about aspects of his the facility that are significant resident. Each resident has interact with members of the and participate in community both inside and outside the resident has a choice of how a week they can take a show Each resident has a right to shower or a bath per plan of The nurse aide assigned to be required to document in the electronic medication record resident received shower as as requested. The Nurse aide the nurse assigned if a residency their scheduled shower will talk with the resident and resident still refuses, the nurse ident still refuses, the nurse ident in the electronic medication record. You are required to revious all residents assigned to you are required to revious the beginning of each shift care needs of the resident.	se activities, ag and waking iders of healt in his or her plan of care ons of this ight to make is or her life in hit to the a right to e community y activities facility. Each y many times wer or bath. receive a f care. each unit will the residents if that the is scheduled of the will notify lent refuses the rese will notify and nedical ew the karde your care price ft to identify	r o	
				 If you do not see a kard consult with your nurse for for instructions. You should always follo care for the residents as out 	urther care w the plan of		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
			D. WILLO			С	
		345284	B. WING _			07/25/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
THE OAK	S			901 BETHESDA ROAD			
				WINSTON SALEM, NC 27103			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIA	DATE	
F 561	Continued From pag	e 13	F 5	kardex. If the resident's corchanged, you feel that the porthe resident refuses to for then you should notify the nadditional guidance regardine. To access the kardex you the resident's name in the eleath record and click on the brick. This in service will be composited by a sistants, med tech's (full that and PRN) and member of the interdisciplinary team who conservice training will not be work until training is complete information has been integrous standard orientation training required in-service refreshed all employees and will be required in-service refreshed all employees and will be required in-service. The Nursing and or Unit Manages alert and oriented (BIMS) of greater) residents each weet that they are receiving their scheduled or as requested. Of Nursing and or Unit Manages also review the electronic defor showers each week to each week	plan is unsafillow the plan urse for any care. Ou can click electronic the kardex letted by rising time, part time allowed to eted. This part at the results of the courses for eviewed by the verify that ined. Director of the er will intervious 13 or each to ensure showers as The Director ager will be residents a cocumentation in the results of this will be weeks then results of this weekly	me, we or the at iew and on	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
				_		(С
		345284	B. WING_			07/	25/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	3			90	01 BETHESDA ROAD		
				V	VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 561 F 584 SS=B	CFR(s): 483.10(i)(1)-(§483.10(i) Safe Environment of the resident has a right comfortable and home but not limited to recessive supports for daily living the facility must prove for facility must prove facility must prove facility must prove for facility must prove facilit	ole/Homelike Environment (7) onment. Int to a safe, clean, elike environment, including iving treatment and g safely.		584	will be presented to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MD Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director Nursing or Administrator for appropriate action. Compliance will be monitored a ongoing auditing program reviewed at Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting attended by Administrator, Director of Nursing, Minimum Data Set Coordinate Unit Manager, Support Nurse, Therapy HIM (Health Information Management) Dietary Manager, Wound Nurse.	S) n c of e nd the / is	8/22/19

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	, ,	TE SURVEY MPLETED
		345284	B. WING _		0	C 7/25/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 901 BETHESDA ROAD WINSTON SALEM, NC 27103		772372019
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 584	Continued From page 15		F 5	584		
		keeping and maintenance o maintain a sanitary, orderly, rior;				
	§483.10(i)(3) Clean I in good condition;	ped and bath linens that are				
	§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and					
	sound levels. This REQUIREMEN	maintenance of comfortable T is not met as evidenced				
	interviews, the facility environment as evide the main dining room courtyard on 300 hal resident rooms (Roo cobwebs behind the overbed light fixture	e ulcers.		The statements made on the Correction are not an admiss not constitute an agreement alleged deficiencies. To reme compliance with all Federal Regulations the facility has take the actions set forth in Correction. The Plan of Corconstitutes the facility's allegent compliance such that all allegent deficiencies cited have been corrected by the date or date	esion to and do t with the nain in and State taken or will this Plan of rrection gation of eged n or will be	
	a). An observation of windows beside the	n 7/21/19 at 12:30 PM of the door to the courtyard on the or visibility out of the windows		F584 Safe/Clean/Comfortab Environment Corrective Action: Main dining room: Windows		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3)) DATE SURVEY COMPLETED
							С
		345284	B. WING _				07/25/2019
NAME OF P	ROVIDER OR SUPPLIER	•	•	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	_			901	BETHESDA ROAD		
THE OAK	5			WIN	ISTON SALEM, NC 27103		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 584	Continued From pag	ge 16	F 5	584			
	due to excessive bu Resident Council M survey on 7/23/19 a stated the windows			Door to the courtyard on 300 hall: W cleaned Rooms 304, 308 and 414: Floors cleaned, stripped and waxed.	indow		
		de at that time revealed by sin the main dining room			Room 414: Cobweb cleaned behind and overbed light fixture cleaned	door	
	had a white residue window.			Resident #106: Pressure reducing be cleaned. Identification of other residents who			
	b). An observation of room 304 revealed			be involved with this practice: All residents have the potential to be			
	noticeable darkened threshold and exten			affected by this practice. On 8/15/20 8/22/2019 all windows, all overbed li fixtures, and all pressure reducing bo	ght		
		7/24/19 at 10:10 AM and on of room 304 revealed the floor			were cleaned. This will be completed 8/22/2019. On 8/16/19 Environment	d by	
	remained dirty with	built up dirt and a noticeable ne floor at the threshold and			Services Director and Administrator audited all resident rooms to identify	floors	
	extending into the ro				in need of stripping and waxing. On 8/19/19 a schedule was put in place		
		7/21/19 at 12:48 PM of room et and a pile of dirt in the			continue stripping, and waxing rema floors over the next 2 months.		
		pehind the door. The floor of red to be dirty and dull with a			Systemic Changes: All Full Time and Part Time and PRN	١,	
	noticeable darkened threshold and exten	d area on the floor at the diding into the room.			environmental services staff (housekeeping and maintenance) will educated on the following by the	l be	
		7/23/19 at 8:11 AM and of room 308 revealed the			Administrator. All windows and floors expected to be clean. Safe Environm		
	lancet was still obse	erved in a pile of dirt behind for of the room was still dull			The resident has a right to a safe, cle comfortable and homelike environment	ean,	
		ceable darkened area on the			including but not limited to receiving	511L,	
	-	d and extending into the room.			treatment and supports for daily livin safely. The facility must provide; A s		
	414 revealed the flo	7/21/19 at 11:53 AM of room oor had a dried, yellowish d on the right side of the room			clean, comfortable, and homelike environment, allowing the resident to his or her personal belongings to the extent possible. (i) This includes ens that the resident can receive care an	use uring	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343204		STREET ADDRESS, CITY, STATE, ZIP CODE		7/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER				Ξ		
THE OAK	S			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 OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 584	Continued From pag	e 17	F 58	4			
F 584	An observation on 7.77/25/19 at 2:45 PM of floor was still observ substance on the rigentering. c). An observation or room 414 revealed in the door from the cellayer of dust located. An observation on 7.414 revealed the spithe door of the room covered with a layer. d). An observation or revealed Resident # reducing boot to her brown stain to the in boot.	/22/19 at 1:30 PM and of room 414 revealed and the ed to have a dried, yellowish the hit side of the room upon n 7/21/19 at 11:53 AM of multiple spider webs behind iling to the floor and a visible on the overbed light of 414A. /25/19 at 3:45 PM of room der webs remained behind the overbed light was still of dust. n 7/22/19 at 8:41 AM 106 wearing a pressure foot that had a large reddish side of the right side of the	F 58	services safely and that the pherometric layout of the facility maximizes independence and does not prisk. (ii) The facility shall exercise reasonable care for the protect resident's property from loss of thousekeeping and maintenant necessary to maintain a sanital and comfortable interior. Cleat bath linens that are in good conceptivate closet space in each resort, Adequate and comfortat levels in all areas, Comfortable temperature levels. Facilities in certified after October 1, 1990 maintain a temperature range 81F; and For the maintenance comfortable sound levels. Eduted began on 8/19/19. This in service more staff (housekeeping and maintenartime, part time, and PRN) and the interdisciplinary team who receive in-service training will	s resident ose a safety sise stion of the or theft. ce services ary, orderly, n bed and ondition; esident ble lighting e and safe nitially must of 71 to e of acation vice will be once) (full member of did not		
	On 7/25/19 at 1:38 PM, an interview was conducted with NA#1. NA#1 stated she didn't notice the stained area to Resident #106's boot. NA #1 was unsure if the boot could be laundered and stated she would ask the treatment aid if there was another one that could be used. On 7/25/19 at 2:45 PM, an interview was conducted with the housekeeper. She stated she worked day shift through the week and every other weekend. She stated that the daily room cleaning includes dusting, sweeping, mopping, cleaning the bathroom and emptying the trash.			allowed to work until training is This information has been inte the standard orientation trainir required in-service refresher of all employees and will be revie Quality Assurance Process to the change has been sustained Monitoring: To ensure compliance, The Act and or Director of Nursing will resident's rooms, hallways and room to ensure that the floors, light fixture and windows are of Director of Nursing will observe	es completed. egrated into ng and in the courses for ewed by the verify that ed. dministrator observe 5 d dining overbed clean. The		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345284	B. WING_			1	C 25/2019
NAME OF PE	ROVIDER OR SUPPLIER	0.020	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	25/2019
TO THE OT TH	TO VIDER OR OUT FEEL						
THE OAKS	3				01 BETHESDA ROAD		
				V	VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 584	Continued From page	e 18	F t	584			
	The housekeeper acc tour of rooms 304, 30 hadn 't gotten to room the day before. She is behind the door in rood during the room clear some of the floors was floors needed to be is: On 7/25/19 at 3:05 Pl conducted with the Histated sweeping, more part of daily room clear spot checks of the room and sometimes doors. She stated the the wax and needed there wasn 't a scheef floors, but they had an responsible for it. She to see them cleaned I on getting them done On 7/25/19 at 3:54 Pl conducted with the Distated she would expused to be clean whe conducted with the Accepted the floors as She stated they are Ic for the floors so a bet them. She stated she cleaned yearly and it	companied the surveyor on a 18 and 414. She stated she in 414 yet and she was off stated the dirt and lancet om 308 should be removed hing. She stated the dirt on its stuck on and most of the tripped and waxed. M, an interview was ousekeeping Director. She oping and dusting were all aning. She stated she did oms but didn't go into every didn't look behind the adirt on the floors was under to be stripped. She stated dule to strip and wax the in employee that was a stated she would like them better and they are working. M, an interview was irector of Nursing. She ect the boot Resident #106 in it was in use.		084	residents with pressure reducing boots ensure that they are cleaned. This will done on weekly basis for 4 weeks then monthly for 3 months. The results of th audit will be reviewed at the weekly Quality Assurance Team Meeting. Rep will be presented to the weekly Quality Assurance Committee by the Director Nursing and/or Minimum Data Set (MD Coordinators to ensure corrective actionitiated as appropriate. Any immediate concerns will be brought to the Directon Nursing or Administrator for appropriate action. Compliance will be monitored a ongoing auditing program reviewed at Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting attended by Administrator, Director of Nursing, Minimum Data Set Coordinate Unit Manager, Support Nurse, Therapy HIM (Health Information Management) Dietary Manager, Wound Nurs	be is orts of of os) on e or of e ond the / is	
F 624	have them cleaned. Preparation for Safe/0	Orderly Transfer/Dschrg	F	624			8/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		345284	B. WING	 	07/25/2019	
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 OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET	
F 624 SS=D	Continued From pag CFR(s): 483.15(c)(7)		F 62	24		
	§483.15(c)(7) Oriented discharge. A facility must provid preparation and oriensafe and orderly transafe and orderly transafe and manner that understand. This REQUIREMENT by: Based on record revagency interviews, the safe discharge for a use of a rolling walker facility did not make have a rolling walker from the facility for 1 361) reviewed for a control of the findings included Resident #361 was a 3/28/19 with a diagnor A review of the 5-day assessment dated 4/4 was cognitively intact assistance with ambor A physical therapy did 4/5/19 revealed Resident #361 to dis Resident #361 to dis Resident #361 to dis	e and document sufficient ntation to residents to ensure sfer or discharge from the on must be provided in a at the resident can T is not met as evidenced riew, staff and outside he facility failed to provide a resident who required the er for safe ambulation, the provisions for the resident to when he was discharged of 2 residents (Resident discharge home. d: d: d: d: d: d: d: d: d: d		The statements made on this Plan Correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and Sta Regulations the facility has taken or take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility sallegation compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indicated for the properties of the process of the proce	te will n of be ated.	

