PRINTED: 08/30/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345284	B. WING _			C 07/23/2021	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 901 BETHESDA ROAD WINSTON SALEM, NC 27103	E	, <u> </u>	23/2021
(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 CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	control survey was c through 7/23/2021. T compliance with the r	on and a focused infection onducted from 7/19/2021 The facility was found in equirement CFR 483.73, iness. Event ID # Y50K11.	F	000			
	A recertification sure and focused infection conducted onsite fror 7/22/2021 and additio obtained on 7/23/202 7/23/2021. Event ID	n 7/19/2021 through onal information was 1. The exit date was					
F 550 SS=D	20 of the 51 compla substantiated resultin Resident Rights/Exer CFR(s): 483.10(a)(1)	g in deficiencies. cise of Rights	F 5	550			8/20/21
	self-determination, ar	Rights. ght to a dignified existence, nd communication with and d services inside and cluding those specified in					
	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					
ADODATORY	access to quality care	cility must provide equal e regardless of diagnosis,	DE	TITLE			(X6) DATE

Electronically Signed 08/16/2021

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  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	COMP	(X3) DATE SURVEY COMPLETED	
		345284	B. WING _		07/	23/2021
NAME OF P	ROVIDER OR SUPPLIER	<b>'</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 0111	20,2021
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	must establish and practices regarding provision of service residents regardles §483.10(b) Exercise. The resident has the rights as a resident or resident of the U §483.10(b)(1) The resident can exercise interference, coercifrom the facility.  §483.10(b)(2) The resident can exercise of interference reprisal from the facility.  §483.10(b)(2) The resident from the facility.  §483.10(b)(2) The resident from the facility.  Sased on observation in a keeping his living eresidents (Resident in a keeping his living eresidents (Resident expresembarrassed by the The findings include Resident #68 was a 4/23/2020.	and transfer, discharge, and the sunder the State plan for all sof payment source.  The of Rights.  The right to exercise his or her of the facility and as a citizen nited States.  The callity must ensure that the se his or her rights without on, discrimination, or reprisal resident has the right to be a coercion, discrimination, and cility in exercising his or her rights as required under this er rights are rights and the right of the	F 5	The statements made on this particle correction are not an admission not constitute an agreement with alleged deficiencies.  To remain in compliance with a and state regulations the facility or will take the actions set forth plan of correction. The plan of constitutes the facility's allegatic compliance such that all alleged deficiencies cited have been or corrected by the dates indicated F550  1. Corrective action for resident affected by the alleged deficiencies.	n to and do th the  Il federal y has taken in this correction on of d will be d.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIANCE (X4) DATE S COMPLIANCE (X4) DATE S COMPLIANCE (X5) DATE S COMPLIANCE (X6) DATE S			1 ' '				
						С	
		345284	B. WING _			07/2	23/2021
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	,			90	1 BETHESDA ROAD		
THE UAK	•			W	INSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page was cognitively intact		F 5	550			
	An observation of the occurred on 7/19/202	e 500-hall common area 11 at 12:18 PM and revealed nat lingered into the common			For resident #68: The Administrator directed the Housekeeping staff on 7.23.21 to change mattress and seat cushion for resident, strip and wax the floor, and treat the floor with an odor eliminating product.		
	on 7/19/2021 at 12:20 urine odor. The floors the room. In the Resi a yellow coating arou was sticky. Dark stair	sident #68's room occurred DPM and revealed a strong s were sticky on both sides of dent's bathroom, there was nd the toilet and the floor ned grout on a tile floor was et and the baseboard of tile.			<ol> <li>Corrective action for residents with the potential to be affected by the alleg deficient practice.</li> <li>Beginning on 7/23/2021 the Director of Nursing and Environmental Services</li> </ol>	ed	
	An interview was con AM with Nursing Assi revealed she had bee for several weeks and Resident #68's room began employment. S primary assignment.	ducted on 7/20/2021 at 9:36 stant (NA) #02 and she en employed with the facility d that the urine odor in had been present since she She revealed this was her She stated that ade aware of the strong			Manager audited 100% of all resident rooms to identify any residents who had odors in their room that would identify a residents where the odor would preven them from having a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outsid the facility. Results: 3 out of 98 resider were identified with odors in their room that interfered with their rights to a	any t	
	7/20/2021 at 9:50 AM #68) required assistated bathroom and used as smell was strong where room. He added that front office to the added done. He stated he has visitors wrinkle their room in the hall or with that the sticky floors affeel unclean and embassistic family did not live in the sticky floor.	ducted with Resident #68 on If and revealed he (Resident ince with going to the is brief. He said the urine en he first moved into the he reported the issue at the inistrator, and nothing was ad observed staff and incoses when walking past the inen they enter. He revealed and the urine odor make him incorrassed. He revealed his he area and because of If not been able to visit during			dignified existence; rooms cleaned, treated with odor eliminating product. New flooring ordered for 2 of the 3 roor 3. Measures /Systemic changes to prevent reoccurrence of alleged deficie practice:  The policy for Residents Rights was reviewed and applied to this situation. There was no change required in the policy. On 08.12.2021, the Administrat began reeducating all full time, part tim and PRN Housekeepers on the following the policy.	nt or e,	

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		(X3) DATE SURVE COMPLETED	Υ			
		345284	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	343204		STREET ADDRESS, CITY, STATE, ZIP CODE	07/23/20	21
NAME OF PI	ROVIDER OR SUPPLIER					
THE OAKS	3			901 BETHESDA ROAD		
				WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMP	X5) PLETION PATE
F 550	Continued From page	∋ 3	F 550			
		mic but if they decided to e embarrassed for them to		<ul> <li>Residents Rights/Exercise of Resident Rights</li> <li>Housekeeping Policy</li> </ul>		
	on 7/20/2021 at 9:52 the bathroom continued grout between the tile going 3/4 of the way up baseboard. The smell and linger the room. The Reside bed with a dark brown on the right-hand side the palm of a hand. The what the substance where the substance of the strong on 7/21/2021 at 9:08 was aware of the strong floor in the room. She of two rooms that had urinating in various lotoilet when urinating.	ducted with the ger in Resident #68's room, AM and she revealed she ong urine odor and sticky e revealed that this was one d a resident with issues of ocations and missing the She stated that the tile floor		This information has been integrate the standard orientation training ar required in-service refresher cours all staff identified above and will be reviewed by the Quality Assurance process to verify that the change hen been sustained. The facility specifin-service will be provided to all ful part time, and PRN Housekeepers staff who does not receive schedulin-service training will not be allow work until training has been complements.  4. Monitoring Procedure to ensure the plan of correction is effective a specific deficiency cited remains or and/or in compliance with regulato requirements.	and in the es for es as fic I time, Any led ed to eted by ethat and that corrected ry	
	tracked into the room the wax to become st reason, the floors in t week. She added that with buffing. She rev urinating in various lo 68. She stated it was urine odors from grout else to do, other than improve the smell and She stated she had re	d the urine and then it is with the wax floors, causing ticky. She added that for this the room are buffed twice a t the wax is not removed ealed the behaviors of tocations was not Resident # difficult to remove excess at and she was not sure what replacing the floor, to d environment in the room. eccived concerns from staff to bathroom and the smell of		The Administrator or designee will compliance utilizing the F550 Qual Assurance Tool weekly x 4 weeks monthly x 3 months. The tool will n reports of any facility odors that we prevent the resident from having a dignified existence. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator to ensure corrective is initiated as appropriate. Complia be monitored and the ongoing aud program reviewed at the weekly Q Assurance Meeting, indefinitely or	ity then nonitor ould action ince will iting uality	

Facility ID: 923497

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		PLETED
		345284	B. WING _			l	C 23/2021
NAME OF PI	ROVIDER OR SUPPLIER			90	REET ADDRESS, CITY, STATE, ZIP CODE  1 BETHESDA ROAD  INSTON SALEM, NC 27103	1 077	23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550 F 580 SS=D	room on 7/21/2021 a hallway outside of the lingering ammonia ur continued to be sticky continued to have dathe edge of the toilet.  An interview was con Administrator on 7/21 revealed that she was Resident #68's room. She stated she was rembarrassed. She ac spends most of his dithe front of the buildinexpectation that the fisituation where a resby the housekeeping their room or to receiprivacy of their room. Notify of Changes (In CFR(s): 483.10(g)(14) Notific (i) A facility must immonsult with the residuction consistent with his or representative(s) where (A) An accident involves (B) A significant changemental, or psychosocideterioration in health	conducted of Resident #68's t 9:10 AM and the room and e room smelled of a strong, ine odor. The floors y and the tile in the bathroom rk stains with urine around  ducted with the 1/2021 at 9:28 AM and she is aware of the issue with in regarding the urine odors not aware he was ided that the Resident ay outside of his room and at ing. She stated it was her facility does not have a ident would be embarrassed or physical environment in inve a family visitor in the injury/Decline/Room, etc.) 1/(i)-(iv)(15) I cation of Changes. I rediately inform the resident; I rent's physician; and notify, I her authority, the resident intere is- ing the resident which inas the potential for requiring in; inge in the resident's physical, cial status (that is, a in, mental, or psychosocial ireatening conditions or		550	longer deemed necessary for complian with room odor. The weekly QA Meetin attended by the Administrator, Director Nursing, Minimum Data Set Coordinate Therapy Manager, Health Information Manager, and the Dietary Manager.	g is of	8/20/21

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C 07/23/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	07723/2021
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 580	a need to discontinu treatment due to adv commence a new for (D) A decision to train resident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatis available and proviphysician. (iii) The facility must resident and the resident a	eatment significantly (that is, e an existing form of rerse consequences, or to rm of treatment); or easier or discharge the eility as specified in etification under paragraph (g), the facility must ensure that ion specified in §483.15(c)(2) eided upon request to the ealso promptly notify the dent representative, if any, en or roommate assignment 10(e)(6); or elent rights under Federal or ens as specified in paragraph end.  To record and periodically (mailing and email) and experience in its admission agreement entition, including the various is ethe composite distinct fy the policies that apply to even its different locations.  To is not met as evidenced excession of the existinct representative excession in the existinct representative excession is existent existinct for the policies that apply to even its different locations.	F 58	The statements made on this plan	
		cal record review, the facility sident representative of a		correction are not an admission to not constitute an agreement with the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER:  A. BUILDING		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
			A. BOILDI	_		Ι,	С
		345284	B. WING _				/23/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	•			90	01 BETHESDA ROAD		
THE OAK	5			W	/INSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From pag	e 6	F	580			
	· -	2 of 2 residents (Resident	' `	500	alleged deficiencies.		
	#214 and Resident #			To remain in compliance with all federa	al		
	of change in conditio	•			and state regulations the facility has ta		
	<b>3</b>				or will take the actions set forth in this		
	Findings included:			plan of correction. The plan of correction	on		
				constitutes the facility□s allegation of			
	1.Resident #214 was			compliance such that all alleged			
	9/11/20 with diagnos			deficiencies cited have been or will be			
	type 2 diabetes, end	stage renal disease.			corrected by the dates indicated. F580		
	Most recent Minimun	n Data Set (MDS) dated			Corrective action for resident(s)		
	9/18/20 showed she	was minimally cognitive			affected by the alleged deficient praction	ce:	
		incontinent of bladder and					
		ired extensive 2 person			Resident #317 was discharged from th	е	
		obility and transfers. There			facility on 02.03.2020 and therefore	_	
	were no pressure ulo	cers.			corrective action could not be complete with legal representative.	ed	
	Resident #214's med	dical record revealed her					
	responsible party and	d the only family			Resident #214 was discharged from th	е	
	representative on file	2.			facility on 12.18.2020 and therefore		
					corrective action could not be complete	ed	
		rd review revealed a skin			with legal representative.		
	1	ed 9/11/20 upon admission			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	_	
	buttocks.	noted on Resident #214's			<ol><li>Corrective action for residents with the potential to be affected by the alleg</li></ol>		
	bullocks.				deficient practice.	jeu	
	A treatment plan for	a right buttock wound dated			assisioni praedes.		
		ated for Resident #214.			On 07.27.2021 the Director of		
					Nurses/Treatment Nurse reviewed all i	new	
	Resident #214 was o	lischarged from the facility on			wound treatment orders for the last 14		
	12/18/20.				days from 07.23.2021 to ensure that the		
					legal representative/resident had been		
		sident's #214's responsible			informed of any newly identified wound	is.	
		ucted 7/21/21 at 11:10 AM.			Results: All residents and/or legal	of	
		Resident #214 did not have to entry to the facility. He			representatives were/were not notified		
		#214 told him that she			all changes. Any residents and/or legaterepresentatives who were identified as		
		ore on her bottom one day in			being notified of changes were	1101	
		sure how long it has been			immediately notified of the changes		

Facility ID: 923497

		(X3) DATE SURVEY COMPLETED			
		345284	B. WING		C <b>07/23/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0112312021
				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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICE DEFICIENCY)	D BE COMPLETION
F 580	580 Continued From page 7		F 580		
	being notified by the twound on her buttock	reating it. He denies ever facility that his mother had a s.s. The RP stated the d to him when Resident #214		Measures /Systemic changes to prevent reoccurrence of alleged definition practice:  On 07.23.2021, the Director of Nurs	cient
	7/22/21 at 12:22 PM procedure for staff to change in condition on nurse who document to also notify the resp was unable to locate Resident's #214's resabout her wound.  2. Resident #317 was 8/12/19 with diagnose protein malnutrition, to cardiomyopathy.  Resident #317's adm	Director of Nursing on revealed that the proper follow when there is a f the resident is for the sit in the resident's record, consible party. The facility any documentation that sponsible party was notified admitted to the facility on es hypertension, severe type 2 diabetes mellitus, and sitting Minimum Data Set 8/19 showed no pressure		(DON), Treatment Nurse, Administra and the Quality Assurance Clinical National Consultant reviewed the policy on Responsible Party Notification of Recondition. There were no changes required to the policy. On 07.25.202 Director of Nurses/Staff Developme Coordinator began reeducation of a time, part time and as needed nurse agency nurses on immediate notification of the resident/resident representation any significant change in the resident physical, mental, or psychosocial status in either life-threatening conditions or clinical complications).	estor, Nurse esident  21, the ent Il full es and eation eve of ent s eatus ental or
	ulcers or skin breakdown under section M. It also revealed that he required one person assistance for bed mobility, transfers, and toileting.  A record review on 7/20/21 showed a nurse note dated 1/21/20 at 10:49 PM written by Nurse #5 stating that she observed an open area to upper intergluteal cleft. He was discharged on 2/3/20 to the hospital for a different concern.  A statement made by Resident #317's responsible party on 2/11/2020 indicated the family had no idea Resident #317 had a wound on his buttocks until he met him at the hospital on 2/3/20. She stated that no one from the facility called to let them know about this change in			This information has been integrated the standard orientation training and required in-service refresher course all staff identified above and will be reviewed by the Quality Assurance process to verify that the change had been sustained. Any staff who does receive scheduled in-service training not be allowed to work until training been completed by 08.20.2021.  The facility will review this information their clinical meeting and discuss are issues at least weekly for the next 3 months unless the Quality Assurance.	I in the s for s f

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	' '	E SURVEY PLETED
						С
		345284	B. WING		07	/23/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
<b>THE 041</b>				901 BETHESDA ROAD		
THE OAKS	5			WINSTON SALEM, NC 27103		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	COMPLETION DATE
F 580	Continued From page	÷ 8	F 58	30		
	condition.			Committee feels this issue has be resolved sooner.	een	
	The facility was unabl	e to provide any				
		e responsible party was		4. Monitoring Procedure to ens		
	notified of Resident #	317's change in condition.		the plan of correction is effective		
				specific deficiency cited remains		
		Director of Nursing on		and/or in compliance with regula	tory	
		evealed that the proper		requirements.		
	·	follow when there is a f the resident is for the		The DON or designee will monitor	or	
	-	it in the resident's record,		compliance utilizing the F580 Qu		
		onsible party. The facility		Assurance Tool weekly x 4 week		
		any documentation that		monthly x 3 months. The DON v		
	Resident's #317's res	ponsible party was notified		monitor compliance to ensure th	at each	
	about his wound.			resident or resident representative		
				receives notification of any signif		
				change in the resident ☐s physic		
				mental, or psychosocial status. F	•	
				will be presented to the weekly ( Assurance committee by the DO		
				ensure corrective action is initiat		
				appropriate. Compliance will be		
				monitored and the ongoing audit		
				program reviewed at the weekly		
				Assurance (QA) Meeting. The v	veekly QA	
				Meeting is attended by the Admi	nistrator,	
				Director of Nursing, Minimum Da		
				Coordinator, Unit Support Nurse		
				Therapy Manager, Health Inform		
E 504	0 ( /0) /0 ( ) /		F 50	Manager, and the Dietary Manag	jer.	0/00/04
F 584 SS=D	CFR(s): 483.10(i)(1)-(	ole/Homelike Environment 7)	F 58	34		8/20/21
	§483.10(i) Safe Enviro	onment.				
	The resident has a rig	ht to a safe, clean,				
		elike environment, including				
	but not limited to rece					
	supports for daily living	g safely.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED			
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  901 BETHESDA ROAD  WINSTON SALEM, NC 27103	1 07723/2021
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 584	Continued From pag	e 9	F 58	4	
	homelike environmenuse his or her person possible.  (i) This includes ensureceive care and serphysical layout of the independence and dii) The facility shall ethe protection of the or theft.  §483.10(i)(2) Housel services necessary thand comfortable interested to comfortable interested to comfortable interested to comfortable in good condition;  §483.10(i)(3) Clean It in good condition;  §483.10(i)(4) Private resident room, as spontaged to comfortable in all areas;  §483.10(i)(5) Adequate levels in all areas;  §483.10(i)(6) Comfortable in the sound levels. Facilities in the sound levels. This REQUIREMENT by:	clean, comfortable, and nt, allowing the resident to nal belongings to the extent uring that the resident can vices safely and that the exacility maximizes resident ones not pose a safety risk. Exercise reasonable care for resident's property from loss receping and maintenance of maintain a sanitary, orderly,		The statements made on this plan of	
		rd review, the facility failed to I odor free living environment		correction are not an admission to an not constitute an agreement with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C <b>07/23/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		7772072021
THE OAK	_			901 BETHESDA ROAD		
THE OAKS	5			WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 584	Continued From pag	ge 10	F 5	84		
F 584	for 2 of 26 residents #68), failed to maint repair for 1 of 26 res failed to place a residrawers or the close (Resident #107) rev  The Findings include 1A. Resident #68 wa 4/23/2020. The most Data Set (MDS), data Set (MDS)	(Resident #15 and Resident ain a nightstand in good sidents (Resident #15), and ident's personal laundry in set for 1 of 26 residents iewed for environment.  ed:  as admitted to the facility on it recent quarterly Minimum ted 5/27/2021, coded the tively intact and able to	F 5	alleged deficiencies.  To remain in compliance wi and state regulations the fa or will take the actions set f plan of correction. The plan constitutes the facility all compliance such that all all deficiencies cited have bee corrected by the dates indic F584  1. Corrective action for resi affected by the alleged defi On 07.25.2021, the room fo was cleaned by the housek include sweeping and mopinightstand, overbed lighting windowsills. The houseked ensured that there was no room. The night stand for twas replaced on 07.26.202  On 7.23.2021, the room for was cleaned by the houseked include sweeping and mopinightstand, overbed lighting windowsills. The houseked ensured that there was not en	dentity has taken forth in this of correction regation of reged of the cated.  dent(s) dentity of the cated.  dent(s) dentity of the cated of the ca	
	AM with Nursing Ass revealed she had be for several weeks an Resident #68's roon began employment. primary assignment	sistant (NA) #02 and she een employed with the facility and that the urine odor in a had been present since she She revealed this was her . She stated that made aware of the strong		room.  On 07.23.2021, the laundry for resident #107 was place appropriate place (closet at 2. Corrective action for resi potential to be affected by t deficient practice:	v and clothing ed in the nd drawers). dents with the	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From pag	e 11	F 5	584			
F 584	An interview was con 7/20/2021 at 9:50 AN knowledge the odor came from his roomi assistance with going brief. He said that he roommate and the unhe first moved into the reported the issue, a stated he had observation of Regord their noses when was hall or when they end.  An observation of Regord 7/20/2021 at 9:52 the bathroom continue grout between the till going 3/4 of the way us. The smell was a strollingered into the hall.  An interview was con Housekeeping mana 7/21/2021 at 9:08 AN aware of the strong the room. She revear rooms with issues of the tile floor absorbs then it is tracked into floors, causing the wadded that for this regare buffed twice a we to remove excess unwas not sure what el the floor, to improve	and ucted with Resident #68 on M and he revealed that to his in his room and the urine mate. He stated he required g to the bathroom and used a was placed with this rine smell was strong when he room. He added that he and nothing was done. He wed staff and visitors wrinkle alking past the room in the ter.  Sesident #68's room occurred that AM and revealed the floor in used to have dark stains in the e surrounding the toilet and up the baseboard tile grout.  Inducted with the	F	584	100% audit of all rooms in the facility we completed by the Floor Technician/Housekeeper on 07.23.202 ensure that all rooms were cleaned according to policy. Results: 23 of 76 floors for stripping and waxing identified. Any rooms not cleaned properly were reported to Environmental Director and cleaned per policy.  100% audit of all rooms in the facility we completed by Director of Nursing and Environmental Services Director on 07.23.2021 to ensure that all rooms we free of odor. Results: 3 of 76 rooms identified. Any rooms that had an odor received interventions to reduce odors.  100% audit of all rooms in the facility we completed by the Environmental Service Director/Maintenance Director on 07.23.2021 to ensure that all night star were in good repair. Results: 5 of 76 rooms needed replacement/repair. An rooms that identified night stands in ne of repair received the necessary repair and replacements of night stands.  100% audits of all rooms in the facility we completed by Environmental Services Director on 07.23.2021 to ensure that a resident spersonal laundry was stored drawers or closets. Results: 8 of 98 residents needed personal laundry placin drawers/closet. Any rooms that identified personal laundry not stored in the facility of the	1 to d. d. vas ere vas ees nds y ed s was all d in	
	from staff about the smell of the room.	urine in the bathroom and the			the proper place was immediately store away properly per resident guidance/request.	ed	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING			1	C (22/2024
NAME OF P	ROVIDER OR SUPPLIER	343204	1 2	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	23/2021
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F 584	Continued From page	e 12	F 5	584			
	room on 7/21/2021 a hallway outside of the lingering ammonia ur continued to be sticky continued to have da the edge of the toilet.  An interview was con Administrator on 7/21 revealed that she wa Resident #68's room. She added that the R day outside of his root building. She stated i the facility does not he resident would be emhousekeeping or phy room and that they be	ducted with the //2021 at 9:28 AM and she saware of the issue with regarding the urine odors. Sesident spends most of his om and at the front of the twas her expectation that ave a situation where a			3. Measures/Systemic changes to preve reoccurrence of alleged deficient pract Education: All housekeepers will be re-educated by the Administrator starting on 08.12.202 on cleaning rooms according to policy regular intervals to include dust mop at damp mop resident room floors, empty trash receptacles, replenish toilet tissurpaper towels, soap, hand sanitizer, and odor control. Clean furnishings used by residents and visitors. Clean spot on walls. Complete cleaning of bathrooms Complete cleaning of window blinds are window sills on regular intervals. Cubic curtains on regular intervals or as need Sanitize beds on deep cleaning schedules. Additionally, all laundry star were educated on storing resident □s personal laundry in the drawer or close	ice:  by 21 on nd , e, d by s. ad ble ded.	
	6/20/17. The compressions assessment dated 4/was cognitively intact.  An observation of Ref 7/19/21 at 11:56 AM stains on the floor an right side of Resident was conducted with F 11:57 AM, during whith what caused the browith had "been there aw Observations of Resident American Compressions of Resident American	sident #15's room on revealed there were brown d the floor was sticky on the #15's bed. An interview Resident #15 on 7/19/21 at ch he said he didn't know wn stains on the floor but that thile."			the resident using the Resident Rights/Personal Laundry Policy/Housekeeping Policy. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all laundry and housekeeping staff. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by		
	was conducted with F 11:57 AM, during whi what caused the brow it had "been there aw Observations of Resi	Resident #15 on 7/19/21 at ch he said he didn't know vn stains on the floor but that while."			in-service will be provided to all laundry and housekeeping staff. Any staff who does not receive scheduled in-service training will not be allowed to work unti		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345284	B. WING _			07/	23/2021
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F 584	on the right side of Resident #15's room She explained if the final been mopped the stripped and waxed at Resident #15's room Housekeeper #1 on 7 verified the floor was unsure what the brow from but that it hadn't she mopped the room An observation of Rescompleted with the Discribed the floor in having a "build up of stripped and waxed." at 1:18 PM the DES eswept and mopped florooms. She shared the technician who stripped entire building and so to other duties such at the floor technician wo days per week. The letchnician focused or sticky floors, bad odo	with Housekeeper #1 on the reported she cleaned daily and mopped the floor. Hoor was still sticky after it ten the floor needed to be again. An observation of was completed with 1/20/21 at 2:57 PM. She sticky and said she was no stains on the floor were come out of the floor when the earlier in the day.  Sident #15's floor was irrector of Environmental 22/21 at 1:16 PM. She Resident #15's room as wax and needed to be In an interview on 7/22/21 explained housekeeping staff pors daily in residents' there was one floor the earlier in the day.  Sident #15's room as wax and needed to be In an interview on 7/22/21 explained housekeeping staff pors daily in residents' there was one floor the earlier she had to pull him as buffing floors. She added orked 6 ½ hours per day, 5 DES stated the floor in resident rooms that had are or stains around the edge of scheduled Resident #15's	F	584	the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements.  The Administrator or designee will monocompliance utilizing the F584 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The tool will monit reports of housekeeping issues and personal laundry issues. Reports will be presented to the weekly Quality Assurance (QA) committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the housekeeping and personal laundry issues. The weekly QA Meeting is attended by the Administrator, Director Nursing, Minimum Data Set Coordinate Therapy Manager, Health Information Manager, Environmental Services Manager, and the Dietary Manager.	itor or ue	
	_	gned the floor tech to work assisting with a delivery of					