PRINTED: 09/09/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 07/25/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	0112312019	
TVAIVIL OF T	TOVIDER OR OUT FEEL			, , ,	-		
THE OAK	3			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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 624	Continued From page 20 F 624		524				
		d 4/7/19 at 2:33 PM revealed ed minimal assistance with g and transfers.		physician orders. All discharge reviewed to have been provide durable medical equipment pe orders. This was completed or Systemic Changes:	ed with er physician		
	Resident #361 needed ordered and would be after discharge. The condicated the referral staff to the agency. An interview was comply with Physical The Resident #361 discharges a rolling walker.	was made by the facility ducted on 7/24/19 at 1:47		All Full Time and Part Time an social services department stated and the following by the Administrator; orientation for the discharge. A facility must provide document sufficient preparation orientation to residents to ensure orderly transfer or discharge from facility. This orientation must be in a form and manner that the can understand. Durable Med equipment must be provided a by physician for residents beir home.	aff will be the ransfer or ride and on and ure safe and rom the pe provided resident ical as ordered		
	he was to be discharge rolling walker. A discharge summary Practitioner (NP) date #361 was seen for dis was feeling better and walker. The NP indicated going home with home continue his therapy. A nurse 's note dated Resident #361 discharge summary a were reviewed. Verbar provided. Escorted in safely. There was no having a rolling walker.	ed 4/5/19 noted Resident scharge visit. He stated he d ambulated with a rolling ated Resident #361 would be the health physical therapy to d 4/7/19 at 8:02 PM revealed arged home with family. The and medication schedule all and written education was to family members car mention of Resident #361 er.		Education began on 8/16/19. This in service was completed 8/19/2019. Any social service department staff (full time, par PRN) and member of the inter team who did not receive in-set training will not be allowed to verticate the training is completed. This information training and in the in-service refresher courses for employees and will be reviewed Quality Assurance Process to the change has been sustained Monitoring: To ensure compliance, The Act and or Director of Nursing will residents discharged home to durable medical equipment is	es rt time, and rdisciplinary ervice work until ormation tandard required or all ed by the verify that ed. dministrator review 5 ensure that provided		
	A Start of Care Physic	cal Therapy Clinical Note		per physician orders. This will			

Facility ID: 923497

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	
NAME OF B	DOVIDED OD CUDDUED	343204	B: Willo _	OTDEET ADDRESS SITV STATE 71D S	•	07/25/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
THE OAK	S			901 BETHESDA ROAD			
				WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 624	Continued From pa	ge 21	F6	24			
F 024	dated 4/12/19 by the therapist revealed F was unsteady and use a rolling walker. The #361 had ambulate cane, not a rolling walker. The #361 had ambulate cane, not a rolling walker. An interview was concerned and what equipment and what equipment are agency the fact and staffed in the stated Resident discharge home with the chose a home he #361 and the informing the followed up with start of care date are to be picked up or whave a copy of the interview was concerned as a copy of the	e home health physical Resident #361 's ambulation unsafe and he required use of e note indicated Resident d 50 feet x 2 with the use of a valker, as recommended. Inducted on 7/24/19 at 1:35 's social worker. He stated, was a discussion about what a resident completes therapy it will be needed at home. He weekly updates from the about Resident #361 's indations for his needs, an 's order, made sure it was to with a home health agency. #361 had an order to he a rolling walker. He stated ealthcare agency for Resident mation was faxed to them and a phone call to determine the individual of the did whether equipment needed would be delivered. He did not information that he faxed to be agency or information on would receive the rolling conducted on 7/25/19 at 8:02 tative from the home health collity 's social worker set up for the stated the home care ride durable medical, patients would need to get medical equipment provider. Hether the family of Resident irmation or not. She was able	F 6	weekly basis for 4 weeks th 3 months. The results of this reviewed at the weekly Qual Team Meeting. Reports will to the weekly Quality Assura Committee by the Director of and/or Minimum Data Set (If Coordinators to ensure corrinitiated as appropriate. Any concerns will be brought to Nursing or Administrator for action. Compliance will be nongoing auditing program reweekly Quality of Life Meet Quality Assurance Committee attended by Administrator, If Nursing, MDS Coordinator, Support Nurse, Therapy, HI Information Management), If Manager, Wound Nurse.	s audit will be lity Assurance be presented ance of Nursing MDS) ective action immediate the Director of appropriate nonitored and eviewed at the ing. Weekly ee meeting is Director of Unit Manager, M (Health		

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 07/25/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 07723/2013
(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 APP DEFICIENCY)	OULD BE COMPLETION
F 624	who confirmed Resident rolling walker at the staffer. A follow up interview conducted on 7/25/1	e 22 erapy with Resident #361 dent #361 did not have a start of care but got it soon with the social worker 9 at approximately 8:15 AM aware that the home care	F 6	24	
F 641 SS=D	agency selected for Resident #361 did not provide durable medical equipment to the residents and one was not provided to Resident #361 prior to discharge home. Accuracy of Assessments		F 6	41	8/22/19
	The assessment muresident's status. This REQUIREMEN' by: Based on staff intentacility failed to accur Data Set (MDS) assessignificant weight los (Resident #47) revier indicate the fall histor (Resident # 98) revier The findings included 1. Resident #47 was 12/14/17 with re-entry Her cumulative diagramon-Alzheimer's deulcer on the sacrum the bottom of the spi	st accurately reflect the T is not met as evidenced views and record reviews, the rately code the Minimum essment to reflect a s for 1 of 8 residents wed for Nutrition and to ry for 1 of 3 residents ewed for Accidents. d: admitted to the facility on ry from a hospital on 5/24/19. hoses included mentia, a Stage IV pressure (a triangular-shaped bone at ne), and placement of a tube placed into the stomach		The statements made on this Plate Correction are not an admission not constitute an agreement with alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken take the actions set forth in this FC Correction. The Plan of Correctic constitutes the facility's allegation compliance such that all alleged deficiencies cited have been or water corrected by the date or dates in the F641 Accuracy of Assessments Corrective Action: Resident #47: Resident Minimum Set (MDS) assessment (Quarterl Assessment Reference Date (AF)	to and do the n State n or will Plan of on n of will be dicated.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C	•
NAME OF D	ROVIDER OR SUPPLIER	040204		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>_</u>	07/25/2019	9
NAIVIE OF PI	ROVIDER OR SUPPLIER				-		
THE OAK	S			901 BETHESDA ROAD			
				WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		5) ETION TE
F 641	F 641 Continued From page 23		F 6				
	A review of Resident Minimum Data Set (M 5/31/19 indicated the impaired cognitive sk The resident required staff for all of her Acti (ADLs). Section K of resident 's weight at was 111 pounds (#). the resident did not hof 5 percent (%) or more i portion of the 5/31/19 been completed by M An interview was con AM with the facility 's Dietitian (RD). Upon Section K of Resident dated 5/31/19. The Finot report the resident loss. The RD then caweight loss from her with the total set of the resident 's weight loss from her with the resi	#47 's most recent quarterly MDS) assessment dated resident had moderately ills for daily decision making. I extensive assistance from vities of Daily Livings the MDS reported the the time of the assessment The assessment indicated ave a significant weight loss ore in the last month or a n the last 6 months. This MDS was signed as having IDS Nurse #1. ducted on 7/24/19 at 10:23 consultant Registered request, the RD reviewed tr #47 's MDS assessment RD confirmed Section K did at had a significant weight alculated Resident #47 's weight on 11/14/18 (124.0#) ght on 5/24/19 (111.4#) used		[5/31/2019] was modified with Corrective Attestation Date of The assessment was submitte state QIES system on 7/26/20 accepted on 7/30/2019. Subm 17186422 Resident #98: Resident Minim Set (MDS) assessment (Quart Assessment Reference Date ([6/30/2019]) was modified with Corrective Attestation Date of The assessment was submitte state QIES system on 7/26/20 accepted on 7/26/2019. Subm 17173291 Identification of other residents be involved with this practice: All current residents with Quart Minimum Data Set (MDS) assed the alleged practice. On 8/15/2 through 8/19/2019 an audit was completed by the MDS Nursed to review the most recent Minim Set (MDS) in the last 6 months	7/26/2019 ad to the 19 and wanission ID um Data terly) with ARD) a 7/25/2019 ad to the 19 and wanission ID as who may terly essments ffected by 2019 as Consultar mum Data as to ensur	as c. d. as c.	
	reported the weight lo Upon further inquiry, have coded the 5/31/	S assessment. The RD oss would have been 10.1%. the RD stated she would 19 MDS to indicate Resident weight loss of more than ays.		that all residents with a weight or more in the last month or lost of more in the last 6 months from ARD were coded accurately in K0300 (Weight loss) and to en Section J1800 [Number of fall	ss of 10% om their section sure that s since		
	PM with MDS Nurse : MDS nurse reviewed s MDS assessment d reviewing the residen nurse reported this M	ducted on 7/24/19 at 1:59 #1. During the interview, the Section K of Resident #47 ' lated 5/31/19. After t 's weight history, the MDS DS should have been coded 7 had a significant weight		Admission/Entry or Reentry or Assessment (OBRA or Schedu was coded accurately. Of the 9 residents, 3 assessments were for Section K0300 for weight to residents were coded accurate quarterly assessments for Section falls. This was completed or	uled PPS) 95 current e modified oss and al ely for the otion J180	i I I ir	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C 07/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	1 0.020	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	25/2019
					1 BETHESDA ROAD		
THE OAK	S				INSTON SALEM, NC 27103		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI) TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 641	Continued From pag	ge 24	F 6	641			
	loss within the last 1	80 days.			8/19/2019.		
		•			Systemic Changes:		
		nducted with the facility 's			On 8/16/2019 The Registered Nurse (F	RN)	
		(DON) on 7/24/19 at 4:16 PM.			Minimum Data Set (MDS) Coordinators	3	
	_	, the DON reported she would			and any other Interdisciplinary team		
		s' MDS assessments to be			member that participates in the MDS		
	coded accurately.				assessment process was in serviced	-4	
	2 Pesident #08 wa	s admitted to the facility on			/educated by the MDS Nurse consultar The education focused on: The facility	II.	
		oses which included: epilepsy,			must ensure that each assessment		
	Parkinson's disease				accurately reflects the resident's status	.	
		,			Section K0300(Weight loss). Code 0, r		
	Review of the incide	ent report and nurse's note			or unknown: if the resident has not		
	dated 5/7/19 revealed	ed during an assisted transfer			experienced weight loss of 5% or more	in :	
		#98 became weak and was			the past 30 days or 10% or more in the		
	lowered to the floor	by the nursing assistant.			last 180 days or if information about pr		
	Deview of the quart	erly Minimum Data Set (MDS)			weight is not available. Code 1, yes on physician-prescribed weight-loss regime		
	-	ated Resident #98 was			if the resident has experienced a weight		
		ely impaired; was totally			loss of 5% or more in the past 30 days		
		fers; and had no falls since			10% or more in the last 180 days, and		
		nt. Section J1800 of the MDS			weight loss was planned and pursuant		
	dated 6/30/19 did no	ot reflect Resident #98's fall			a physician's order. In cases where a		
	on 5/7/19.				resident has a weight loss of 5% or mo		
					in 30 days or 10% or more in 180 days		
	_	on 7/25/19 at 5:02 p.m., MDS			a result of any physician ordered diet p	lan	
		he was not aware Resident			or expected weight loss due to loss of		
		7/19 and confirmed Resident was inaccurate regarding			fluid with physician orders for diuretics, K0300 can be coded as 1. Code 2, yes		
		e the prior MDS assessment.			not on physician-prescribed weight-los		
	Tiaving no lans since	the phor MBO assessment.			regimen: if the resident has experience		
					weight loss of 5% or more in the past 3		
					days or 10% or more in the last 180 da		
					and the weight loss was not planned a	•	
					prescribed by a physician. A resident n		
					experience weight variances in betwee		
					the snapshot time periods. Although th		
					require follow up at the time, they are r		
					captured on the MDS. • If the resident	is	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	١ , ,	E SURVEY IPLETED
		345284	B. WING		0.	C
NAME OF P	ROVIDER OR SUPPLIER	0.10204		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	0	7/25/2019
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641	Continued From pag	e 25	F 64	losing a significant amount of we facility should not wait for the 30 180-day timeframe to address the problem. Weight changes of 5% month, 7.5% in 3 months, or 100 months should prompt a thoroug assessment of the resident's nurstatus. • To code K0300 as 1, ye expressed goal of the weight lost the expected weight loss of eder through the use of diuretics must documented. • On occasion, a rewith normal BMI or even low BM placed on a diabetic or otherwist calorie-restricted diet. In this instintent of the diet is not to induce loss, and it would not be considered physician-ordered weight-loss respection J1800 [Number of falls Admission/Entry or Reentry or Passessment (OBRA or Schedule Code 0, no: if the resident has not any fall since the last assessme Swallowing Disorder item (K010 1, yes: if the resident has fallent last assessment. Continue to NuFalls Since Admission/Entry or Prior Assessment (OBRA or Schen PPS) item (J1900), whichever is recent. This in service was completed be 8/19/2019. Any The Registered (RN) Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member the participates in the MDS assessment process who did not receive in-straining will not be allowed to wortaining will not be allowed to wortaining is completed. This informatical process who did not receive in-straining will not be allowed to wortaining is completed. This informatic interdisciplinary team to the modern and the participates in the MDS assessment.	or o	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345284	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	0.10204		STREET ADDRESS, CITY, STATE, ZIP (901 BETHESDA ROAD WINSTON SALEM, NC 27103	CODE	07/25/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	
F 641	Continued From pag	ge 26	F 64	has been integrated into the orientation training and in inservice refresher course employees and will be revered Quality Assurance Process the change has been sustantioning: To ensure compliance, The Nursing and/or Administratesident electronic medical Minimum Data Set (MDS) this could be either one of assessments that is Compacterly / PPS Mini Data (Assessments) per week the Section J1800 [Number of Admission/Entry or Reentry Assessment (OBRA or Sciand Section K0300 (Weigh coded accurately. This will weekly basis for 4 weeks the 3 months. The results of the reviewed at the weekly Quality Assurance Committed as appropriate. And concerns will be brought to Nursing or Administrator for action. Compliance will be ongoing auditing program Weekly Quality of Life Mee Quality Assurance Committended by Administrator, Nursing, MDS Coordinator Support Nurse, Therapy, Information Management).	the required es for all iewed by the s to verify that ained. e Director of tor will review I records assessment the following orehensive/ Set o ensure that f falls since ry or Prior heduled PPS) at loss) was I be done on then monthly for its audit will buildity Assurance of Nursing (MDS) rrective actionary immediate of the Director or appropriate monitored an reviewed at the ting. Weekly ttee meeting is, Director of r, Unit Manage HIM (Health	of of the cests