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	I	01/23/2021
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F 584	the facility had staffin housekeeping depart technicians. She sait technician was pulled or another area which being stripped and w  2. Resident #15 was 6/20/17. The compressessment dated 4/ was cognitively intact.  An observation of Re 7/19/21 at 11:56 AM front of the three draw peeled away from the During an interview wat 11:57 AM he said lover a year and their same condition since.  Observations of Resi at 2:35 PM and 7/21/ vinyl on the front of the peeled away from the On 7/22/21 at 1:05 P Resident #15's nights the Maintenance Dire with the Maintenance Dire with the Maintenance PM, he said the vinyl peeled away and add to be discarded and a Resident #15's room maintenance work or no work orders for Resident was pulled to the discarded and a Resident #15's room maintenance work or no work orders for Resident was pulled to the discarded and a Resident #15's room maintenance work or no work orders for Resident was pulled to the discarded and a Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maintenance work or no work orders for Resident #15's room maint	g issues in the ment and needed more floor d at times the floor I to the laundry department in prevented the floors from exed.  admitted to the facility on exhensive Minimum Data Set 3/21 indicated Resident #15 in sident #15's room on revealed the vinyl on the ever nightstand had partially exhibit and had been in the room for hightstand had been in the he resided in the room.  Ident #15's room on 7/19/21 in he had been in the room for hightstand had been in the he resided in the room.  Ident #15's room on 7/20/21 in 12:56 PM revealed the ine nightstand had partially exhibit and was completed with extor. During an interview in Director on 7/22/21 at 1:11 on the nightstand needed a new one placed in	F 5	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		07723/2021
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F 584	disrepair and said th housekeeping depair responsible for replate furniture was in disress. An observation of Recompleted with the Eservices (DES) on 7 interview on 7/22/21 explained housekee notified her that the During the observation unaware of the conditional transportation on the facility had not construct the facility had not constru	nely for furnishings in e furnishings were kept in the street and they were accements when a piece of epair.  esident #15's nightstand was Director of Environmental 1/22/21 at 1:16 PM. In an at 1:18 PM the DES ping staff should have nightstand was in disrepair. on she said she was lition of the nightstand and to be discarded and a new sident #15's room.  Impleted with the 2/21 at 3:55 PM. She stated completed room audits or furniture in disrepair and eadding room audits on a	F 5	84		
	The Admission Minir assessment dated 6 #107 had moderatel required extensive a dependence with on mobility and transfer On 7/19/21 at 11:03	e to two people for bed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	345284	B. WING _	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	07/	23/2021
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F 636 SS=D	observation, the large personal laundry removered personal laundry removered personal laundry removered personal laundry removered personal laundry recorner of the room.  On 7/21/21 at 8:50 Al of personal laundry recorner of the room.  On 7/22/21 at 3:45 Pl conducted with the As She stated it was the members to put the recomprehensive Asse CFR(s): 483.20(b)(1)(1)(1)(1)(2)(1)(1)(2)(2)(1)(3)(3)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	s a large clear plastic ersonal laundry.  AM, during a wound care clear plastic bag of ained on the chair in the am, an interview was set. She stated she did not were on the chair.  M, the large clear plastic bag emained on the chair in the amined on the chair in the assistant Director of Nursing. It is responsibility of the family esidents clothing away. It is sement a standardized the control of each resident's ensive Assessment Instrument.		536			8/17/21

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING				23/2021
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F 636	(ix) Continence. (x) Disease diagnosis (xi) Dental and nutritio (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatmen (xvi) Discharge plann (xvii) Documentation regarding the additior on the care areas trig the Minimum Data Se (xviii) Documentation assessment. The ass include direct observa with the resident, as v licensed and nonlicer members on all shifts §483.20(b)(2) When r timeframes prescribed chapter, a facility mus assessment of a resid timeframes specified through (iii) of this see prescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmission significant change in	or patterns.  collibrations.  collibrations.  containing and structural problems.  containing and structural problems.  containing and structural problems.  containing and health conditions.  containing and procedures.  contai	F	636			

		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C <b>7/23/2021</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		772372021	
				901 BETHESDA ROAD			
THE OAK	5			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 636	Continued From page	e 18	F 63	66			
	following a temporary or therapeutic leave.) (iii)Not less than once This REQUIREMENT by: Based on staff interv			The statements made on this I			
	Data Set (MDS) asse admission for 2 of 26 (Resident #313 and F	essment within 14 days of residents reviewed Resident #54).		not constitute an agreement wi alleged deficiencies. To remain compliance with all Federal and Regulations the facility has take	ith the n in d State en or will		
	The findings included:  1.Resident #313 was admitted to the facility on 7/2/21 with diagnoses including, in part, cirrhosis			take the actions set forth in this Correction. The Plan of Correction constitutes the facility sallegate compliance such that all allege	ction ation of		
	and severe protein-ca			deficiencies cited have been or corrected by the date or dates	r will be		
	observed and had be Medicare & Medicaid	acker dated 7/2/21 was en submitted to Centers for		F 636 COMPREHENSI ASSESSMENT & TIMING Corrective Action: Resident #313. Admission Comprehensive Assessment, A Reference Date (ARD) 7/9/202 Completed, Submitted and Acc	Assessment 11.		
	AM with MDS nurse # #313's admission MD been completed by 7 have been behind on			7/28/2021 to the State Quality Improvement Evaluation Syste system. Resident #54. Admission Compassessment, Assessment Refe Date (ARD) 4/26/2021. Comple Submitted and Accepted on 6/8 the State Quality Improvement System QIES system.	m QIES prehensive erence eted, 8/2021 to		
	PM with the Director stated that the facility behind in completing	ducted on 7/22/21 at 3:19 of Nursing (DON). She was aware that MDS was assessments. The facility g a system in place and had		Identification of other residents be involved with this practice: All current residents with Comp Minimum Data Set (MDS) assedue have the potential to be aff	orehensive essments		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
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F 636	F 636 Continued From page 19		F 6	36			
	recently rehired a pr remotely to help con DON also explained	evious employee to assist inplete assessments. The the facility had received corporate office as well.		the alleged practice. On 8/9 was completed by the MDS consultant to ensure that the conducted a comprehensive standardized reproducible a each resident standardized functional of the 107 current residents residents did not have their comprehensive assessmen within 14 calendar days after excluding readmission in which is a significant change in the residents.	Nurse e facility had e, accurate, assessment of capacity. Out , 21 number of ts completed er admission, nich there is no		
	2. Resident #54 was admitted to the facility on 8/3/17. His cumulative diagnoses included severe protein-calorie malnutrition and non-Alzheimer's dementia.  Resident #54's Minimum Data Set (MDS) assessments included a comprehensive annual MDS dated 5/4/20. The resident 's most recent comprehensive MDS was an annual assessment with an Assessment Reference Date (ARD) of 4/26/21. A review of the 4/26/21 annual MDS revealed the section on Assessment Administration was signed by a Registered Nurse (RN) verifying this assessment was completed on 6/7/21.  An interview was conducted on 7/22/21 at 11:33 AM with MDS Nurse #1. During the interview, the MDS nurse reviewed Resident #54's annual MDS dated 4/26/21 and confirmed the assessment was signed and dated as having been completed			physical or mental condition assessments were complet 8/12/2021.  Systemic Changes: On 8/12-13/2021 The Regis (RN) Minimum Data Set (M Coordinator, Licensed Prace (LPN) Minimum Data Set (I nurses any other Interdiscip member that participates in assessment process was in /educated by the MDS nurs The education focused on: must conduct initially and procomprehensive, accurate, se reproducible assessment of resident set functional capace OBRA-required comprehen assessments include the coboth the MDS and the CAA well as care planning. Compassessments are completed	stered Nurse DS) tical Nurse MDS) Support blinary team the MDS serviced e consultant. The facility eriodically a standardized f each city. sive ompletion of process, as prehensive		
	of 4/26/21. MDS Nui	6/7/21. She reported the assessment should be been completed 14 days after the ARD date 6/26/21. MDS Nurse #1 stated the MDS was because the facility's assessments were sind schedule.		admission, annually, and wisignificant change in a residence has occurred or a significant a prior comprehensive asserequired. They consist of: A	hen a dent⊡s status it correction to essment is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(>	(X3) DATE SURVEY COMPLETED					
		345284	B. WING _			C <b>07/23/2021</b>		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  901 BETHESDA ROAD  WINSTON SALEM, NC 27103				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE		
F 636	An interview was cor PM with the facility's During the interview, recognized the reside were behind schedul working on putting a	e 20 Inducted on 7/22/21 at 3:19 Director of Nursing (DON). Ithe DON reported the facility ents' MDS assessments e. She stated the facility was system in place to receive aught up on their MDS	F	Assessment, Annual A Significant Change in (SCSA) and Significant Comprehensive Asses Admission assessmer comprehensive asses resident and, under so a returning resident the completed by the end the date of admission as day 1 if: this is the in this facility, OR the admitted to this facility discharged return not resident has been adreand was discharged re and did not return with discharge. The Annual comprehensive asses that must be completed basis (at least every 3 SCSA or a SCPA has since the most recent assessment was composite on the most recomprehensive and part ARDs and completion Assessment Instrume make a comprehensive and part of the comprehensive and part of the composite of the composite of the comprehensive and part of the composite of the composit	Status Assessment t Correction to Prior Sement (SCPA). The sement (SCPA). The sement for a new ome circumstances that must be of day 14, counting to the nursing homoresident as first time resident has been and was anticipated, OR the mitted to this facility eturn anticipated hin 30 days of all assessment is a sment for a resident as a sment for a resident comprehensive pleted. Its es/CAA(s)/care plane as a seessments at assessment of a facility must be assessment of a facility must be assessment (RAI) as a seessment must lowing: (i) a communication. (vincommunication. (vincommunication. (vincommunication. (vincommunication).	or liee of the control of the contro		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		CTION	(X3) DATE SURVEY COMPLETED				
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NAME OF P	ROVIDER OR SUPPLIER			901 BETHES	DRESS, CITY, STATE, ZIP CODE SDA ROAD SALEM, NC 27103	1 0112	10,2021
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F 636	Continued From pag	e 21	F6	(vii) Ps Physical probler diagno and nu (xiii) Ac Special Discha of sum addition care ar the Mir Docum assess must ir commus as com license shifts. This in 8/13/20 time, a interdis in-serv work un informa standa require all emp Quality the cha Monito To ens Nursing Coordi resider Set(ME one of	sychological well-being.(viii) cal functioning and structural ms.(ix) Continence.(x) Disease cois and health conditions.(xi) De cutritional status.(xii) Skin Conditi- ctivity pursuit.(xiv) Medications. al treatments and procedures.(xi- carge planning.(xvii) Documentati- carge planning.(xvii) Documentati- carge planning.(xviii) Documentati- carge planni	ons.  vi) on he n of sell on all part eive o he eior the at	