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345284	B. WING		C 07/25/2019	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 01/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 641	Continued From pag		F 64	Manager, Wound Nurse.	9/22/40	
F 656 SS=D	S483.21(b) Compres §483.21(b)(1) The faimplement a compres care plan for each resident rights set for §483.10(c)(3), that is objectives and time function medical, nursing, and needs that are ident assessment. The condescribe the following (i) The services that or maintain the resident of the under §483.24, §482 provided due to the under §483.10, inclustreatment under	thensive Care Plans acility must develop and behensive person-centered besident, consistent with the borth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial diffied in the comprehensive comprehensive care plan must fing - are to be furnished to attain dent's highest practicable d psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights adding the right to refuse 3.10(c)(6). services or specialized best he nursing facility will of PASARR f a facility disagrees with the ARR, it must indicate its dent's medical record. dith the resident and the	F 65	6	8/22/19	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		COMPLETED
		345284	B. WING			C 07/25/2019
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	<u> </u>	0112312013
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656		es and/or other appropriate	F 65	56		
	plan, as appropriate requirements set for section. This REQUIREMEN by: Based on observati and staff interviews, person centered car	in the comprehensive care , in accordance with the th in paragraph (c) of this T is not met as evidenced ons, record reviews, resident the facility failed to develop e plans in the areas of		The statements made on this Pla Correction are not an admission t not constitute an agreement with	to and do	
	risk of or actual pres	pain management and for sure ulcer development for 2 ents (Residents #92 & #106).		alleged deficiencies. To remain in compliance with all Federal and S Regulations the facility has taken take the actions set forth in this P Correction. The Plan of Correction constitutes the facility's allegation compliance such that all alleged	State or will Plan of on	
	1/16/18 with diagnost pneumonia, chronic disease and conges	obstructive pulmonary tive heart failure.		deficiencies cited have been or w corrected by the date or dates inc F656 Develop/Implement Compre Care Plan	dicated.	
	dated 5/10/19 indica cognitively intact and	erly minimum data set (MDS) Ited Resident #92 was d received oxygen therapy.		Corrective Action: Resident #92 and 106: Care plan reviewed and updated on 7/30/20 Identification of other residents w	019.	
	revealed oxygen the	#92's most recent care plan grapy was not addressed.		be involved with this practice: All current residents with oxygen on pain management and at risk	of or	
	4:05 p.m., an oxyge next to Resident #92	on and interview on 7/21/19 at n concentrator was observed 2's bed. The resident revealed therapy at night, when		actual pressure ulcer developmer the potential to be affected by the practice. On 8/15/2019 through 8 an audit was completed by the M Data Set (MDS) Nurse Consultan Minimum Data Set Coordinators,	e alleged /19/2019 inimum nt and	
	Nurse#1 revealed R	on 7/25/19 at 4:52 p.m., MDS esident #92 received nerapy at night when needed		ensure that a care plan was imple for current residents with oxygen on pain management and at risk	emented therapy,	

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DENTIFICATION NUMBER: (X3) MULTIPLE CONSTRUCTION (X3) A. BUILDING			(X3) DATE SURVEY COMPLETED			
		0.4500.4	D. MINIC				
		345284	B. WING _			07/	25/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	3			9	01 BETHESDA ROAD		
IIIE OAK	•			٧	VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX				(X5) COMPLETION DATE
F 656	Continued From page	÷ 29	F	656			
	and this should have				actual pressure ulcer development. All		
		200 0ao p.a0a.			current residents with pressure ulcers		
	1b. Resident #92 was	s admitted to the facility on			have updated care plans. This was		
		es which included: peripheral			completed on 8/19/2019.		
	vascular disease, gou	it, and a history of malignant			Systemic Changes:		
	neoplasm of the large	intestine.			On 8/19/2019 The Registered Nurse (F	,	
					Minimum Data Set (MDS) Coordinators	6	
	•	ly minimum data set (MDS)			and any other Interdisciplinary team		
	dated 5/10/19 indicate				member that participates in the MDS		
		frequent pain; and received			assessment process was in serviced		
	scheduled and when	needed pain medication.			/educated by the MDS Nurse consultar The education focused on: The facility	ıt.	
	Paviou of Posidont #	92's most recent care plan			must develop and implement a		
		ement was not addressed.			comprehensive person-centered care	olan	
	revealed pain manage	cinent was not addressed.			for each resident, consistent with the	Jian	
	During an observation	and interview on 7/21/19 at			resident rights set forth and that include	es	
		92 requested and received			measurable objectives and timeframes		
	T	codone 5) for pain in his left			meet a resident's medical, nursing and		
		asked on a scale of 0 to 10			mental psychosocial needs that are		
	(10 being intense pair	n), the resident indicated his			identified in the comprehensive		
	pain was at a pain sca	ale level of 10.			assessment. The comprehensive care		
					plan must describe the following: the		
	•	n 7/23/19 at 1:25 p.m., the			services that are to be furnished to atta	iin	
	•	ctor revealed Resident #92			or maintain the resident's highest		
		tions due to his complaints			practicable physical, mental, and	.00	
		He stated that the resident ecessary) .6mg (milligram)			psychosocial wellbeing; and any service that would otherwise be required but a		
		.6mg oxycodone to be			not provided due to the resident's	C	
	given independently	• •			exercise of rights, including the right to	,	
	given independently c	overy environes.			refuse treatment; and any specialized		
	During an interview of	n 7/25/19 at 4:45 p.m., MDS			services or specialized rehabilitative		
	•	t the time of Resident #92's			services the nursing facility will provide	as	
	comprehensive asses	ssment, the resident's pain			a result of PASARR recommendations		
	was controlled; he wa	s not asking/receiving prn			and after consultation with the resident		
		nere was no CAA (care area			and the resident's representative's on t	he	
	assessment) to trigge	·			residents goals for admission and desi		
		admitted to the facility on			outcomes, the resident's preference ar	nd	
	_	sis of right heel pressure			potential for future discharge, and		
	ulcer.				discharge plans. A comprehensive per	son	

Facility ID: 923497

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED					
		345284	B. WING			C 07/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	******	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	011231	2019
TO WILL OF TH	TO VIDER OR OUT FEEL			901 BETHESDA ROAD	CODE		
THE OAK	3						
				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 O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA		(X5) OMPLETION DATE
F 656	Continued From page	e 30	F 6				
	A review of an annual assessment dated 7/3 had the presence of a risk for pressure ulcerassessment indicated was triggered and wo care plan. A review of the care proposed to have a horizontal formula observation of wo 7/22/19 at 10:39 AM. observed to have a horizontal her right heel approxiculty observed with a greeral was cleaned with prep was applied. An interview with NA revealed she knew wo by the Kardex and she assistant and the nurse An interview with MD revealed she was sur	I Minimum Data Set (MDS) 3/19 revealed Resident #106 a pressure ulcer and was at rs. The care area If the area of pressure ulcers and be addressed in the Dian dated 7/3/19 revealed for actual pressure ulcer. und care was completed on Resident #106 was ealing deep tissue injury to mately nickel sized and nish/brown covering. The h wound cleanser and skin #1 on 7/22/19 at 8:41 AM hat Resident #106 needed iff report from the nursing se. S nurse #1 on 7/25/19 prised Resident's #106 essure ulcers was not care		centered care plan must be for all residents requiring and must be developed for receiving activities of daily lidentifies the type of care activities of daily living. This in service was comp 8/22/2019. Any Minimum (full time, part time, and Formember of the interdiscip did not receive in-service be allowed to work until the completed. This information integrated into the standator training and in the requires refresher courses for all ewill be reviewed by the Quality and in the requires refresher courses for all ewill be reviewed by the Quality and/or Assistant Nursing and/or Assistant Nursing will observe 5 respondent to ensure the implemented. This will be basis for 4 weeks then mononths. The results of this reviewed at the weekly Quality Assis Committee by the Director and/or Minimum Data Set Coordinators to ensure contitied as appropriate. A	catheter care or all resident's y living that needed for leted by n Data Set nur PRN) and linary team w training will n raining is on has been and orientation of in-service employees and uality Assurar change has ne Director of Director of Sident's requir management of re ulcer at care plan is done on wee onthly for 3 s audit will be uality Assurar vill be present urance or of Nursing t (MDS) orrective actio	se ho ot dince ing and skly ince ed in	
				concerns will be brought to Nursing or Administrator f action. Compliance will be	or appropriate	e	