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER	040204	J	ST	REET ADDRESS, CITY, STATE, ZIP CODE	07/	23/2021
TO WILL OF TH	to vibert of tool i eleft				1 BETHESDA ROAD		
THE OAKS	S			INSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 636	Continued From page		F 6		Annual Assessment, and Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment) to ensure that the comprehensive assessments a completed timely. This will be done on weekly basis to include the weekend for weeks then monthly for 3 months. Repwill be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinate to ensure corrective action initiated as appropriate. Any immediate concerns where brought to the Director of Nursing on Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager Wound Nurse.	or 4 orts  ors  vill  the	8/17/21
SS=D	CFR(s): 483.20(c)  §483.20(c) Quarterly A facility must assess quarterly review instruand approved by CMS once every 3 months. This REQUIREMENT by:	Review Assessment a resident using the ument specified by the State S not less frequently than is not met as evidenced					
	review, the facility fail Minimum Data Set (M	iews and medical record ed to complete a quarterly IDS) assessment within 92 ent Reference Date (ARD) of sessment for 3 of 26			The statements made on this Plan of Correction are not an admission to and not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State	do	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		345284	B. WING _				23/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	077	23/2021	
TVAIVIL OF T	TOVIDER OR GOLT EIER							
THE OAKS	3				01 BETHESDA ROAD			
				V	VINSTON 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 638	Continued From page	e 23	F 6	38				
	residents (Residents	#1, #6 and #15) reviewed			Regulations the facility has taken or wil	ı		
	,	of MDS assessments.			take the actions set forth in this Plan of			
	, ,				Correction. The Plan of Correction			
	The findings included	<b>!</b> :			constitutes the facility□s allegation of			
	3				compliance such that all alleged			
	1. Resident #1 was a	dmitted to the facility on			deficiencies cited have been or will be			
		ses that included adult			corrected by the date or dates indicated	d.		
	failure to thrive and A				F 638 QRTLY ASSESSMENT A			
					LEAST EVERY 3 MONTHS			
	A review of the Minim	num Data Set (MDS)			Corrective Action:			
		ident #1 revealed the last			Resident #1. Quarterly Assessment,			
	assessment completed was an admission				Assessment Reference Date (ARD)			
	assessment complete	ed on 2/10/2021. No other			5/132021. Completed, Submitted and			
	MDS assessments ha	ad been completed since			Accepted on 8/10/2021 to the State			
	2/10/2021. The next	quarterly MDS assessment			Quality Improvement Evaluation Syster	n		
	had been scheduled	for 5/13/2021.			QIES system.			
					Resident #6. Quarterly Assessment,,			
	An interview was con	ducted with the MDS			Assessment Reference Date (ARD)			
	Coordinator on 7/22/2	2021 at 11:33 AM and she			6/18/2021. Completed, Submitted and			
	revealed the MDS as	sessments had been behind			Accepted on 8/6/2021 to the State Qua	lity		
		I that the MDS staff had			Improvement Evaluation System QIES			
	_	er facility that was recently			system.			
		orate company, to learn the			Resident #15. Quarterly Assessment,			
		ated the corporate company			Assessment Reference Date (ARD)			
		upport to the MDS nurses			7/4/2021. Completed, Submitted and			
	_	mpleting the assessments.			Accepted on 7/27/2021 to the State			
		ening since the middle to end			Quality Improvement Evaluation Syster	n		
	_	nad one full time MDS nurse			QIES system.			
	and one part time MD	OS nurse.			Identification of other residents who ma	ıy		
					be involved with this practice:			
		iducted with the Director of			All current residents with Quarterly			
	- , ,	22/2021 at 3:19 PM and she			Minimum Data Set (MDS) assessments			
	•	lity was aware, prior to the			due have the potential to be affected by			
		, that the MDS assessments			the alleged practice. On 8/9/2021 an au	IDIT		
		e facility had been working			was completed by the MDS Nurse	J		
		to date and a previous			consultant to ensure that the facility had	-		
		contracted to assist remotely.			conducted Quarterly Review assessme			
		any had also been working to nd additional education to			of each resident⊡s. Out of the 107 curr residents, 22 number of residents did n			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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		345284	B. WING			07/	23/2021		
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE				
THE OAK	S				BETHESDA ROAD NSTON SALEM, NC 27103				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI)		PREFIX	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 638	Continued From page the MDS nurses.	e 24	F 63	38	have their quarterly review assessmen completed within 92days since the ARI the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment. This assessments were completed and				
	8/14/20 with diagnose dementia and history with cerebral infarction.  A review of the quarte 6/18/21 revealed that were complete. Furth assessment was to be	erly MDS assessment dated only sections C, D, E, and K her review indicated that the e completed by 7/2/21. The sment was completed and			submitted by 8/12/2021. Systemic Changes: On 8/12-13/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the nurse consultant. The education focused on: The facility must conduct initially and periodically as	he			
	AM with MDS nurse assessment should has weeks ago. She state full-time MDS nurse as been behind for about corporate added on a were helping complete added that corporate providing additional hassessments.  An interview was con PM with the Director stated that the facility behind in completing had worked on putting recently rehired a present stated that the present of the present of the state of	ducted on 7/22/21 at 3:19 of Nursing (DON). She was aware that MDS was assessments. The facility g a system in place and had evious employee to assist			Quarterly Review Assessment of each resident □s functional capacity.  OBRA-required quarterly review assessments are to be completed within 92 days since the ARD of the previous OBRA Quarterly Review Assessment of ARD of previous comprehensive assessment, or significant Correction to Prior Quarterly Assessment (ARD of an of the mentioned assessments + 92 calendar days). The MDS completion of (item Z0500B must be no later than 14days after the ARD (ARD + 14 calendays).  This in service was completed by 8/13/2021. Any MDS nurse (full time, putime, and PRN) and member of the interdisciplinary team who did not recein-service training will not be allowed to	ony late dar part			
	remotely to help com	plete assessments. The the facility had received			work until training is completed. This information has been integrated into th	e			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	\ /	(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C
NAME OF DE	ROVIDER OR SUPPLIER	343204		STREET ADDRESS, CITY, STATE, ZIP CODE	0	7/23/2021
NAIVIE OF PI	ROVIDER OR SUPPLIER					
THE OAKS	8			901 BETHESDA ROAD		
				WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 638	Continued From page	e 25	F 63	8		
	assistance from the c	corporate office as well.		standard orientation training and required in-service refresher cou all employees and will be review Quality Assurance Process to ve	urses for red by the	
	3. Resident #15 was admitted to the facility on 6/20/17 with diagnoses that included, in part, peripheral vascular disease.			the change has been sustained. Monitoring: To ensure compliance, The Dire	ctor of	
	7/4/21 was reviewed. indicated the assessr revealed sections A, had not been comple indicated the assessr	ssessment with an ARD of The computer system ment was "in progress" and B, H, I, J, L, M, N, O and P ted. The system further ment was due 7/18/21. The sment was completed on		Nursing and/or Designee will revieweekly, 5 residents electronic red. Minimum Data Set(MDS) Quarter assessments to ensure that the assessments are to be completed 92days since the ARD of the precount of the	ecords erly ed within evious ement or ection to	
	on 7/22/21 at 11:33 A #15's quarterly assessigned as completed MDS assessments w MDS staff had assister recently switched to a She added since the corporate office had poffice and assisted in	orporate help was provided		of the mentioned assessments - calendar days) and completed ti MDS completion date (item Z05 be no later than 14days after the (ARD + 14 calendar days). This done on weekly basis to include weekend for 12 weeks then mor months. Reports will be present weekly QA Committee by the Di Nursing and/or Mini Data Set (M Coordinators to ensure correctivinitiated as appropriate. Any imr concerns will be brought to the I	mely: the 00B must e ARD will be the nthly for 3 ed to the rector of IDS) re action nediate	
	on 7/22/21 at 3:19 PM the facility recognized survey that the MDS schedule. The facility system in place and I previous employee to assessments. The D			Nursing or Administrator for app action. Compliance will be moni ongoing auditing program review Weekly Quality of Life Meeting. QA Committee meeting is attended Administrator, Director of Nursin Coordinator, Unit Manager, Sup Nurse, Therapy, HIM, Dietary M Wound Nurse.	ropriate tored and ved at the Weekly ded by g, MDS port	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		07/23/2021	
NAME OF PI	ROVIDER OR SUPPLIER		!	STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	, 0.7.20.202	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION	
F 638	Continued From page in efforts to get caugh re-educating the MDS	nt up and had been S nurses.	F 638		247724	
F 641 SS=D	resident's status. This REQUIREMENT by: Based on record revifacility failed to accurred facility failed for 2 of 26 (Residents #73 and 1 findings included:  1. Resident #73 was facility on 2/28/17 and diagnoses which included with behavioral disturnment failed	of Assessments. It accurately reflect the  is not met as evidenced liew and staff interviews, the lately code the Minimum lessment in the areas of leting, and behaviors and skin sampled residents  07).  originally admitted to the lateradmitted on 3/1/17 with laded: vascular dementia bance, hemiplegia and la cerebral infarction affecting	F 64 <sup>2</sup>	The statements made on this Plan of Correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or take the actions set forth in this Plan Correction. The Plan of Correction constitutes the facility sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated F641 Accuracy of Assessments Corrective Action:  Resident # 73 Resident Minimum Daset (MDS) assessment (Quarterly Assessment,) with Assessment /Reference Date (ARD) [5/18/2021] with Assessment /Reference Date (ARD) [6/18/2021] was modified.  Resident # 107 Resident Minimum Daset (MDS) assessment (Admission Comprehensive Assessment) with Assessment /Reference Date (ARD) [6/18/2021] was modified.  Identification of other residents who is be involved with this practice:  All current residents who have behave presence of symptoms during the Minimum that is the presence of symptoms during the Minimum of th	e will of fee ted.  Ata was example ata was example ata wioral	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
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NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0772372021	
				901 BETHESDA ROAD			
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(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641	F 641 Continued From page 27		F 6	41			
	incontinent of bowel	toileting; was always and bladder; and had range on one side of the upper 		Data Set (MDS) 7 day look back quarterly assessment reference who requires activities of daily li assistance during the Mini Data (MDS) 7 day look back for quart	date(s); ving Set		
	During an observation on 7/20/21 at 2:00 p.m., Resident #73 was asleep in a low bed. The resident was lying on her back and covered with a quilt. She appeared clean and dry with no odors.  During an interview on 7/20/21 at 2:01 p.m., Nurse Aide (NA#1) stated Resident #73 required total assistance of two staff with all her activities of daily living (ADL), including bed mobility. She also revealed the resident required the use of a			assessment reference date(s), a have wounds during the Mini Da (MDS) 7 day look back for admi assessment reference date(s), h potential to be affected by the all	and who ata Set ssion nave the		
				practice. On 8/6/2021 through 8 an audit was completed by the I Nurse Consultant to review all C Minimum Data Set (MDS) assesthe last 6 months to ensure that	MDS Quarterly ssments in		
	resident would exhibited during ADL care and stated that during care	nsfers. NA#1 stated the t combative behaviors during incontinent care. She te the resident would bite, dig her fingernails into the		residents who have behavioral pof symptoms during the Mini Da (MDS) 7 day look back is coded accurately. All assessments coaccurately. On 8/6/2021 through	ta Set led		
	awake the resident w	NA also revealed when ould pick at her own skin.		8/10/2021 an audit was complet MDS Nurse Consultant to review Quarterly Minimum Data Set (M	w all DS)		
	#2 stated Resident #	n 7/20/21at 2:34 p.m., Nurse 73 exhibited behaviors e (scratching, biting, yelling).		assessments in the last 6 month ensure that all residents who re- activities of daily living assistant during the Mini Data Set (MDS)	quires ce wounds		
	MDS Coordinator #1 data entry errors on I	n 7/22/21 at 10:06 a.m., acknowledged there were Resident #73's 5/18/21 MDS. ent required only one staff to		back is coded accurately. All as coded accurately. On 8/6/2021 8/10/2021 an audit was complet MDS Nurse Consultant to review	through ted by the		
	assist the resident wi should have been a t to the resident requir lift. However, MDS C because the resident	th eating; and, the resident otal assist with transfers due ed the use of a mechanical oordinator #1 stated could occasionally inform		Quarterly Minimum Data Set (M assessments in the last 6 month ensure that all residents who ha wounds during the Mini Data Seday look back for admission ass	DS) as to ave et (MDS) 7 sessment		
	was coded as requiri	n incontinent accident, she ng extensive assistance with inator #1 indicated the		reference date(s) is coded accurately. completed on 08/12/2021.	-		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	3			901 BETHESDA ROAD		
IIIE OAK	•			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 COMPLETION	
F 641	F 641 Continued From page 28		F 64	1		
	facility's Social Worke	er (SW) was responsible for				
		coding of the behavior		Systemic Changes:		
	section of the MDS.	or and bonario.		On 8/12-13/2021 The Registered N	ırse	
				(RN) Minimum Data Set (MDS)		
	During an interview o	n 7/22/21 at 10:56 a.m., the		Coordinator and MDS Support nurs	e and	
	SW stated his assess			any other Interdisciplinary team me	I	
		vior on the MDS was based		that participates in the MDS assess		
		d communication with the		process was in serviced /educated	I	
	resident during the look back period of seven			MDS Nurse consultant.	,	
	days or more. He stated that the resident was			The education focused on: The faci	ity	
	always cooperative during his questioning and			must ensure that each assessment		
	answering period. He			accurately reflects the resident□s s	atus.	
		resident's behaviors if the		Section G: Functional Status within		
	<u> </u>	communicate with him even		7day look back period. Review the		
	if his/her responses w	vere not always correct.		documentation in the medical record	d for	
				the 7-day look-back period. Talk wit	h	
				direct care staff from each shift that	has	
	2. Resident # 107 wa	s admitted to the facility on		cared for the resident to learn what	the	
	6/18/21 with diagnose	es of urinary retention and		resident does for himself during each	h	
	protein calorie malnut	trition.		episode of each ADL activity definiti	on as	
				well as the type and level of staff		
	_	assessment dated 6/18/21		assistance provided. Remind staff t	I	
		Resident #107 had a		focus is on the 7-day lookback period	od	
	•	d left scrotal areas and a		only. When reviewing records,		
	wound to his medial a	and posterior penis.		interviewing staff, and observing the		
				resident, be specific in evaluating ea	I	
	An admission Minimu			component as listed in the ADL acti	-	
		25/21 revealed Resident		definition. For example, when evalu		
	#10/ had no ulcers, v	vounds, or skin problems.		Bed Mobility, observe what the resid		
	0 7/00/04 1 10 00 1			able to do without assistance, and t		
		AM, Treatment Aide #1 was		determine the level of assistance th		
		d Resident #107 had the		resident requires from staff for movi	_	
		the scrotal breakdown on		and from a lying position, for turning		
	admission.			resident from side to side, and/or fo		
	On 7/00/04 -+ 0:40 D	M the Director of News-		positioning the resident in bed. Sec	ION E:	
		M, the Director of Nursing		Behavioral Symptoms : Review the	a alc	
		stated she expected the		medical record for the 7-day look-ba	I	
	important to help drive	te as possible as it was very		period. Interview staff, across all sh and disciplines, as well as others w	I	
	important to neip driv	e uie pian oi care.		and disciplines, as well as others wi	io riau	