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 _				25/2019
NAME OF PI	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 11 BETHESDA ROAD VINSTON SALEM, NC 27103	1 011	23/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page			656	ongoing auditing program reviewed at Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting attended by Administrator, Director of Nursing, Minimum Data Set Coordinate Unit Manager, Support Nurse, Therapy HIM (Health Information Management) Dietary Manager, Wound Nurse.	/ is or, /,	8/22/19
SS=D	be- (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practive the resident and their and their resident reput practicable for the resident's care plan. (F) Other appropriate disciplines as determined or as requested by th (iii)Reviewed and revision in the resident resident resident resident reput practicable for the resident's care plan.	ensive Care Plans brehensive care plan must I days after completion of ssessment. terdisciplinary team, that lited to- visician. The with responsibility for the I and nutrition services staff. It ticable, the participation of the sident's representative(s). The included in a resident's the participation of the resident tresentative is determined the development of the staff or professionals in tined by the resident's needs the resident. The including both the					

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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 07/25/2019	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	20/2013
					01 BETHESDA ROAD		
THE OAKS	3				VINSTON SALEM, NC 27103		
					T TON SALEW, NC 27 105		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 657	Continued From page	e 32	F 6	357			
	l <u>.</u>	is not met as evidenced					
	facility failed to revise sampled residents (R	iews and staff interviews, the e the care plan of 1 of 7 Resident #161) who ro pressure ulcer to her right			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		
	Findings included:				take the actions set forth in this Plan of Correction. The Plan of Correction		
	Resident #161 was a	dmitted to the facility on			constitutes the facility □s allegation of		
	5/1/11 with diagnoses	s which included: dementia			compliance such that all alleged		
	with behavioral distur	bance and diabetes mellitus.			deficiencies cited have been or will be		
					corrected by the date or dates indicate	ed.	
		an dated 6/3/18 revealed					
		t risk for impaired skin			F657 Care Plan Timing and Revision		
		nited bed mobility and urinary					
		ice secondary to hemiplegia,			Corrective Action:		
		es mellitus. Interventions			Resident #161: Care plans reviewed a	ind	
		n for redness/open areas			updated on 7/30/2019.		
		ny areas noted; and weekly			Identification of other residents who m	ay	
	full body skin assessi	ments.			be involved with this practice:		
	The Weekly Pressure	Lillogr Davious dated			All current residents with pressure ulc		
	•	sident #161 was noted with a			have the potential to be affected by the alleged practice. On 8/15/2019 through		
		er to her right hip on 7/18/18.			8/19/2019 an audit was completed by		
	Stage 2 pressure dice	er to her right hip on 77 for fo.			Minimum Data Set (MDS) Nurse	uie	
	Poviow of the guarter	rly minimum data set (MDS)			Consultant and Minimum Data Set		
		ed Resident #161 was			Coordinators, to ensure that a care plant	an .	
		impaired and had developed			was implemented for current residents		
	a stage two pressure				with pressure ulcers. All current resident		
	a stage two pressure	uicei.			with pressure ulcers. All current reside		
	 Resident #161's care	plan was not revised to			plans. This was completed on 8/19/20		
		pressure ulcer on her right			Systemic Changes:	10.	
	hip.	procedure dioor on her right			On 8/16/2019 The Registered Nurse (RN)	
	יייי.				Minimum Data Set (MDS) Coordinato	-	
	Review of the Weekly	y Pressure Ulcer Review			and any other Interdisciplinary team	J	
	-	d the stage 2 pressure ulcer			member that participates in the MDS		
		ight trochanter (hip) had			assessment process was in serviced		

Facility ID: 923497

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			X3) DATE SURVEY COMPLETED			
		345284	B. WING			C 07/25/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		07723/2019
				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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From page	e 33	F 6	57		
F 657	healed and was resol During an interview o Treatment Nurse reve treatment nurse durin the facility. However, resident's wound recoresident had a stage onset date of 7/18/18 by the physician. During an interview o Nurse#1 acknowledg plan was not revised	n 7/23/19 at 3:46 p.m., the ealed he was not the gresident #161's stay at after reviewing the ords, he stated that the two to her right hip with the and was resolved on 8/1/18 n 7/25/19 at 5:23 p.m., MDS ed Resident #161's care in July 2018 but should have tage two pressure ulcer to	F6	/educated by the Minimum Data Nurse consultant. The education focused on: The must develop and implement a comprehensive person-centere for each resident, consistent wi resident rights set forth and tha measurable objectives and time meet a resident s medical, nur mental psychosocial needs that identified in the comprehensive assessment. The comprehensive assessment. The comprehensive plan must describe the following services that are to be furnished or maintain the resident shigh practicable physical, mental, ar psychosocial wellbeing; and and that would otherwise be required not provided due to the resident exercise of rights, including the refuse treatment; and any specific services or specialized rehabilities services the nursing facility will a result of PASARR recommental and after consultation with the resident services.	e facility ed care plan ith the at includes eframes to rsing and t are eve care g: the d to attain nest ad by services ed but are at s e right to cialized tative provide as dations,	
				and after consultation with the rand the resident sepresentate the residents goals for admission desired outcomes, the resident preference and potential for fut discharge, and discharge plans comprehensive person centere must be implemented for all reserve quiring catheter care and must developed for all resident street activities of daily living that ident type of care needed for activities living. This in service was completed 18/19/2019. Any Minimum Data	tive s on on and sure s. A d care plan sidents st be ceiving ntifies the es of daily	

Facility ID: 923497

	OF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED		
		345284	B. WING		C 07/25/2019	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07/23/2019	
	_			901 BETHESDA ROAD		
THE OAKS	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 657	Continued From page	or Dependent Residents	F 65	(full time, part time, and PRN) and member of the interdisciplinary team will did not receive in-service training will rise allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees an will be reviewed by the Quality Assura Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will observe 5 resident with pressure ulcers to ensure that care plaimplemented. This will be done on were basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assura Team Meeting. Reports will be present to the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective actionitiated as appropriate. Any immediate concerns will be brought to the Director Nursing or Administrator for appropriate action. Compliance will be monitored a ongoing auditing program reviewed at Weekly Quality of Life Meeting. Weekl Quality Assurance Committee meeting attended by Administrator, Director of Nursing, Minimum Data Set Coordinat Unit Manager, Support Nurse, Therapy HIM (Health Information Management) Dietary Manager, Wound Nurse.	not not not donce an is ekly ence ted on e or of e and the y is or,	
1 011	, LDE Galo i Toviada id	2 Depondent Residents	'07	'	GIZZI 13	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C 07/25/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 01/20/2013
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 677	Continued From pag		F 67	77	
SS=D	out activities of daily services to maintain personal and oral hy This REQUIREMEN by: Based on observati and staff interviews, facility failed to proveating for a resident unplanned weight to and with written phy meals. This occurre (Resident #81) revie Living. The findings include Resident #81 was a 6/13/17 from another's cumulative diagn s dementia and dys A review of the resident weight be 84.4 pounds (#). A review of Resident Minimum Data Set (the resident had moskills for daily decision assessment indicate extensive assistance.	ident who is unable to carry a living receives the necessary good nutrition, grooming, and a lygiene; IT is not met as evidenced ions, Nurse Practitioner (NP), and record reviews, the ide staff assistance with a identified to have an loss related to poor oral intake a sician orders to be fed all do for 1 of 7 residents are wed for Activities of Daily and: dmitted to the facility on the er nursing facility. The resident loses included non-Alzheimer are included non-Alzheimer phagia (difficulty swallowing). Ident 's medical record lon 1/24/19 was reported to at #81 's most recent quarterly lymbs) dated 6/11/19 revealed lympaired cognitive lon making. The MDS led Resident #81 required le from staff for bed mobility,		The statements made on this Plan Correction are not an admission to not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and St. Regulations the facility has taken of take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility allegation compliance such that all alleged deficiencies cited have been or will corrected by the date or dates indice the corrective Action: Residents Corrective Action: Resident #81: Resident assisted we eating all meals per physician order Identification of other residents who is involved with this practice: All current residents with physician to be assisted with all meals have potential to be affected by the allegoractice. On 8/15/2019 through 8/1 an audit was completed by the Min Data Set (MDS) Nurse Consultant MDS Coordinators, to ensure that	and do ne ate or will an of of l be cated. ith ers. o may orders the ged 9/2019 imum and
	dependent on staff tunit, dressing and p	d toileting; she was totally for locomotion on and off the ersonal hygiene. Section K of the resident weighed 79		plan was implemented for current residents with physician orders to be all meals. All current residents with physician orders to be assisted with	ı

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						(
		345284	B. WING _			07/	25/2019
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK				9(01 BETHESDA ROAD		
THE OAKS				٧	/INSTON SALEM, NC 27103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 677	Continued From page	∋ 36	F6	377			
	pounds (#) and receive	ved a therapeutic and			meals have those orders implemented.		
	mechanically altered	•			This was completed on 8/19/2019.		
	•				Systemic Changes:		
	A review of Resident	#81 ' s current care plan			On 8/19/2019 the Director of Nursing a	nd	
	was completed. The	care plan included an area			Unit Manager began in-servicing the		
	of focus (not dated) re	elated to a potential			nursing staff (Registered nurses and		
	•	ue to fair meal intake, and			Nurse Aides: Full time, Part time and		
	_	ally altered and therapeutic			PRN) that a resident who is unable to		
	diet. The planned goal for this area of focus was for the resident to maintain adequate nutritional status as evidenced by maintaining weight with				carryout activities of daily living receive		
					the necessary services to maintain goo		
					nutrition, grooming, and personal and o	oral	
	_	s and eating 50% or more of			hygiene; The facility must ensure to		
		olan also included an area of			provide assistance with eating for all		
		ted to an unplanned weight			resident with physician orders to be fed	ı alı	
	•	intake. The planned goal			meals.		
		o consume 50% to 75% at			This in service was completed by 8/22/2019. Any nurse and nurse aide (f11	
	two or trifee means da	ally through the next 90 days.			time, part time, and PRN) who did not	iuii	
	Deview of the resider	nt 's diet order revealed she			receive in-service training will not be		
	was prescribed a low				allowed to work until training is comple	ted	
) Level 3 diet with liquids of			This information has been integrated in		
		NDD Level 3 diet is one			the standard orientation training and in		
	_	foods in bite-size pieces			required in-service refresher courses for		
		ew and swallow. A Mighty			all employees and will be reviewed by		
	_	nigh protein nutritional			Quality Assurance Process to verify that		
		o ordered (initiated on			the change has been sustained.		
	4/11/18) to be provide	ed with meals for extra			Monitoring:		
	calories.				To ensure compliance, The Director of		
					Nursing or Unit Manager will observe 5		
		#81 's medical record			residents each week to include the		
		was seen on 7/1/19 for a			weekend who have physician orders to	be	
		e Practitioner (NP) #1. NP			fed all meals to ensure that orders are		
		had an ongoing progressive			implemented at breakfast, lunch and		
		ctional and mental status			dinner. This will be done on weekly bas		
		nd debility. The resident 's			for 4 weeks then monthly for 3 months.		
		e care at times and having			The results of this audit will be reviewe	d at	
	_	was also reported Resident			the weekly Quality Assurance Team		
		en feeding self and needing			Meeting. Reports will be presented to the		
	assistance with meals	s. NP #1 indicated an order			weekly Quality Assuarance Committee	ру	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245204	B WING		С
		345284	B. WING _		07/25/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE
THE OAK	6			901 BETHESDA ROAD	
THE UAK	5			WINSTON SALEM, NC 271	03
(X4) ID PREFIX TAG			ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (X5) (E ACTION SHOULD BE COMPLETION DATE (ICIENCY)
F 677	Continued From pa	ge 37	F 6	577	
	would be written for the resident to be assisted with all meals. On 7/2/19, an order was written by NP #1 which provided instruction for Resident #81 to be fed all			the Director of Nursing Data Set (MDS) Coord corrective action initial Any immediate concer the Director of Nursing	dinators to ensure ted as appropriate. rns will be brought to
	meals. This order was noted to have been typed in all capital letters in Resident #81 's electronic medical record.			for appropriate action. monitored and ongoin reviewed at the Weekl Meeting. Weekly Qual	g auditing program ly Quality of Life lity Assurance
	medical record incli 7/6/19 at 1:38 PM. Administration Note "Resident to be fed	rther review of Resident #81 's electronic edical record included a Nursing Note dated 6/19 at 1:38 PM. This note was a Medication Iministration Note which read (in capital letters), esident to be fed all meals with meals." The te also reported the Nursing Assistant (NA) as notified.		Committee meeting is Administrator, Director Minimum Data Set Co Manager, Support Nur (Health Information Manager, Wound Nurs	r of Nursing, ordinator, Unit rse, Therapy, HIM anagement), Dietary
		dent 's medical record t on 7/16/19 was reported to			
	Report (printed on instructions on Eati follows:Give me supplem nurse/dietary mana routine basis;I need staff assist intake (noted on 11Monitor and recorOffer substitutes a prefer: (left blank);Please assist me meals;Provide and serve and,	d food intake at each meal; as requested or indicated. I into my wheelchair prior to e supplements as ordered; et as ordered. Monitor intake			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345284	B. WING _			C 07/25/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 901 BETHESDA ROAD WINSTON SALEM, NC 27103		01720/2013
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	up in bed with a bre bedside table on 7/2 member was in the observation. A cont as the resident was to feed herself some bread. On 7/22/19 a noted to have eaten scrambled eggs and	made of Resident #81 sitting akfast tray placed on her 22/19 at 8:29 AM. No staff room at the time of the inuous observation was made observed to use her fingers e of the scrambled eggs and at 8:45 AM, the resident was approximately ½ of the 1½ slice of bread. An attempt	F 6	77		
	was made at that tir she was not intervie attempted to say so as she appeared to liquid (identified as ticket). On 7/22/19 observed from the hea. No staff membroom. On 7/22/19 observed to have st breakfast. At that tir tea had been consuscrambled eggs and noted. No staff mem the room to assist the during the continuous	ne to interview the resident; wable. The resident mething (not understandable) point to a cup of light brown the abythe resident 's meal at 8:49 AM, the resident was callway as she reached for her the was observed to enter the at 9:02 AM, the resident was copped feeding herself the, approximately 2 ounces of med in addition to the 1/4 at 1/2 slice of bread previously observed to enter the resident with her meal us observation. On 7/22/19				
	On 7/22/19 at 9:18 awas observed as shroom and removed. A second continuou beginning at 1:00 Pl was observed to britray into the residen meal set-up for the 1:03 PM. On 7/22/1	dent appeared to be asleep. AM, Nursing Assistant (NA) #6 e went into the resident 's the breakfast tray. s observation was made M on 7/22/19 when NA #6 ng Resident #81's lunch meal t 's room. The NA provided resident and left the room at 9 at 1:49 PM, the resident alone with her lunch tray in				

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 _			C 07/25/2019	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 901 BETHESDA ROAD WINSTON SALEM, NC 27103	•	0172072010	
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 677		dent was observed to have	F 6	777			
	mashed potatoes ar vegetables, or cake cream had been cor container was noted No staff member wa	ately 10% of her meat and ad ¼ slice of bread; no soup, had been eaten; and, no ice asumed (the ice cream as not having been opened). It is observed to have entered at to assist her with the meal time.					
	#81's room and wa as she asked the re- eating?" No respon heard. NA #6 picker	PM, NA #6 entered Resident s overheard from the hallway sident, "Are you finished se from the resident could be d up the resident 's lunch tray s she exited the room with it.					
	PM with NA #6. Whe was able to feed her Upon further inquiry	nducted on 7/22/19 at 1:50 en asked whether the resident reelf, the NA stated she was. , the NA stated Resident #81 ell with eating and usually ate					
	at 2:22 PM with NA NA reported she was Sunday" and was no NA for orientation. Nation what care each	was conducted on 7/22/19 #6. During the interview, the s "released (from training) on o longer working with another When asked how she would h resident required, NA #6 k on the computer (referring dex Report).					
	PM with NA #7. NA shift NA who was fre Resident #81. Whe s meal intake, the N	#7 reported she was the 1st equently assigned to care for a sked about Resident #81 'A stated the resident did not orted Resident #81 would try					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345284	B. WING		1	C / 25/2019
THE OAK	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 OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	likely about all. Upor resident needed to be a telephone interview at 12:00 PM with NP continuous observative trying to feed herself without staff assistant stated, "I think that is (Resident #81) could finger foods." The NF not doing very well arroods and that she contacted that Resident is meals. An interview was contacted the province of the pr	d drink her tea, but that was inquiry, the NA stated the e fed by staff. was conducted on 7/24/19 #1. During the interview, the ons made of Resident #81 two consecutive meals be was discussed. NP #1 unfortunate because help herself at one time with preported the resident was nymore even with finger huld not use utensils. NP #1 #81 needed to be fed all ducted on 7/24/19 at 4:16 is Director of Nursing. During	F 6	77		
F 686 SS=D	#81 to be fed all mea the continuous obser attempting to feed he assistance on 7/22/19 the order was enterer record and whether the communication had be nursing assistants kn resident. The DON in investigate this further if an order had been all meals, she would resident the meals. Treatment/Svcs to Pr	een followed so nurses and ew of the need to feed this ndicated she would need to r. However, the DON stated received to feed a resident expect staff to feed the event/Heal Pressure Ulcer (i)(ii)	F 6	36		8/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED				
		345284	B. WING		0	C 7/25/2019		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 0	1720/2010		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	Continued From page Based on the comparised resident, the facility	rehensive assessment of a	F 68	36				
	(i) A resident received professional standar pressure ulcers and ulcers unless the incidemonstrates that the standard pressure ulcers unless the incidemonstrates that the standard processary treatment with professional standard promote healing, pronew ulcers from device professional standard promote healing, pronew ulcers from device professional standard pressure ulcers unless the standard professional standard professional standard pressure ulcers unless the incident pressure unl	es care, consistent with rds of practice, to prevent does not develop pressure dividual's clinical condition ney were unavoidable; and ressure ulcers receives t and services, consistent andards of practice, to event infection and prevent						
	Based on observati interviews, the facili pressure reducing d			The statements made on this F Correction are not an admission not constitute an agreement with alleged deficiencies. To remain compliance with all Federal and Regulations the facility has take take the actions set forth in this Correction. The Plan of Correction	n to and do th the in d State en or will Flan of			
	7/27/18 with diagnoulcer.	admitted to the facility on sis of right heel pressure all Minimum Data Set		constitutes the facility's allegation compliance such that all alleged deficiencies cited have been or corrected by the date or dates in	on of d will be			
	assessment dated 7 needed extensive a mobility and transfe had a deep tissue ir and was at risk for part A July 2019 physicia for a pressure relievatimes, dated 7/13/19. An observation made	7/3/19 revealed Resident #106 ssistance x 2 people for bed rs, was non-ambulatory and sjury present on admission pressure ulcer development. an's orders revealed an order ing boot to the right heel at all		P686 Treatment/Svcs to Prever Pressure Ulcer Corrective Action: Resident #106: Pressure reduction implemented for resident per playorders. Identification of other residents be involved with this practice: All current residents with pressure the potential to be affected alleged practice. On 8/15/2019 8/19/2019 an audit was comple	cing device hysician who may ure ulcers d by the through			