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 <b>07/23/2021</b>	
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE		0172072021	
TUE 0416	•			901 BETHESDA ROAD			
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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE		
F 641	when Resident #107' was only an order for Nurse #1 stated she #107's MDS assessn	e 29  M, MDS Nurse #1 stated 's MDS was completed, there r a cream to be applied. MDS did not complete Resident nent but the resident's skin ramined at the time of the	F 6	close interactions with the resist the 7-day look-back period, incompleted frequent contact with the Observe the resident in a varies situations during the 7-day looperiod. Section M: Other Ulcer and Skin Problems. Review the record, including skin care flow other skin tracking forms. Speadirect care staff and the treatm to confirm conclusions from the record review. Examine the redetermine whether any ulcers, skin problems are present. "Ke diabetic foot ulcers include the (bottom) surface of the foot, es metatarsal heads (the ball of the last 7 days, check none of This in service was completed 8/13/2021. The Registered Nuand or Licensed Practical Nurse Support Minimum Data Set (M. Coordinators and any other Interdisciplinary team member participates in the MDS assess process who did not receive in training will not be allowed to verialing is completed. This information training and in the rein-service refresher courses for employees and will be reviewed Quality Assurance Process to the change has been sustained Monitoring:  To ensure compliance, The Din Nursing and/or Administrator were refresher to the consumer of the point of th	cluding uently or resident. ety of k-back rs, Wounds ie medical w sheets or ak with nent nurse e medical sident and wounds, or e plantar specially the he foot). if roblems in the above. I by urse (RN) IDS)  r that sment n-service work until ormation tandard required or all ed by the verify that ed. rector of		

PRINTED: 08/30/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		245004	B WING	P. WING		С	
		345284	B. WING _		07/	23/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAK	8			901 BETHESDA ROAD			
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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 655 SS=E	CFR(s): 483.21(a)(1)- §483.21 Comprehens Planning §483.21(a) Baseline ( §483.21(a)(1) The fac- implement a baseline	r(3) Sive Person-Centered Care	Fé	resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the followin assessments Admission, Annual or Quarterly Assessment to ensure that section Section G: Functional Status within the 7day look back period, Sec E: Behavioral Symptoms, and Section Other Ulcers, Wounds and Skin Problems. are coded accurately. This be done on weekly basis for 4 weeks monthly for 3 months. The results of the audit will be reviewed at the weekly of Team Meeting. Reports will be present to the weekly QA Committee by the Director of Nursing and/or Mini Data S (MDS) Coordinators to ensure correct action initiated as appropriate. Any immediate concerns will be brought to Director of Nursing or Administrator for appropriate action. Compliance will b monitored and ongoing auditing progreviewed at the Weekly Quality of Life Meeting. Weekly QA Committee mee is attended by Administrator, Director Nursing, MDS Coordinator, Unit Mans Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse.	g tion n M: will then nis A ted othe or e am ing of ager,	8/17/21	

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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 _	B. WING		C 07/23/2021	
THE OAKS	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE D1 BETHESDA ROAD 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	that meet professional The baseline care plat (i) Be developed with admission.  (ii) Include the minimus necessary to properly including, but not limit (A) Initial goals based (B) Physician orders.  (C) Dietary orders.  (D) Therapy services.  (E) Social services.  (E) Social services.  (F) PASARR recomm §483.21(a)(2) The factom care plan if the compication (i) Is developed within admission.  (ii) Meets the requirer (b) of this section (except the baseline care plan it is section).  §483.21(a)(3) The factom care plan it is section (except the baseline care possible to the baseline care possible to the baseline care possible to the dietary instructions.  (iii) Any services and administered by the facility (iv) Any updated inform of the comprehensive This REQUIREMENT by:	centered care of the resident al standards of quality care. In mustin 48 hours of a resident's care for a resident ted to-I on admission orders.  endation, if applicable.  cility may develop a colan in place of the baseline rehensive care planna 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary clan that includes but is not at the resident.  If the resident.  If the resident the resident and the resident's medications and treatments to be acility and personnel acting	F	355	The statements made on this plan of		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343204	5: 11:10	STREET ADDRESS, CITY, STATE, ZIP CO	•	7/23/2021	
NAME OF F	ROVIDER OR SUFFLIER				DE		
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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 655	Continued From pa	ge 32	F 6	55			
F 655	facility failed to devivithin 48 hours of the of 9 newly admitted #416, Resident #41 Resident #313).  The findings include 1. Resident #416 w 7/9/21. Her cumula 2 diabetes with chron The resident's electric included a baseline baseline care plans hours of the resident hours of the resident An interview was confused and with the facility. Nurse #1. During the reviewed Resident her baseline care plans for newly admiresident's comprehence at the	elop a baseline care plan the resident's admission for 4 residents reviewed (Resident 5, Resident #413, and ed: as admitted to the facility on ative diagnoses included Type onic kidney disease.  Fronic medical record (EMR) care plan dated 7/12/21. This was not completed within 48 ont's admission.  Inducted on 7/21/21 at 10:20 one interview, the MDS Nurse on MINIMUM Data Set (MDS) the interview, the MDS Nurse on MINIMUM Data Set (MDS) the facility utilized the onmary as the baseline care on the day assessment was  Inducted on 7/21/21 at 2:02 In Sassistant Director of The ADON reported the nurse on the day be responsible to print up the The ADON reported that if the would put the admission	F 6	correction are not an admiss not constitute an agreement alleged deficiencies.  To remain in compliance with and state regulations the factor will take the actions set for plan of correction. The plan constitutes the facility alle compliance such that all alle deficiencies cited have been corrected by the dates indicated by the dates indicated by the alleged deficed by the alleged deficed.  Resident #416 was discharged facility on 07.26.2021. Prior the Baseline Care Plan was reviewed with the resident 07.12.2021.  Resident #415 alleged with the representative, and a copy was to the resident representative. The prior the Baseline Care Plan was reviewed with the resident representative on 07.12.2021.  Resident #413 was discharged facility on 07.20.2021. Prior the Baseline Care Plan was reviewed with the resident representative on 07.21.2021.  Resident #413 was discharged facility on 07.20.2021. Prior the Baseline Care Plan was reviewed with the resident reand a copy was provided to representative on 07.21.202	th all federal cility has taken orth in this of correction egation of eged or or will be ated.  Sident(s) cient practice:  ged from the to discharge printed, and a copy to on  Care Plan was esident was provided e on  ged from the to discharge printed, and a copy to on  ged from the to discharge printed, and a copy to on  ged from the to discharge printed, and a copy to on  ged from the to discharge printed, appresentative, the resident control of the c		
	PM with the facility Nursing (ADON). T who verified a resid of admission would baseline care plan. she was working, sl orders into the EMF care plan herself.	's Assistant Director of The ADON reported the nurse ent 's medications on the day be responsible to print up the The ADON reported that if		facility on 07.20.2021. Prior the Baseline Care Plan was reviewed with the resident re and a copy was provided to representative on 07.21.202	to discharge printed, epresentative, the resident 11.  ged from the to discharge printed,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345284	B. WING		C <b>07/23/2021</b>	
NAME OF PE	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	01720/2021	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION	
F 655	admissions.	e 33 seline care plan for new ducted on 7/22/21 at 3:19	F 655	was provided to the resident on 07.05.2021.		
	PM with the facility's I During the interview, been made aware of residents' baseline or completed within 48 h stated the facility four admitted on a Friday care plan completed Monday. The DON reviewing and revising ensure the timely inition 2. Resident #415 was 7/9/21. His cumulative 2 diabetes with long that and Parkinson's demonstrated included a baseline of	Director of Nursing (DON).  the DON reported she had the concerns regarding are plans not being nours of admission. She and some residents who were were not getting a baseline until the ADON came in on eported the facility was g the system in place to ation of baseline care plans.  Is admitted to the facility on the diagnoses included Type therm (current) use of insulin the entia.  In the medical record (EMR) are plan dated 7/12/21. This as not completed within 48		2. Corrective action for residents with the potential to be affected by the alleg deficient practice.  Beginning on 07.23.2021, The Director Nurses (DON) initiated an audit of all current residents admitted during the I 14 days to identify any residents who do not have a base line care plan develop within 48 hours of the resident sadmission and where there was no summary provided to the resident and resident representative. The audit was completed on 07.23.2021. Results: 2 18 residents did not have base line caplan developed with 48 hours. All residents or resident representatives we provided with a summary of the baselicare plan.	r of ast did bed /or s of re	
	An interview was conducted on 7/21/21 at 2:02 PM with the facility's Assistant Director of Nursing (ADON). The ADON reported the nurse who verified a resident's medications on the day of admission would be responsible to print up the baseline care plan. The ADON reported that if she was working, she would put the admission orders into the EMR and complete the baseline care plan herself. The ADON reported the facility was aware of the 48-hour requirement to complete an initial baseline care plan for new admissions.			3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:  Education:  On 08.13.2021, the DON began reeducating Assistant Director of Nurs Registered Nurse Weekend Supervisor Licensed Practical Nurse Evening Supervisor on the following topics:  "Timeline for Initiating a Base Line"	ing, or,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345284	B. WING		07/2	23/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAK				901 BETHESDA ROAD			
THE OAKS	•			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 655	655 Continued From page 34		F 65	5			
		ducted on 7/22/21 at 3:19		Care Plan			
		Director of Nursing (DON).		" Review of the Base Line Care	Plan		
	_	the DON reported she had		Requirements	5 i idii		
		the concerns regarding		requirements			
	residents' baseline ca			This information has been integra	ted into		
		nours of admission. She		the standard orientation training a			
		nd some residents who were		be reviewed by the Quality Assura			
	•	were not getting a baseline		process to verify that the change			
	care plan completed until the ADON came in on Monday. The DON reported the facility was reviewing and revising the system in place to ensure the timely initiation of baseline care plans.			been sustained. As of 08.17.2021			
				staff who does not receive schedu	ıled		
				in-service training will not be allow	ed to		
				work until training has been comp	leted.		
		s admitted to the facility on		The facility will review this information			
		ive diagnoses included		their clinical meeting and discuss	-		
	fibromyalgia.			issues at least weekly for the next			
				months unless the Quality Assura			
		nt's electronic medical		Committee feels this issue has be	en		
	, ,	ted on 7/19/21 revealed		resolved sooner.			
	there was no baseline	e care plan in the EMR.		4 44 11 1 5			
	A = i=t== :i=	durate di air 7/04/04 at 40:00		4. Monitoring Procedure to ensu			
		ducted on 7/21/21 at 10:20		the plan of correction is effective a			
	_	Minimum Data Set (MDS) interview, the MDS Nurse		specific deficiency cited remains of and/or in compliance with regulators			
	_	13's medical record and		requirements.	y y		
		it's baseline care plan was		requirements.			
		MDS Nurse #1 reported the		The Director of Nursing or design	ee will		
	_	ysician Order Summary as		monitor compliance utilizing the F			
	the baseline care plar			Quality Assurance Tool weekly x 4			
	residents. She stated			then monthly x 3 months. The DC			
		olan would be created when		designee will monitor for compliar			
	his/her MDS assessm			initiating base line care plans with			
				specified time frame and provide			
	An interview was con-	ducted on 7/21/21 at 2:02		resident and/or their representativ			
		Assistant Director of Nursing		summary of the baseline care plan			
	(ADON). The ADON	reported the nurse who		Reports will be presented to the w	eekly		
	verified a resident's m	nedications on the day of		Quality Assurance (QA) committe	e by the		
		esponsible to print up the		DON to ensure corrective action is			
	baseline care plan. Tl	ne ADON reported that if		initiated as appropriate. Complian	ce will		