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 07/25/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	<u> </u> DF	077	25/2019	
	10115211 011 001 1 21211			901 BETHESDA ROAD				
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				WINSTON SALEM, NC 27103				
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F 686	Continued From page	e 42	F 6	86				
	boot to the left (unaffe			Director of Nursing, Unit Mar	-			
	10:39 AM of wound or right heel wound by the procedure was explained resident was assessed was observed with an sized to right heel, condried skin. The area work cleanser and skin president was an interview on 7/22/revealed the boot should be and she didn't kin foot. An observation made revealed Resident #1 feet against the footbot or in the side of the side of the right foot or in the side of the	ned to the resident. The ed for pain. The right heel in area approximately nickel vered over with green/brown was cleaned with wound ep was applied. 19 at 8:41 AM with NA #1 build have been on the right ow why it was on the wrong on 7/24/19 a 10:10 AM 06 lying in her bed with her oard. No boot was observed the bed.		Minimum Data Set Coordinathat pressure reducing device implemented for residents will ulcers per physician orders. I reducing devices ordered by implemented. This was compart 8/19/2019. Systemic Changes: On 8/19/2019 the Director of Unit Manager began in-servinursing staff (Registered nur Nurse Aides: Full time, Part the PRN) that a Skin Integrity (b) Integrity 1) Pressure ulcers. I comprehensive assessment the facility must ensure that (ireceives care, consistent with standards of practice, to prevulcers and does not develop ulcers unless the individual's condition demonstrates that	es were ith pressure All pressure physician a pleted on f Nursing ar cing the rses and time and)(1) Skin Based on ti of a reside i) A resider h professio vent pressure cinical they were	e e are nd he nt, nt		
		19 at 10:15 AM with NA #1 now why Resident #106 did the right foot.		unavoidable; and (ii) A reside pressure ulcers receives ned treatment and services, cons professional standards of pra	cessary sistent with			
	Director of Nursing re	19 at 3:54 PM with the evealed if there is an order devices to be used at all in place at all times.		promote healing, prevent information prevent new ulcers from devices may be pressure reducing devices may be implemented per orders. This in service was completed 8/22/2019. Any nurse and not ime, part time, and PRN) who receive in-service training with allowed to work until training. This information has been in the standard orientation train required in-service refresher all employees and will be revening to the prevent of the standard orientation train required in-service refresher all employees and will be revening the standard orientation.	ection and eloping. nust be ed by urse aide (food in out of the eloping and in eloping and eloping along and eloping and eloping along and eloping and eloping along and eloping along along and eloping along alo	ed. to the r		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	1, ,	OATE SURVEY OMPLETED
		345284	B. WING			C
NAME OF PR	ROVIDER OR SUPPLIER	340204		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		07/25/2019
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 686	Continued From page	2.43	F 6	Quality Assurance Process to verthe change has been sustained Monitoring: To ensure compliance, The Dire Nursing or Unit Manager will obtoe residents each week to include weekend with physician orders of pressure reducing devices, to enthey are implemented as ordered will be done on weekly basis for then monthly for 3 months. The this audit will be reviewed at the Quality Assurance Team Meetin will be presented to the weekly Assurance Committee by the Dinursing and/or Mini Data Set (Marcondinators to ensure corrective initiated as appropriate. Any immore concerns will be brought to the Nursing or Administrator for apparation. Compliance will be moniting on auditing program review Weekly Quality of Life Meeting. Quality Assurance Committee mattended by Administrator, Direct Nursing, Minimum Data Set Cool Unit Manager, Support Nurse, Thim (Health Information Manager) Dietary Manager, Wound Nurse	ector of serve 5 the to have nsure that ed. This 4 weeks results of exectly g. Reports Quality irector of MDS) we action mediate Director of oropriate stored and wed at the Weekly neeting is ctor of ordinator, Therapy, ement),	
F 689 SS=D	CFR(s): 483.25(d)(1)(1)(1)(4)(4)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)		F 6	89		8/22/19
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345284 B. WING 07/25/2019)19	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
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WINSTON SALEM, NC 27103		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	(X5) MPLETION DATE	
F 689 Continued From page 44 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to keep the environment free of safety hazards by placing positioning wedges on both sides of the bed putting the resident at higher risk of injury by the resident going over the wedges and falling for 1 of 3 residents (Resident #47) reviewed for accidents. The findings included: Resident #47 was admitted to the facility on 12/14/17 with re-entry from a hospital on 5/24/19. Her cumulative diagnoses included non-Alzheimer's dementia and a Stage IV pressure ulcer on the sacrum (a triangular-shaped bone at the bottom of the spine). A review of a Fall/incident Report dated 3/13/19 at 6.41 AM described an unwitnessed incident when Resident #47 was observed on the floor screaming for help. She was reported to be unable to state what transpired. No injuries were noted. Review of a Fall/incident Report dated 3/16/19 at 2.15 PM was completed. The incident description noted a nursing assistant (NA) heard the resident calling for help when she was walking down the hall. The resident was found on the floor beside her bed. The resident was reported to have sustained a small abrasion on her left knee and bruise on her right knee.		

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F 689	Continued From page	e 45	F	689			
	· -	#47 ' s Minimum Data Set		000	PRN) Accidents. The facility must ens	ıre	
		nificant change assessment			that (d)(1) The resident environment		
		MDS revealed the resident			remains as free of accident hazards as	sis	
		d cognitive skills for daily			possible; and (2)Each resident receive	_	
		e resident required extensive			adequate supervision and assistance	_	
	_	for all of her Activities of			devices to prevent accidents. Positioni	na	
	Daily Livings (ADLs).	Section G of the MDS			devices such as wedges are used per	J	
	coded the resident as				physician orders to aid in wound heali	ng	
	assistance for bed me	obility and transfers. A			so as to offload pressure on the pressure	ıre	
	review of the Care Ar	ea Assessments for this			ulcer/injury and to assist with turning a	nd	
	MDS included the foll	lowing care plan			repositioning. Positioning devices /wed	lges	
		e topic of Falls: "At risk for			are not to be utilized on both sides for		
		endent on staff for all			resident who are at risk for falls.		
	-	v. She is also diagnosed with			This in service was completed by		
		is not capable of making			8/22/2019. Any nurse and nurse aide	(full	
		s for herself as evidenced by			time, part time, and PRN) who did not		
		alls because she believes			receive in-service training will not be	41	
		ould result in fractures,			allowed to work until training is comple		
	-	eadmission to the hospital.			This information has been integrated in		
	and reduction of risk	ecessary for identification			the standard orientation training and in		
	and reduction of risk	iaciois.			required in-service refresher courses f all employees and will be reviewed by		
	Δ review of a Fall/Inc	ident Report dated 4/11/19 at			Quality Assurance Process to verify th		
		n unwitnessed incident when			the change has been sustained.	a t	
		out for help and was found			Monitoring:		
		e bed lying face down on her			To ensure compliance, The Director of		
	right side. No injuries	, ,			Nursing or Unit Manager will observe		
	3				residents at risk for falls and who use		
	A review of Resident	#47 's Device and Bed Rail			positioning devices , each week to incl	ude	
	Review dated 4/17/19	9 was conducted. Question			the weekend , to ensure that they don		
	#2 on the form inquire	ed if any devices were used.			have two positioning wedges on both		
	The answer was "No	-			sides of the bed. This will be done on		
					weekly basis for 4 weeks then monthly	for	
	Review of a Fall/Incid	lent Report dated 5/4/19 at			3 months. The results of this audit will	be	
	4:30 PM revealed an	NA observed the resident			reviewed at the weekly Quality Assura	nce	
	lying on the floor besi	ide her bed. No injuries			Team Meeting. Reports will be present	ed	
	were reported.				to the weekly Quality Assurance		
					Committee by the Director of Nursing		
	A review of a Fall/Inci	ident Report dated 5/19/19			and/or Minimum Data Set (MDS)		

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 07/25/2019	
NAME OF D	ROVIDER OR SUPPLIER	0-1020-1		STREET ADDRESS, CITY, STATE, ZIP COI		07/2	25/2019	
NAME OF FI	NOVIDER OR SUFFLIER				<i>)</i>			
THE OAKS	3			901 BETHESDA ROAD				
				WINSTON SALEM, NC 27103				
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page	e 46	F 6	89				
	#47 had an unobserv on the floor next to he sustained a laceration forehead and was tra Room (ER) for evaluareturned from the hos with a diagnoses which the left temporal area. A review of Resident Minimum Data Set (No 5/31/19 indicated the impaired cognitive sk The resident continue.	n to the left side of her nsported to the Emergency ation and treatment. She spital on 5/24/19 at 12:30 PM ch included a hematoma to		Coordinators to ensure corre initiated as appropriate. Any concerns will be brought to the Nursing or Administrator for a action. Compliance will be mongoing auditing program rew Weekly Quality of Life Meetir Quality Assurance Committe attended by Administrator, D Nursing, Minimum Data Set Unit Manager, Support Nurse HIM (Health Information Mar Dietary Manager, Wound Nu	immediate ne Director appropriate onitored a viewed at the ng. Weekly e meeting irector of Coordinator e, Therapy nagement)	r of e nd the / is		
	Resident #47 includerisk for development healing of a Stage IV (tail bone)/sacral area included, in part, use mattress on her bed a frequent position charreduction and comfor wedges was not included a focus. Thincluded a focus area indicated the resident falls with injuries relational plan interventions did positioning wedge(s) bed.	at care plan (not dated) for d a focus area related to her of pressure ulcers and pressure ulcer to her coccyx a. The interventions of a pressure reducing and staff assistance with neges/turning for pressure t. The use of positioning aded as an intervention for the current care plan also a related to falls, which is continued to be at risk for each to confusion. The care not include the use of while the resident was in						
		22/19) was conducted. The						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING _				25/2019
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY 901 BETHESDA ROAD WINSTON SALEM, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689	An observation was on PM of the resident lyicovers pulled over he appeared to be an elesides of the bed. The interviewable. An interview was comp PM with Nurse #2. No hall nurse assigned to Upon inquiry, the numbumpers had been us past 2 weeks or so. See being used, the nurse her in bed because the recent falls. When No have initiated the bur #47's bed, she suggo Treatment Nurse might into this. An interview was comp PM with the facility's inquiry was made into bed for Resident #47 as he went to the residence of the residence of the residence of the residence of the wedges manner they were play wedge could be used second one should not side of the residence o	conducted on 7/25/19 at 4:50 ng asleep in bed with bed er. At that time, there evated perimeter on both e resident was not ducted on 7/25/19 at 4:53 durse #2 was the 2nd shift of care for Resident #47. See stated she believed sed for the resident over the When asked why they were estated it was to help keep he resident had a history of curse #2 was asked who may hippers placed on Resident lested the facility 's hit be able to provide more ducted on 7/25/19 at 5:00 is Treatment Nurse and of the use of bumpers on the control of the use o	F	889			
	bed. He then instruc	ved one wedge from the ted Nurse #2 and NA #4 that be used in this way while					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C / 25/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 901 BETHESDA ROAD WINSTON SALEM, NC 27103		23/2019
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F 689	Continued From page	ge 48	F 68	39		
	reported he would be during 3rd shift that the nursing staff to a	n bed. The Treatment Nurse be calling in to the facility evening and would talk with ensure positioning wedges d in the manner they had been				
	PM with NA #4. NA assistant assigned to When asked, the Na wedges being place was, "To keep her fit the interview, the Na positioning wedges for about two month."	anducted on 7/25/19 at 5:05 a #4 was the 2nd shift nursing to care for Resident #47. A stated the purpose of the ad on each side of the bed from falling out of bed." During A reported she thought had been used in this manner as and she inquired as to what by (staff) could take to keep the out of the bed.				
	at 5:26 PM with the interview, the nurse wedges found on R have been positione they were found to I should be positione the bed sheet, and place until the resid stated, "I am part of interventions for the the procedure used for a resident who have after a resident conduct an interdisc The IDT would atter and extrinsic risk fafall. These factors in history of previous for the section of the sec	Treatment Nurse. During the explained the positioning esident #47's bed should not ed under the bed sheet as pe. Instead, one wedge d between the turn sheet and that wedge would stay in ent was re-positioned. He the team that does the falls." The nurse described to put interventions into place and fallen. He reported the fell, nursing staff would siplinary team (IDT) meeting. The nurse described to put interventions into place and fallen. He reported the fell, nursing staff would siplinary team (IDT) meeting. The nurse described to put interventions into place and fallen. He reported the fell, nursing staff would siplinary team (IDT) meeting. The provided the resident is may include the resident is may include the resident is may include the resident is alls, diagnoses, cognition, it psychotropic medications (all				

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 07/25/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		0112312013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	causes. He reporte factors and try to co intervention. The Trassumed responsibility the IDT meeting and to the resident 's inwho attended the mresponsible to care implemented. The a resident had faller the use of positioning placed for Resident the level where the stated, "We need to An interview was cop M with the facility." During the interview positioning wedges Resident #47 was dishe was puzzled as place. She stated the positioning wedge wresident (not one on positioning wedges to try to keep a resident (not one on positioning wedges to try to keep a resident on each side prevented this resid she actually wanted also reported two pointended to be used the wedges should way. When asked, use of a positioning	tion to any known root d the IDT would look at all the me up with an appropriate reatment Nurse stated he dity for taking the minutes of d for adding the interventions cident report. The MDS nurse orning meeting would be plan the interventions Treatment Nurse stated that if n, he would not recommend g wedges as they had been #47. He reported, "It raises resident would fall from" and do more education." Inducted on 7/25/19 at 5:50 s Director of Nursing (DON).	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, , ,	PLE CONSTRUCTION G	COMPL	(X3) DATE SURVEY COMPLETED		
		345284	B. WING		O7/2	5/2019	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		1 0772372013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT 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 API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 690 F 690 SS=D	Bowel/Bladder Incor CFR(s): 483.25(e)(1 §483.25(e)(1) The faresident who is contadmission receives maintain continence condition is or become not possible to main §483.25(e)(2)For a incontinence, based comprehensive asse ensure that- (i) A resident who enditional continence, based comprehensive asse ensure that- (i) A resident who enditional continence in a special contact of the contact of th	ntinence, Catheter, UTI)-(3) ence. acility must ensure that inent of bladder and bowel on services and assistance to unless his or her clinical mes such that continence is tain. resident with urinary on the resident's essment, the facility must enters the facility without an sonot catheterized unless the indition demonstrates that necessary; enters the facility with an or subsequently receives one oval of the catheter as soon the resident's clinical condition atheterization is necessary; enters the facility with an or subsequently receives one oval of the catheter as soon the resident's clinical condition atheterization is necessary; enters the facility with an or subsequently receives one oval of the catheter as soon the resident's clinical condition atheterization is necessary; enterstand to restore the tent possible.	F 69	90	8	8/22/19	
	incontinence, based comprehensive asso ensure that a reside receives appropriate restore as much nor possible.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING		0.	C // 25/2019
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		723/2019
				901 BETHESDA ROAD		
THE OAK	5			WINSTON SALEM, NC 27103		
240.15	CUIMMA DV CI	CATEMENT OF DEFICIENCIES			DECTION	0/5)
(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 690	Continued From pag	e 51	F 69	0		
F 690	Based on observation record review, the fact catheter bag from too floor to reduce the rist of 3 residents (Resid reviewed with indwell and the findings included the findings included the findings included the findings included the content of the spine). A review of the spine	ons, staff interviews and cility failed to keep a urinary uching or dragging on the sk of infection or injury for 2 ent #47 and Resident #50) ling urinary catheters. d: admitted to the facility on y from a hospital on 5/24/19.	F 69	The statements made on this is Correction are not an admission not constitute an agreement will alleged deficiencies. To remain compliance with all Federal and Regulations the facility has take take the actions set forth in this Correction. The Plan of Corrections to the facility's allegatic compliance such that all alleged deficiencies cited have been on corrected by the date or dates. F690 Bowel/Bladder Incontiner Catheter, UTI Corrective Action: Resident #47 and #50: Indwellic catheter not touching or draggifloor; secured in place. Identification of other residents be involved with this practice: All current residents with indwest urinary catheters have the potentification of the residents with industriance and the process of the securing of the securi	in to and do th the in d State en or will s Plan of ction ion of d r will be indicated. ince, ing urinary ing the who may elling ential to be e. On in audit was ing to ordwelling devices to ot touch or with ve securing	
	and tubing was to be the bladder; and, tub kinks throughout the	positioned below the level of ing should be checked for		On 8/19/2019, the Director of I serviced all Nursing staff (Regi Nurses, Licensed practical nurse Nurse Aides: Full time, Part time, PRN) that the facility must ensi	stered se, and ne and	

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 25/2019	
NAME OF PE	ROVIDER OR SUPPLIER	1.020		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	25/2019	
TO UNIC OF TH	TO VIDER OIL OUT I EIER				01 BETHESDA ROAD			
THE OAKS	3				VINSTON SALEM, NC 27103			
					 T			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 690	Continued From pag	ge 52	F6	390				
	12:50 PM as Reside	ent #47 was lying in bed. A			resident who is continent of bladder ar	d		
		was observed to be hanging			bowel on admission receives services	and		
	-	with approximately 1-inch of			assistance to maintain continence unle	ess		
	the bag lying on the				his or her clinical condition is or become	ies		
					such that continence is not possible to			
	An observation mad	e on 7/21/19 at 3:22 PM			maintain. For a resident with urinary			
	revealed the resider	nt was asleep in bed.			incontinence based on the residents			
	Approximately 6-inc	hes of the catheter bag and			comprehensive assessment, the facilit	y		
	3-inches of the tubin	ng were lying on the floor at			must ensure that a resident who enters	3		
	the time of the obse	rvation.			the facility without an indwelling cathet	er is		
					not catheterized unless the resident's			
		made on 7/22/19 at 9:12 AM			clinical condition demonstrates that			
		lying in her bed. A urinary			catheterization was necessary, a resid			
		served to be hanging from			who enters the facility with an indwellir	-		
		approximately 1-inch of the			catheter or subsequently receives one			
	bag lying on the floo	or.			assessed for removal of the catheter a	S		
	A	7/00/40			soon as possible unless the resident's			
		was made on 7/23/19 at			clinical condition demonstrates that			
		dent was lying in her bed.			catheterization is necessary and a			
		irinary catheter bag revealed			resident who is incontinent of bladder			
	lying on the floor.	hes of the catheter bag was			received appropriate treatment and services to prevent urinary tract infection	one		
	lying on the noor.				and to restore continence to the extent			
	Accompanied by the	e facility 's Director of			possible. For a resident with fecal	•		
	•	ition of Resident #47 was			incontinence, based on the resident's			
		19 at 3:25 PM. Upon			comprehensive assessment, the facilit	V		
		#47 's catheter bag to be			must ensure that a resident who is	,		
	_	1-inch on the floor, the DON			incontinent of bowel received appropris	ate		
		the floor." During the			treatment and services to restore as m			
	_	g Assistant (NA) #4 entered			normal bowel function as possible. Als			
		I asked NA #4 what was			that physician orders have to be obtain			
		eter bag. The NA replied, "It's			for all indwelling catheters and have a			
	_	stated she would expect that			medical justification for the use of the			
	if the catheter bag o	r tubing touched the floor, it			catheter. This in service was complete	d		
		ped with a bleach wipe to			by 8/22/2019. Any nurse and nurse ai			
	disinfect it. At the tir	me of this interview, the DON			(full time, part time, and PRN) who did			
	was informed of the	previous observations made			receive in-service training will not be			
		catheter bag and/or tubing			allowed to work until training is comple			
	throughout the past	3 days. The DON stated that			This information has been integrated in	nto		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C	
		343204	B. WING _		•	07/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
THE OAKS	3			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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 690	Continued From page	÷ 53	F 6	90			
L 090	since the catheter bag frequently, she would tubing changed for the observed as she requite catheter bag and 2) Resident #50 was 11/19/15 with re-entry His cumulative diagnoral supra-pubic catheter A review of Resident Minimum Data Set (M5/21/19) was complet resident had severely daily decision making extensive assistance Activities of Daily Living exception of requiring locomotion on the united pendent on staff for Section H of the MDS resident had an individent of the section H of the make a supra-pubic of the current included a focus area use of a supra-pubic of noted the resident work catheter-related traun symptoms of urinary in review date. Intervent the following, in part: was to be positioned bladder; and, tubing significant was no observation was in	g had been on the floor so prefer to have the bag and e resident. The DON was rested the hall nurse replace tubing for Resident #47. admitted to the facility on a from a hospital on 4/22/19. Doses included placement of er due to urinary retention. #50 's significant change IDS) assessment (dated ed. The MDS indicated the impaired cognitive skills for and being totally and being totally and being totally and being totally assessment indicated the elling urinary catheter. It care plan for Resident #50 (not dated) related to the catheter. The planned goals and infection through the next tions for the goals included the catheter bag and tubing below the level of the should be checked for kinks	F6	the standard orientation trairequired in-service refresher all employees and will be requality Assurance Process the change has been sustain Monitoring: To ensure compliance, The Nursing or Unit Manager wiresidents who have indwelligensure that the urinary cath touching or dragging on the reduce the risk of infection of will be done on weekly basis then monthly for 3 months. This audit will be reviewed a Quality Assurance Team Mewill be presented to the week Assurance Committee by the Nursing and/or Minimum Dace Coordinators to ensure corrinitiated as appropriate. Any concerns will be brought to Nursing or Administrator for action. Compliance will be rongoing auditing program rewelly Quality of Life Meet Quality Assurance Committee attended by Administrator, In Nursing, Minimum Data Set Unit Manager, Support Nurshilm (Health Information Made Dietary Manager, Wound Notes and will be required to the standard program of the set of the	cr courses for eviewed by the to verify that ined. Director of all observe 5 ing catheter to be ter bag is not end floor to or injury. This is for 4 weeks. The results of the the weekly eeting. Reports eakly Quality the Director of the tax Set (MDS) rective action by immediate the Director of appropriate monitored and eviewed at the ting. Weekly ee meeting is Director of the Coordinator, se, Therapy, anagement),		
	bladder; and, tubing s throughout the shift. An observation was n as Resident #50 was	should be checked for kinks					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C 07/25/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 901 BETHESDA ROAD WINSTON SALEM, NC 27103	I DE	07723/2019
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 690	Continued From page	e 54	F 6	590		
	observed to be dragg resident slowly self-p hallway. An interview was cor AM with Nursing Ass	urinary catheter bag was jing on the floor as the ropelled himself towards the ducted on 7/24/19 at 9:17 istant (NA) #5. NA #5 was in ere Resident #50 was				
	observed in his Broda at the position of the NA stated, "It's too I as she adjusted Resi catheter bag was no was then asked if any with the catheter bag floor. The NA reported done because the ca on the floor. NA #5 r	a chair. When asked to look resident 's catheter bag, the ow." The NA was observed dent 50 's chair up so the longer on the floor. NA #5 withing needed to be done once it was raised off of the ed nothing needed to be theter tubing had not been eported if the catheter tubing r, it needed to be wiped off				
	at 12:00 PM with the care for Resident #50 observation of the resobserved to be dragg discussed. The NP s good job about keepi floor. However, the Nhope it's not on the fl should be an interver was taken off of the f wiping the bag off with been a good thing to	stated staff usually did a ng the catheter bag off of the NP reported she, "would oor." When asked if there ntion once the catheter bag loor, the NP stated that the a bleach wipe would have do.				
	PM with the facility 's During the interview,	ducted on 7/24/19 at 4:16 s Director of Nursing (DON). the observation of Resident dragging on the floor was				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C 07/25/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 07723/2019
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 744 SS=D	DON had made an oresident 's catheter previous day (7/23/1 at that time she expetubing to be kept off stated she would export tubing touched the wiped with a bleach of treatment/Service for CFR(s): 483.40(b)(3) A residuagnosed with demerappropriate treatment maintain his or her homental, and psychosomathis REQUIREMENT by: Based on observation interviews the facility centered care plan was a resident with demeraprovide their care and residents (Resident of diagnosis of dementions). Resident #37 was accompany to the provide their care and resident #37 was accompany to the provide their care and resident #37 was accompany to the provide their care and resident #37 was accompany to the provide the resident provided the	knowledged at that time the bservation of another oag touching the floor on the electron of the DON had indicated of the floor. The DON also pect that if the catheter bag and of the floor, it would need to be wipe to disinfect it. In Dementia Ident who displays or is entia, receives the that and services to attain or ighest practicable physical, ocial well-being. In is not met as evidenced In it is not met as evidenced ons, record review, and staff failed to develop a person which addressed the needs of intia and how staff were to did treatment for 1 of 3 \$\$37) reviewed with a	F 69		and do ne ate or will an of n of l be cated. ntia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			D WING				С
		345284	B. WING _			07/	/25/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	2			9	01 BETHESDA ROAD		
IIIL OAK	•			٧	VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 744	Continued From pag	ge 56	F 7	744			
	living (ADLs), and h				be involved with this practice:		
	non-Alzheimer's der				All current residents with diagnosis of		
	TION / NZHOMICI 3 dei	nonua.			dementia have the potential to be affect	cted	
	Review of active Ph	ysician Orders and a			by the alleged practice. On 8/15/2019	, lou	
		5/28/19 revealed that the			through 8/19/2019 an audit was		
		ibed Seroquel 12.5 milligrams			completed by Director of Nursing to		
	two times a day.				ensure that all residents with diagnosis	s of	
	-			dementia had a care plan implemented	d.		
		plan dated 6/5/19 revealed			All residents with diagnosis of dementi	а	
there was no care plan developed to ac		•			had a care plan implemented. This wa	S	
	dementia diagnosis.			completed on 8/19/2019.			
					Systemic Changes:		
	Observations of Res			On 8/19/2019, the Director of Nursing	in		
		10:32 AM revealed the			serviced all Nursing staff (Registered		
		ed and yelling out. When the			Nurses, Licensed practical nurse, and		
		ached, she stated that she did ause I was having an affair			Nurse Aides: Full time, Part time and PRN) that the facility must ensure that	۸	
	with her husband.	ause i was naving an anan			resident who displays or is diagnosed		
	with her hasband.				dementia, receives the appropriate	WILLI	
	During an interview	with the Nurse #1 on 7/22/19			treatment and services to attain or		
	_	ited that the resident exhibited			maintain his or her highest practicable		
	behaviors that include	ded yelling out, confusion,			physical, mental, and psychosocial		
	poor safety awarene	ess with falls, and delusions			well-being. This in service was comple	ted	
	about her husband I	having affairs.			by 8/22/2019. Any nurse and nurse ai	de	
					(full time, part time, and PRN) who did	not	
	_	v with the Medical Director on			receive in-service training will not be		
		he stated that Resident #37			allowed to work until training is comple		
		es and had delusions about			This information has been integrated in		
		ated that the resident's			the standard orientation training and ir		
	Parkinson's disease				required in-service refresher courses f		
		oint that she had told him she get how to speak in English.			all employees and will be reviewed by Quality Assurance Process to verify th		
		eceiving medications twice a			the change has been sustained.	aι	
		th behaviors that included			Monitoring:		
	visual and auditory l				To ensure compliance, The Director of	:	
	1.5dai and duditory i	indiagnia di			Nursing or Unit Manager will review 5		
	During an interview	with MDS Nurse #2 on			residents who have a diagnosis of		
	_	she stated that based on			dementia to ensure a care plan is		
		entia diagnosis, there should			implemented. This will be done on wee	ekly	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345284	B. WING				C 25/2040
NAME OF PI	ROVIDER OR SUPPLIER	040204		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	25/2019
THE OAK	S				1 BETHESDA ROAD 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 744	F 744 Continued From page 57		F 7	' 44			
	dementia care, and the oversight. During an interview wand the Administrator both stated that it was	n in place to address her nat it must have been an with the Director of Nursing on 7/24/19 at 5:05 PM they is their expectation that the be individualized to address dementia.			basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurar Team Meeting. Reports will be present to the weekly Quality Assurance Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinate to ensure corrective action initiated as appropriate. Any immediate concerns to be brought to the Director of Nursing of Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at Weekly Quality of Life Meeting. Weekly Quality Assurance Committee meeting attended by Administrator, Director of Nursing, Minimum Data Set Coordinate Unit Manager, Support Nurse, Therapy HIM (Health Information Management) Dietary Manager, Wound Nurse.	ors will the is	
F 761 SS=D	Drugs and biologicals	of Drugs and Biologicals used in the facility must be with currently accepted s, and include the y and cautionary	F 7	' 61			8/22/19
	§483.45(h)(1) In according from the factor of the factor o	ordance with State and sility must store all drugs and compartments under proper and permit only authorized cess to the keys.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C 7/25/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1720/2013
				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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From page	e 58	F 76	31		
	locked, permanently storage of controlled the Comprehensive I Control Act of 1976 a abuse, except when package drug distribut quantity stored is mirble readily detected. This REQUIREMENT by: Based on observation staff interviews, the face prized medication in rooms (Station 3 Medications will date on 1 of 3 medications.)	•		The statements made on this I Correction are not an admissio not constitute an agreement wi alleged deficiencies. To remain compliance with all Federal and Regulations the facility has take take the actions set forth in this Correction. The Plan of Correctionstitutes the facility's allegatic compliance such that all allege	n to and do th the i in d State en or will s Plan of ction ion of	
	made of the Station 3 7/22/19 at 3:05 PM. opened multi-dose vi injectable medication diagnosis of tubercularefrigerator. A hand- Tuberculin PPD med 5/30/19. The manufacontaining the Tubercularement: "Discard opened Accompanied by the (DON), a 2nd observ	(used for skin testing in the osis) was stored in the written date indicated the ication was opened on acturer's labeling on the box culin PPD solution read, in id product after 30 days." facility's Director of Nursing ation was made of the		deficiencies cited have been or corrected by the date or dates. F761 Label/Store drugs and Bid Corrective Action: Medication discarded from medications with shortened expiration on 30 station 2 med room. Identification of other residents be involved with this practice: All current residents with have potential to be affected by the appractice. On 8/15/2019 through an audit was completed by Directice.	indicated. ologicals dication labelled 00 hall and who may the alleged 18/19/2019	
	(DON), a 2nd observ opened and expired			potential to be affected by the a	alleged n 8/19/2019 ector of	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			D WING			С	
		345284	B. WING _	-		07/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
THE OAK	•			901 BETHESDA ROAD			
THE UAK	•			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 761	Continued From page	÷ 59	F 7	61			
	Store Room on 7/22/was conducted with the inquiry, the DON states not have been in the the shortened expirate manufacturer. 2a) Accompanied by Nursing (DON), an observation 2 Medication 3:20 PM. The observanti-dose vials of Turnedication (used for the second conduction of the second conduction	19 at 3:18 PM. An interview he DON at that time. Upon ed the tuberculin vial should refrigerator as it was past ion date indicated by the the facility 's Director of oservation was made of the Store Room on 7/22/19 at vation revealed two opened, berculin PPD injectable skin testing in the diagnosis		was discarded and all medical shortened expiration were lab expired medications were discall medications with a shortent expiration were labelled. This completed on 8/19/2019. Systemic Changes: On 8/19/2019, the Director of serviced all Nursing staff (Reg Nurses, Licensed practical nurses Aides: Full time, Part time, Part time, Pand biologicals Drugs and biologicals.	eled. All carded and eed s was Nursing in gistered urse, and me and and cals used i	n	
	Neither of the Tuberc indicate when the me manufacturer 's label the Tuberculin PPD s "Discard opened prod	duct after 30 days."		the facility must be labeled in with currently accepted profes principles, and include the apaccessory and cautionary instand the expiration date when applicable. Storage of Drugs a Biologicals1) In accordance was and Faderal laws the facility.	ssional propriate tructions, and vith State		
	observation on 7/22/1 During the interview, opened vials of Tuber medication should ha determination of a sh	ducted at the time of the 19 at 3:20 PM with the DON. the DON reported the rculin PPD injectable ve been dated to allow the ortened expiration date. Nurse Manager #1, an		and Federal laws, the facility in all drugs and biologicals in loc compartments under proper to controls, and permit only authoresonnel to have access to the facility must provide separate permanently affixed comparting storage of controlled drugs lis	cked emperature orized he The ly locked, nents for		
	observation of the 30 conducted on 7/22/19 observation revealed 200 milligram (mg) pelidocaine injectable manesthetic) was store opened vial of lidocai it had been opened. stated she thought thup until the manufactor	0 Hall Medication Cart was o at 3:30 PM. The an opened multi-dose vial of		Schedule II of the Compreher Abuse Prevention and Contro and other drugs subject to ab when the facility uses single u drug distribution systems in w quantity stored is minimal and dose can be readily detected service was completed by 8/2 nurse and nurse aide (full time and PRN) who did not receive training will not be allowed to	nsive Drug of Act of 19 use, excep unit packag which the d a missing This in 12/2019. A e, part time e in-service	76 ot ge J nny e,	