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 <b>07/23/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 901 BETHESDA ROAD WINSTON SALEM, NC 27103		07723/2021
(X4) ID PREFIX TAG			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 655	orders into the EMR care plan herself. Ushe recalled talking 7/19/21 but acknow outside the 48-hour baseline care plan.  An interview was concern was a concern with the facility's During the interview been made aware or residents' baseline completed within 48 stated the facility for admitted on a Fridat care plan completed Monday. The DON reviewing and revisive ensure the timely in 4. Resident #313 was 7/2/21 with diagnost disease of the liver malnutrition.  The resident's elect included a baseline baseline care plan whours of the resident.	ne would put the admission and complete the baseline Upon inquiry, the ADON stated with Resident #413 on ledged this would have been window for completion of her window for complete had in the concerns regarding care plans not being a baseline do until the ADON came in on reported the facility was ing the system in place to itiation of baseline care plans.  The complete the baseline window for complete within 48 was not completed within 48	F 68	,	g auditing ekly Quality ekly QA dministrator, Director of lurses, Manager, Unit mation anager.	
	working, she would for the resident or re stated that the date	N reported that if she was print the baseline care plan esponsible party to sign. She shown on the baseline care as printed out for review and				

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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 07/23/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  901 BETHESDA ROAD  WINSTON SALEM, NC 27103	07723/2021	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 655	#313's printed date w window for completion.  An interview was completion.  An interview was completed with the facility's I During the interview, been made aware of not being completed with admission. She state residents who were a getting a baseline car ADON came in on Mothe facility was review in place to ensure the care plans.  Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a furth applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profession place on observation interviews, the facility for 6 days to a non-prince in the complete with the care plan, and the resident plan plan plan plan plan plan plan plan	agrees that Resident as outside the 48-hour of his baseline care plan.  ducted on 7/22/21 at 3:26 Director of Nursing (DON). the DON reported she had some baseline care plans within 48 hours of did the facility found some dmitted on a Friday were not e plan completed until the onday. The DON reported ving and revising the system of timely initiation of baseline  are indamental principle that not and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of tensive person-centered sidents' choices.  The is not met as evidenced in the provide a treatment essure wound for 1 of 5 or pressure ulcers (Resident).	F 6		and do le deral s taken his	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C	
	201/1252 02 01/221/52	345264	D. WING		0	7/23/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAKS	3			901 BETHESDA ROAD			
IIIE OAK	•			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OULD BE	(X5) COMPLETION DATE			
F 684	Continued From page 37 Resident # 107 was admitted to the facility on 6/18/21 with a diagnosis of urinary retention.  An admission nursing assessment dated 6/18/21 revealed Resident #107 had a wound to his		F 68	4			
				constitutes the facility□s allegation compliance such that all alleged deficiencies cited have been or v	vill be		
				corrected by the dates indicated. F684			
	scrotal area and on th	ne medial and posterior		Corrective action for resident	ıt(s)		
	aspect of his penis.  A review of the care plan dated 6/22/21 revealed a focus area of risk for pressure ulcer development; had a small split-like area on penis due to catheter and a wound to his scrotal area. Interventions included treatment to penis as			affected by the alleged deficient	practice:		
				Resident #107, discharged from facility on 08.07.2021, therefore			
				corrective action could be comple			
				him. Treatment orders were initiation	ated on		
				06.23.2021 for him prior to his di	scharge.		
	ordered and monitor t	for infection.		Resident received wound care as	s ordered		
				once the treatment order was init	tiated.		
	An admission Minimu	m Data Set (MDS)					
	assessment dated 6/2	25/21 revealed Resident		Corrective action for resident	its with		
	#107 was cognitively	impaired. The MDS		the potential to be affected by the	e alleged		
	indicated Resident #1 problems.	07 had no wounds or skin		deficient practice.			
	·			On 07.27.2021, the treatment nu	rse		
	A review of the physic	cian's orders for June 2021		audited all new admit residents r	equiring	<b> </b>	
	revealed no treatmen	t was started for the wound		wound care and any newly identi	ified		
	to Resident #107's pe	enis until 6/23/21.		facility wounds for the last 14 day	ys from		
				07.23.2021 to ensure that each r	esident		
	On 7/20/21 at 10:30 A	AM, an observation of		had wound treatment orders initia	ated in a		
		was conducted. Resident		timely manner to ensure that res			
	#107 had an opening	on his penis from the top to		receive treatment and care in ac	cordance		
	approximately midwa	y down to the base.		with professional standards of pr	actice.		
	Resident #107 had ar	n indwelling catheter in		This was completed on 07.28.20	21.		
	place.						
				Measures /Systemic change			
	On 7/20/21 at 10:30 A			prevent reoccurrence of alleged	deficient		
		eatment Aide. He stated		practice:			
		dmitted to the facility with					
	the open area to his p	penis.		On 07.23.2021, the DON, Treatn		<b> </b>	
				Nurse, Administrator, and the Qu			
	On 7/21/21 at 7:20 Al			Assurance Clinical Nurse Consu	Itant		
	conducted with the Tr	eatment Nurse. She stated		reviewed the policy on wound			

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		345284	B. WING _			C <b>07/23/2021</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		<b>V</b> 1/20/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATION (PROPRIED TO THE APPROPRIATION)  TO PROVIDER'S PLAN OF CORRECTION OF CORRECTIVE ACTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD PROVIDE TO THE APPROPRIATION)		CTION SHOULD BE O THE APPROPRIA	DATE			
F 684	the open area to his padmitting nurse was assessment and if the were to fill out a new tool. They were supp physician and get an She stated she did not Resident #107, so she skin issues. She state and called the physician of 1/22/21 at 4:18 P conducted with the D #107 was admitted w	dmitted to the facility with penis. She stated the supposed to complete a skin ere were any areas, they skin development tracking osed to also call the order to initiate a treatment. It receive the form for the was unaware he had any ed she found out on 6/23/21 ian to obtain an order.  M, an interview was ON. She stated Resident with the open area to his ed the nurse that completed sment needed further	F 6	documentation. There we required for the policy. Of the Director of Nursing (Director of Nursing (Director of Nurses) all Licensed Registered Nurses, Licer Nurses, and any Treatmetime, part time, agency sethe following topics:  "What to do when we identified  "Timely Wound Asses"  "Proper Treatment of This information has been the standard orientation for required in-service refres all staff identified above a reviewed by the Quality Aprocess to verify that the been sustained. Any stareceive scheduled in-service not be allowed to work unbeen completed by 08.20.  The facility will review this their clinical meeting and issues at least weekly for months unless the Qualit Committee feels this issues at least weekly for months unless the Qualit Committee feels this issues of committee feels this iss	On 07.25.2021, DON) began Nurses, need Practical ent Aides, full staff, and PRN of the properties of t	to the r  tt ill is at at at ted	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		(X3) DATE SURVEY COMPLETED		
		345284	B. WING				C
	201/1252 02 01/221/52	343204	D. WING _			07/	23/2021
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	3				1 BETHESDA ROAD		
				W	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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	S483.25(b) (1) (1) (1) (2) (3) (4) (3) (2) (4) (1) (1) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	event/Heal Pressure Ulcer (i)(ii) grity gree ulcers. Thensive assessment of a formulate ensure that- as care, consistent with the soft of practice, to prevent does not develop pressure evidual's clinical condition for ey were unavoidable; and the essure ulcers receives and services, consistent and ards of practice, to event infection and prevent		684	monthly x 3 months. The DON will monitor compliance to ensure that each resident had wound treatment orders initiated in a timely manner to ensure the residents receive treatment and care in accordance with professional standards practice. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance whe monitored and the ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly Meeting is attended by the Administrate Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.	nat s of he y rill y QA or,	8/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		C	
		345284	B. WING		07/23/2021	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE	01/23/2021	
				901 BETHESDA ROAD		
THE OAK	S			WINSTON SALEM, NC 27103		
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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 686	686 Continued From page 40		F 68	6		
	the facility failed to er	sure skin breakdown was		correction are not an admission to a	and do	
	identified and treated	for 1 of 6 residents		not constitute an agreement with the	e	
	(Resident #317) revie	wed for pressure ulcers.		alleged deficiencies.		
				To remain in compliance with all fed	leral	
	Findings included:			and state regulations the facility has	s taken	
				or will take the actions set forth in the		
		dmitted to the facility on		plan of correction. The plan of corre	ection	
		al with the following, in part,		constitutes the facility□s allegation	of	
	diagnoses: hypertension, severe protein			compliance such that all alleged		
	malnutrition, type 2 di	abetes mellitus, and		deficiencies cited have been or will	be	
	cardiomyopathy.			corrected by the dates indicated. F686		
	Resident #317's admitting Minimum Data Set			Corrective action for resident(s	)	
	, ,	8/19 showed no pressure		affected by the alleged deficient pra	ictice:	
		own under section M. It also				
		ired one person assistance		Resident #317, discharged from the	;	
	for bed mobility, trans	fers, and toileting.		facility on 02.03.2020, therefore no corrective action could be complete	d for	
		20/21 showed a nurse note I9 PM written by Nurse #5		him.		
		ved an open area to upper		Corrective action for residents		
		area was cleansed with		the potential to be affected by the a	lleged	
		oam applied. The note also		deficient practice.		
		#317 was provided with a				
		ce under left buttock to		On 07.27.2021, the treatment nurse		
	relieve pressure. The			audited all new admit residents requ	_	
		regarding this wound until		wound care and any newly identified		
	1/28/21.			facility wounds for the last 14 days	to	
	A f - 4/00/00			ensure that each resident receives		
		weekly skin check states		necessary treatment and services,	rdo of	
	there are no new skin	i area concerns.		consistent with professional standal		
	Interview on 7/24/24	at 2:20 PM with Nurse #1		practice to promote healing, preven		
		wound is identified, the		infection, and prevent new ulcers from developing. This was completed on		
		rmation in "a book" at the		07.28.2021.		
	•	vound to be assessed by the		07.20.2021.		
		rders be made if necessary.		3. Measures /Systemic changes t		
		s book is not kept as part of		3. Measures /Systemic changes to prevent reoccurrence of alleged def		
		or did she remember if she		practice:	IOIOIIL	

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 _			07/	23/2021	
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 0772	23/2021	
					BETHESDA ROAD			
THE OAK	3							
				VVIIV.	STON 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From pag	ge 41	F 6	886				
	did that for this resid	ent. She was unable to						
	provide a clear expla	anation as to why the weekly			On 07.23.2021, the Director of Nursing	1		
	1 -	following day stated that he			DON), Treatment Nurse, Administrato			
	had no new skin are	- ·			and the Quality Assurance Clinical Nur			
					Consultant reviewed the policy on wou			
	Interview on 7/22/21	at 9:45 AM with the		C	documentation. There were no change	es		
	Treatment Aide who	was unable to locate any		r	required for the policy. On 07.25.2021	,		
	treatment orders for	Resident #317 whom he		t	he Director of Nursing (DON) began			
		s not recall doing any			educating all Licensed Nurses, Registe			
		uring his time at the facility.			Nurses, Licensed Practical Nurses, an			
		aff will normally put a note in			any Treatment Aides, full time, part tim			
		ks at the nurse's station and			agency staff, and PRN on the following	j		
	then the treatment team will assess the resident			t	opics:			
	for any possible inte	rvention.		ic	What to do when wounds are dentified			
	An interview was co	nducted on 7/22/21 at 12:22		"	Timely Woulld Assessment			
	_	Director of Nursing (DON).		"	r roper rreatment of wounds			
	She provided me wit			- 1	Γhis information has been integrated ir			
		1/28/20 stating Resident			he standard orientation training and in			
		nd was as follows: 4.3 x 3.1			required in-service refresher courses for	or		
		ranulation and 30% eschar.		-	all staff identified above and will be			
		did not know what the		- 1	reviewed by the Quality Assurance			
		1/21/20 by Nurse #1 was all			process to verify that the change has	_1		
		ted that resident was referred on 1/28/20 when the issue			peen sustained. Any staff who does no			
		ever made it there because he			eceive scheduled in-service training w not be allowed to work until training ha			
		2/3/20 to the hospital for a			peen completed by 08.20.2021.	5		
	_	he was unable to provide any		"	cerr completed by 00.20.2021.			
		any care was done for the		1	Γhe facility will review this information	in		
		s between 1/28/20 and his			heir clinical meeting and discuss any			
		acility on 2/3/20 either. She			ssues at least weekly for the next 3			
	•	ent process for addressing			months unless the Quality Assurance			
		ounds on residents will			Committee feels this issue has been			
		quality process improvement		r	resolved sooner.			
	meetings.	•						
	-			4	4. Monitoring Procedure to ensure th	at		
				ti	he plan of correction is effective and the	nat		
					specific deficiency cited remains correc	cted		
				a	and/or in compliance with regulatory			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		1	23/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	23/2021
	_			901 BETHESDA ROAD		
THE OAK	5			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 686	CFR(s): 483.25(c)(1)- §483.25(c) Mobility. §483.25(c)(1) The factoresident who enters the range of motion does range of motion unless condition demonstrate of motion is unavoidal. §483.25(c)(2) A reside motion receives approximately	crease in ROM/Mobility (3)  cility must ensure that a ne facility without limited not experience reduction in state resident's clinical es that a reduction in range ble; and  ent with limited range of	F 68	requirements.  The DON or designee will monitor compliance utilizing the F686 Quality Assurance Tool weekly x 4 weeks ther monthly x 3 months. The DON will monitor compliance to ensure that eac resident receives necessary treatment and services, consistent with professio standards of practice to promote healir prevent infection, and prevent new ulcour from developing. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly Meeting is attended by the Administrat Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.	h ng, ers y QA or,	8/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345284	B. WING _		0-	C 7/23/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 901 BETHESDA ROAD WINSTON SALEM, NC 27103		1/23/2021
(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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 688	§483.25(c)(3) A resider receives appropriate assistance to maintathe maximum praction reduction in mobility. This REQUIREMENT by:  Based on observation interviews, the facility right hand splint (Residents reviewed for 1. Residents reviewed for 1. Residents reviewed for 1. Resident #22 was 7/17/20 with hemiple A quarterly Minimum assessment dated 4/had severely impaire extensive assistance her activities of daily range of motion to he on one side.  The care plan dated area of right resting hand contracture. The to wear a right resting in applied and removed staff or restorative aid.  The physician's orde 4/19/21 that read "pair or maximum provided and the physician's orde 4/19/21 that read "pair or maximum provided and pair or the physician's orde 4/19/21 that read "pair or the physician	dent with limited mobility services, equipment, and in or improve mobility with table independence unless a is demonstrably unavoidable. It is not met as evidenced ons, record review and staff of failed to apply a resting sident #22) and a right hand desident #38) for 2 of 2 or contracture management.  Data Set (MDS) 124/21 revealed Resident #22 of cognition, required of two people for most of living and had a limitation in er upper and lower extremity 1/22/21 revealed a focus from the facility of the goal was for Resident #22 of hand splint application due to be goal was for Resident #22 of hand splint for the goal was for Resident #23 of hand splint for the goal was for Resident #24 of hand splint for the goal w	F 6	The statements made on thi correction are not an admiss not constitute an agreement alleged deficiencies.  To remain in compliance with and state regulations the fac or will take the actions set fo plan of correction. The plan of constitutes the facility's alleg compliance such that all alleged deficiencies cited have been corrected by the dates indicated by the alleged deficiencies cited have been corrected by the dates indicated by the alleged deficiencies cited have been corrected by the dates indicated by the alleged deficiencies cited have been corrected by the dates indicated by the alleged deficiencies cited have been corrected by the dates indicated by the alleged deficiencies cited have been corrected by the dates indicated by t	ion to and do with the  all federal ility has taken rth in this of correction ation of ged or will be ated.  ident(s) ient practice:  s applied for ened this e was no tion observed  at was applied creened this e was no tion observed	
		proximately 2 hours a day as y nursing and/or restorative		<ol><li>Corrective action for res the potential to be affected b</li></ol>		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345284	B. WING			C 07/23/2021	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO	 DDE	0772072021	
				901 BETHESDA ROAD			
THE OAK	3			WINSTON SALEM, NC 27103			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIA		
F 688	F 688 Continued From page 44 staff."		F 68	deficient practice.			
	An occupational therapy screen was conducted on 7/12/21 at 12:01 PM. The screening was conducted for a quarterly review. The screen indicated Resident #22 had increased tone in her right hand and had a splint. The screen further indicated Resident #22 was currently on a restorative or maintenance program and recommended to continue restorative nursing program for splinting. An occupational therapy evaluation was not indicated due to no change in level of function.  A Restorative Nursing Review dated 7/20/21 indicated Resident #22 was on a restorative program of splinting with skin checks. The note read: "resident tolerates application/removal well. Denies pain. No skin issues reported." The plan was to continue current program with existing goals.  An observation on 7/21/21 at 12:45 PM revealed Resident #22 did not have a right resting hand splint in place.  An observation on 7/22/21 at 1:42 PM revealed Resident #33 did not have a right resting hand splint in place.			On 08.16.2021, the Director (DON) audited 100% of all rorders for splints to ensure orders in place to apply the Results: 15 of 15 residents had orders to apply the splints to apply the splints or splints to ensure that the Certified Nursing Assistant for the restorative aides to a Results: 15 of 15 residents had CNA task to apply the second or coordinator ensured that all were updated to reflect the The restorative team met or to discuss ways to better coany changes in treatment place.  3. Measures /Systemic characteristics:  On 07.23.2021, the Director (DON), Treatment Nurse, A and the Quality Assurance of the second or splints and the quality Assurance of th	residents withat there at splint. with splints of Nursing its with ordere is a (C N A) task apply the splints.  In Data Set I Care plans splint use. In 08.16.202 ommunicate lan. In anges to eged deficie of Nursing dministrator	th re re rs c lint.	
	she did not apply Res she did not have her stated she did not hav	er chart application. She		Consultant reviewed the porestorative nursing – Range (ROM) contractures. There changes required for the po 07.25.2021, the Director of began reeducating all Licen (Registered Nurses and Lic	licy on of Motion were no licy. On Nursing (DO sed Nurses	ON)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII			C		
		345284	B. WING _			07	7/23/2021	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	72072021	
				90	01 BETHESDA ROAD			
THE OAK	S			W	/INSTON SALEM, NC 27103			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFII TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 688	Continued From pag	e 45	F	886				
	On 7/22/21 at 2:32 P		' `		Practical Nurses), and Certified Nursin	a		
		ted she was responsible for			Assistants (CNA) full time, part time,	9		
		prative Nursing Review note			agency staff, and PRN on the following	1		
	of residents receiving	g restorative care by			topics:	,		
		She stated she received a department on 6/11/21 and			Guidelines for the restorative ROM	Л		
		the list for splinting, so she			program			
		ill having it applied. She			What to do if there is a change in	the		
		ceive any communication			resident's ROM			
	from Restorative Aide	e #1 that Resident #22 was			<ul> <li>Who to contact in the event of any</li> </ul>	,		
	not receiving the spli	nt. She further stated she			issues related to restorative program.			
		rative Nursing Review note			<ul> <li>Staff was educated on applying sp</li> </ul>			
		vering questions such as:			per schedule and documenting instanc	es		
		eceived, how procedure			of resident non – compliance.			
		ue or change activity" without			All CNA's and nurses will be			
		d basing accuracy on not			in-serviced on the proper use and			
	receiving any report	that indicated otherwise.			application of splints and documenting			
					<ul> <li>Education on alerting supervisor if unable to provide scheduled Restoration</li> </ul>			
	2 Resident #38 was	admitted to the facility on			Program on any day scheduled was	/C		
		noses which included			provided to Restorative Aide.			
		paresis following cerebral			provided to receivative ride.			
		e right side, contractures,			This information has been integrated in	nto		
	and aphasia.	, ,			the standard orientation training and in			
	•				required in-service refresher courses for			
	The current care plar	n dated 12/22/20 revealed			all staff identified above and will be			
	Resident #38 had the	e diagnoses of right			reviewed by the Quality Assurance			
	hemiplegia related to				process to verify that the change has			
		oper extremity and right			been sustained. Any staff who does n			
		actures requiring splinting			receive scheduled in-service training w			
		hes included: apply splints to			not be allowed to work until training ha	S		
		eg daily; remove hand splint			been completed by 08.20.2021.			
		e splint after 2-3 hours;			The feetite will need to the con-	•		
	wash/clean skin, nail				The facility will review this information	in		
		nt as tolerated and at least			their clinical meeting and discuss any			
	every 2 hours.				issues at least weekly for the next 3			
	During an interview of	on 7/22/21 at 1:27 n m tha			months unless the Quality Assurance Committee feels this issue has been			
	During an interview on 7/22/21 at 1:37 p.m., the Occupational Therapist (OT) stated Resident				resolved sooner.			

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 <b>07/23/2021</b>		
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0111	20/2021	
				90	1 BETHESDA ROAD			
THE OAKS	3				INSTON 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 688	Continued From page #38's most recent que 4/20/21 which showed with no new recommendation from 4/15/21 through management using recommendation for contracture prevention #38 also received resident was discharated recommendation for contracture prevention #38 also received resident was also received resident extremed and had rate the upper extremity of extremities on both so During an interview of RNA revealed Residerestorative treatment the training with the obegan working with the May 2021 on range of right leg and, range of the recommendation in the recommendation of the recommendation of the recommendation in the recommendation	e 46 arterly OT assessment was ad no change in her condition endations at that time. She areceived physical therapy 5/11/21 for contracture ange of motion manual at lower extremity. The ged from therapy with the the restorative program for on. The OT stated Resident storative for splinting using a and a hand splint and at set dated 5/11/21 as was severely, cognitivelyinge of motion impairment of on one side and lower	F 6	688		at nat cted		
	after noticing that the range of motion was application, the RNA exercise and reportestated she continued the resident until son Resident #38 could rethe leg extending reciping. She revealed excruciating pain and	Monday through Friday. But hand splinting and hand not in the charting stated she discontinued the diffusion that the diffusion to the nurse. The RNA leg splinting treatment with netime in June 2021 when to longer endure the pain of luired when applying the leg she reported the resident's diffusion to discontinue that are likely and the state of the stat			Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.			

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 07/23/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	<b>I</b>	01/23/2021
(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 688	F 688 Continued From page 47		F 6	88		
		ed they would investigate it. t #38 had not received any since June 2021.				
	Resident #38 was to for splinting applicat	an dated 6/10/21 revealed preceive restorative nursing ion. Approaches included on and removal of splint ile.				
	#5 revealed she was the Restorative Nurs residents receiving a restorative nurse aid explained that all resplinting applications. Monday through Frie prior to this interview RNA that she had ditthe knee splint to Reseverity of her contribecause she was ur completing the Rest Friday indicating Rerestorative treatment data/report used to Nursing Review Not acknowledged she of direct knowledge an receiving any report #5 stated most days with the RNA and was restorative Nursing Review Not acknowledged she of direct knowledge and receiving any report #5 stated most days with the RNA and was restorative nurse residence.	o.m., an interview with Nurse is responsible for completing sing Review Notes of restorative care by the de (RNA). She further istorative exercises and is were done during first shift, day. Nurse #5 revealed that wishe was informed by the discontinued the application of resident #38's leg due to the actures. Nurse #5 stated in aware of this, she had been orative Review form every sident #38 tolerated the t. When questioned on the complete the Restorative is for Resident #38, Nurse #5 completed the review without indicating otherwise. Nurse is she did not communicate as unaware if the RNA torative visits or where such sintained.				
	Resident #38 was re	on on 7/19/21 at 11:48 a.m., eclining in bed with the head mately 80 degrees and both				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C <b>07/23/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE  901 BETHESDA ROAD  WINSTON SALEM, NC 27103	1 07720/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 688	resident's right hand with the fingers folderesident was non-ve	ge 48 the bed covers. The I was bent forward at the wrist ed toward the right palm. The rbal but when asked if she I, she slightly nodded no.	F 68	38	
F 761 SS=E	Drugs and biological labeled in accordance professional principle appropriate accessor instructions, and the applicable.  §483.45(h) Storage  §483.45(h)(1) In accessor in the second se	of Drugs and Biologicals ls used in the facility must be ce with currently accepted es, and include the ery and cautionary expiration date when of Drugs and Biologicals cordance with State and cility must store all drugs and compartments under proper s, and permit only authorized coess to the keys.  Accility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the nimal and a missing dose can  T is not met as evidenced ons and staff interviews, the	F 76	The statements made on this pla	
	quantity stored is mi be readily detected. This REQUIREMEN by: Based on observati facility failed to disca	nimal and a missing dose can  T is not met as evidenced		The statements made on this pla correction are not an admission to not constitute an agreement with	o and do