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 07/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	7172372019	
	_			901 BETHESDA ROAD			
THE OAK	5			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		SHOULD BE	(X5) COMPLETION DATE	
F 761	Multi-dose vials shou after the first use, und specifies otherwise. on the lidocaine vial of An interview was con AM with the facility 's During the interview, observations were di opened vial of 1% lid stored on a medication	ted From page 60 ed expiration date once it was opened. ose vials should be discarded 28 days ef first use, unless the manufacturer is otherwise. The manufacturer labeling idocaine vial did not specify otherwise. viview was conducted on 7/23/19 at 8:05 to the facility 's Director of Nursing (DON). the interview, the medication storage attions were discussed and included the vial of 1% lidocaine needed to be ed. He did to be discarded 28 days ef first use, unless the manufacturer labeling idocaine vial did not specify otherwise. Viview was conducted on 7/23/19 at 8:05 to the facility 's Director of Nursing (DON). The interview, the medication storage attions were discussed and included the vial of 1% lidocaine needed to be ed. He facility 's Director of Nursing (DON). The interview is the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing or Unit Manager will boserve all the medication arts and medication storage rooms to ensure that expired medications are discarded and all medication with a shortened expiration date are labelled. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly Quality Assurance Committee by the Director of Nursing and/or Minimum Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality Assurance Committee meeting is					
F 812 SS=F	Food Procurement,S CFR(s): 483.60(i)(1)(tore/Prepare/Serve-Sanitary 2)	F 8	attended by Administrator, Dire Nursing, Minimum Data Set Co Unit Manager, Support Nurse, HIM (Health Information Manag Dietary Manager, Wound Nurs	oordinator, Therapy, gement),	8/22/19	

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		0.7	C	
NAME OF PROVIDER OR SUPPLIER THE OAKS				STREET ADDRESS, CITY, STATE, ZIP COI 901 BETHESDA ROAD WINSTON SALEM, NC 27103	HESDA ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOULD BE COMPLI		(X5) COMPLETION DATE	
F 812	PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 8	DEFICIENCY	is Plan of sion to and do	DATE	
	and by not ensuring a and muffin pans were storage rack. Findings included: 1. During a kitchen o 11:47 a.m., two men meal preparation, wit men were observed processor in the food working on the ice m	bservation on 7/25/19 at were in the kitchen during hout hair restraints. The two working on the food preparation area then, achine located next to the e tray line service in the		alleged deficiencies. To rema compliance with all Federal a Regulations the facility has to take the actions set forth in the Correction. The Plan of Correctionstitutes the facility's alleg compliance such that all alleged deficiencies cited have been corrected by the date or date F812 Food Procurement, Store Sanitary Corrective Action: Food Service Repair persons on the food processor and ice	and State aken or will his Plan of rection jation of ged or will be es indicated. pre/Prepare		

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 07/25/2019	
NAME OF PROVIDER OR SUPPLIER THE OAKS				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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 812	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 8	CROSS-REFERENCED TO THE APPROPRIATE			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	()	(X3) DATE SURVEY COMPLETED	
		245204	B. WING			С	
		345284	B. WING _			07/25/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
THE OAK	s			901 BETHESDA ROAD			
THE CARS				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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	Continued From pag	e 63	F8	Services Director will monitor of personal hygiene policy and complete Dietary inspection for weekly for 4 weeks then week months then monthly for 3 moderary Director or designee with the Dietary Audit Tool: Washir Drying Techniques for 6 mont results of this audit will be reviewely Quality Assurance Tead Reports will be presented to the Quality Assurance Committee Dietary Services Director to ecorrective action initiated as a Any immediate concerns will be the Director of Nursing or Adn for appropriate action. Complimonitored and ongoing auditing reviewed at the Weekly Quality Meeting. Weekly Quality Assurance Committee meeting is attended Administrator, Director of Nurse, The (Health Information Managem Manager, Wound Nurse.)	d will orm 5 times on	te le lo to e	