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMPLETED	
		345284	B. WING _			C 07/23/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 901 BETHESDA ROAD WINSTON SALEM, NC 27103	DE	01720/2021
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 761	and in 1 of 2 medica Med Room) observed The findings include 1-a) In the presence was conducted of th 7/20/21 at 2:50 PM. opened insulin lispro Resident #61 was sinsulin pen was note 6/11/21.  An interview was co 7/20/21 at 2:55 PM. insulin lispro prefille the insulin pen was A review of the man instructions indicate that have been open	Cart, and 400 Hall Med Cart) ation rooms (200/300 Hall ed.  d: e of Nurse #3, an observation e 200 Hall Med Cart on The observation revealed an openfilled pen dispensed for tored on the med cart. The ed to have been opened on  Inducted with the Nurse #3 on Upon review of the opened dipen, the nurse confirmed expired.	F 7		all federal lity has taken th in this of correction gation of ged or will be ted. ent(s) ent practice: oro pen was scarded. A btained and esident on  oro pen was scarded. A	
	AM with the facility's The findings of the N discussed during the DON stated she wo expired insulin and of when the insulin wa  1-b) In the presence was conducted of the 7/20/21 at 2:50 PM. opened insulin lispre Resident #14 was s	nducted on 7/21/21 at 10:10 EDirector of Nursing (DON). Medication Storage task were enterview. When asked, the full expect staff to watch for remove it from the med cart is expired.  The observation revealed an operfilled pen dispensed for tored on the med cart. The ed to have been opened on		Resident #79, the Insulin Lisp removed from the cart and dinew Insulin Lispro pen obtain when opened for this residen 07.20.2021.  Resident #101 was discharge 06.23.2021, therefore no concould be completed for him.  Resident #418 discharged 6. therefore no corrective action completed for her, medication from cart 7.20.21.	scarded. A ned and dated ton ed on rective action 12.21, n could be	

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 / <b>23/2021</b>	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, Z		72072021	
				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 ( (EACH CORRECTIVE .	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 761	7/20/21 at 2:55 PM. insulin lispro prefilled the insulin pen was e A review of the manuinstructions indicated that have been opened at room temperature. An interview was con AM with the facility's The findings of the M discussed during the DON stated she wou expired insulin and rewhen the insulin was.  2. In the presence of was conducted of the 7/20/21 at 8:10 AM. opened Novolog insulin Resident #79 was sto handwritten date on i had been opened on Upon request, Nurse the Novolog insulin popened was 6/8/21 or A review of the manual and the insulin popened was 6/8/21 or A revie	ducted with the Nurse #3 on Upon review of the opened pen, the nurse confirmed xpired.  facturer's storage insulin lispro prefilled pensed (in use) should be stored and used within 28 days.  ducted on 7/21/21 at 10:10 Director of Nursing (DON). edication Storage task were interview. When asked, the ld expect staff to watch for emove it from the med cart expired.  f Nurse #1, an observation at 500 Hall Med Cart on The observation revealed an ulin pen dispensed for ored on the med cart. The insulin pen indicated the peneither 6/8/21 or 6/9/21.  #1 reviewed the labeling on en. She reported the date of 6/9/21.	F 7		ector of Nurses expired medications arded from the residents with the by the alleged ty who take otential to be 2021, the Night nedication carts, edication rooms to andated s were made eated. This was 2021.  To be affected by a order to ensure ected, a continued editity medication is was conducted fort Nurses, and the fort o ensure there expond the there were no the cart. immediately		
	stored at room tempe days.  A follow-up observati conducted on 7/20/2	punctured (in use) should be erature and used within 28 on and interview were 1 at 12:55 PM with Nurse #1. blog insulin pen for Resident		08.12-13.2021.  3. Measures/Systemic of prevent reoccurrence of practice: Education: On 07.23.2021, the DOI	f alleged deficient		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		07/	
NAME OF D	ROVIDER OR SUPPLIER	040204	1	STREET ADDRESS, CITY, STATE, ZIP CODE	07/2	23/2021
NAME OF FI	NOVIDER OR SUFFLIER					
THE OAK	3			901 BETHESDA ROAD		
				WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 761	Continued From page	÷ 51	F 76	1		
	#79 was observed to	remain on the med cart.		Nurse, Administrator, and the Qu	uality	
		se reported the insulin pen		Assurance Clinical Nurse Consu	-	
		ays. Upon further inquiry,		reviewed the policy on McNeill		
		e Novolog insulin pen was		Long-Term Pharmacy Recomme		
	expired and needed t			Storage for Selected Items. The		
	medication cart.	·		no changes required for the police		
				07.25.2021, the DON began edu	icating all	
	An interview was con	ducted on 7/21/21 at 10:10		full time, part time, agency staff,	and PRN	
		Director of Nursing (DON).		Licensed Nurses, RNs, LPNs, ar	nd	
		edication Storage task were		Medication Aides on the following	g topics:	
		interview. When asked, the				
		d expect staff to watch for		" Checking medications for ex	-	
		move it from the med cart		date prior to administering the m		
	when the insulin was	expired.		" Labeling medications when	opened	
				with date open as indicated.  " McNeill□s Pharmacy recom		
		Nurse #2, an observation		Wichellias i Haimacy recom	mended	
		400 Hall Med Cart on		storage for selected items.		
		The observation revealed a		This information has been into an	-4	
		eled as "GI Cocktail 4:1"		This information has been integr		
		harmacy for Resident #418		the standard orientation training		
		ed cart. The expiration date edication bottle was 6/16/21.		be reviewed by the Quality Assurprocess to verify that the change		
		t2 stated the medication		been sustained. As 08.20.2021,		
	shouldn't have been o			who does not receive scheduled	•	
	Shouldh't have been t	on the med out.		in-service training will not be allo		
	A follow-up interview	was conducted on 7/20/21		work until training has been com		
		se #2. During the interview,			.p. 31041	
		e had placed the expired		The facility will review this inform	nation in	
		ail 4:1 in the pharmacy tote		their clinical meeting and discuss		
	to be returned to the			issues at least weekly for the ne		
		•		months unless the Quality Assur		
	An interview was con	ducted on 7/21/21 at 10:10		Committee feels this issue has b		
	AM with the facility's I	Director of Nursing (DON).		resolved sooner.		
		edication Storage task were		4. Monitoring Procedure to ensu	ire that	
	discussed during the	interview. When asked, the		the plan of correction is effective		
	DON stated she woul	d expect staff to watch for		specific deficiency cited remains	corrected	
	expired medications a	and to remove them from		and/or in compliance with regula	tory	
	the med cart.			requirements.		
				The Director of Nursing or design	nee will	

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 <b>07/23/2021</b>		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 901 BETHESDA ROAD WINSTON SALEM, NC 27103	E	07/25/2021		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE
F 761	was conducted on 7/2 200/300 Hall Med Ro revealed an opened of the pharmacy on 6/13 opened) for Resident refrigerator. Upon including the pharmacy on 6/13 opened) for Resident refrigerator. Upon including the stated the insulin vial of the manual instructions indicated vial of Lantus insulingual stored at room temperature. An interview was conformed at room temperature of the Microsed during the DON stated she would expired insuling and remed room when it was Food Procurement, Sing CFR(s): 483.60(i)(1)(1)(s) §483.60(i) Food safety The facility must - substituting from local authority (i) This may include for from local producers, and local laws or regulations from using personal forms in the substitution of the pharmacy of t	Nurse #3, an observation 20/21 at 2:30 PM of the om. The observation vial of Lantus insulin filled by 3/21 (not dated when #101 was stored in the quiry, Nurse #3 reported she e vial was opened. She needed to be discarded.  facturer's storage once punctured (in use), a may be refrigerated or rature; use within 28 days.  ducted on 7/21/21 at 10:10 Director of Nursing (DON). edication Storage task were interview. When asked, the d expect staff to watch for move the insulin from the s expired.  sore/Prepare/Serve-Sanitary 2)  by requirements.  re food from sources ed satisfactory by federal, es. cood items obtained directly subject to applicable State ulations. In sort prohibit or prevent roduce grown in facility ompliance with applicable	F 7	monitor compliance utilizing the Quality Assurance Tool weekled then monthly x 3 months. The designee will monitor for compliance and ensuring the cart medication room is free of examedications. Reports will be the weekly Quality Assurance by the DON to ensure correct initiated as appropriate. Comple monitored and the ongoing program reviewed at the weekly Assurance (QA) Meeting. The Meeting is attended by the Active Director of Nursing, Minimum Coordinator, Therapy Manage Support Nurses, Health Inform Manager, and the Dietary Manager, and the Dietary Manager.	y x 4 weeks e DON or pliance with ate when and the pired presented to committee vive action is pliance will g auditing kly Quality e weekly QA dministrator Data Set er, Unit mation	n so s		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		07/23/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 07720221
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 812	(iii) This provision do	ge 53 pes not preclude residents ds not procured by the facility.	F 812		
	serve food in accord standards for food standards facility failed to main kitchen by not labelifiems; by failing to standards free from debris; and tray service beverage preparation and disk maintained in good	ons and staff interviews, the stain sanitary conditions in the ng and dating resealed food tore food items off the floor; the kitchen was clean and d by failing to ensure the meal		The statements made on this plar correction are not an admission to not constitute an agreement with ti alleged deficiencies.  To remain in compliance with all fe and state regulations the facility had or will take the actions set forth in plan of correction. The plan of corrections the facility sallegation compliance such that all alleged deficiencies cited have been or will corrected by the dates indicated.  F812  1. For dietary services, a correct	and do he ederal as taken this rection n of
	food items and case were observed on the room of the kitchen. plastic bags of nood rice stored on the st dated.  During an interview Assistant Dietary Marevealed the items of dry storage room we to this date.  1b. On 7/19/21 at 10 observation of the weight of the storage room of the storage room of the weight of the storage room of	50 a.m., multiple cases of dry es of food service supplies he floor in the dry storage. Also, there were 3-resealed lles and 1-large bag of brown orage racks but were not on 7/19/21 at 9:51 a.m., the enager (Assistant DM) observed on the floor in the ere delivered three days prior 0:19 a.m., during an valk-in freezer, there were ags of unidentifiable breaded		action was obtained on 07.19.202 07.29.21, 08.09.2021, 08.11.2021  During initial walk through of the k was noted dietary services had fai store items off the floor, remove el cardboard boxes, date 3 re-sealed of pasta noodles and 1 bag of brown properly store a pan of cooked chi tenders, and label or date resealed of unidentifiable breaded items. The Dietary Service Director properly sitems off the dry storage floor and discarded the cardboard boxes, 3 re-sealed bags of pasta noodles, 1 brown rice, and pan of chicken tenders.	1, . itchen, it led to mpty I bags wn rice, cken I bags ne stored

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BUILDING		С
		345284	B. WING		07/23/2021
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
				901 BETHESDA ROAD	
THE OAK	8			WINSTON SALEM, NC 27103	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	
PRÉFIX TAG	T	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	
F 812	Continued From page	e 54	F 81	2	
	items that were not d	ated or labeled and 1-6 inch		During observation of kitchen,	
		chicken tenders covered with		noted 2 of 2 faucets had a per	
	foil which was torn, e	xposing the chicken.		water drip even in off position	
				leaked from the cold water swi	
				next to the dish machine. Also	
		vation of the kitchen on		a hole in the wall by the door le	
		the faucets of 2 of the 2		the dining room. A contracted	·
		s had a persistent water drip on. Also observed was water		repaired faucets and cold wate 07.29.2021 and the Maintenar	
		-water switch of the faucet at		repaired the hole by the dining	
	_	to the dishwashing machine.		on 08.11.2021.	Troom door
	During an interview on 7/21/21 at 12:25 p.m., the			During observation of tray line	and use of
	Dietary Manager (DM	l) stated he submitted a		beverage cooler, 3 sampled m	ilks were
		the facility's maintenance		tempted to be above 41 degre	- I
	department approxim			the beverage cooler stating it	
	_	uous drip/drizzle of the		degrees. All milks were remove	
		preparation sinks and the		beverage cooler and instead of	
		iter handle at the sink next		from walk-in cooler for tray line	
	to the dishwashing m	acnine.		gaskets on beverage cooler w replaced. Gaskets replaced o	
	During an interview o	n 7/21/21 at 2:34 n m tha		New refrigerator ordered 8.16.	
	_	n 7/21/21 at 2:34 p.m., the stated the leak in the sink		New reingerator ordered 6.16.	21.
		achine was repaired on		Corrective action for resid	ents with
		er was scheduled to return		the potential to be affected by	
		his leak for the second time,		deficient practice.	and amoget
		ood preparation sinks, and 2			
	other leaks in the kitc	• •		All residents have the potentia	I to be
				affected by the alleged deficie	
	2b. On 7/19/21 at 9:4	5 a.m., a large hole		On 7/19/2021, the Dietary Ser	
		nes wide and 5-inches in		Director completed a kitchen v	•
		l in one of the walls in the		to ensure all food items were I	abeled,
		s located directly above the		dated, and stored properly.	
		door which opened into the			
	main dining room.			On 08.17.2021 the Dietary Se	
	<u> </u>	7/04/04 1 10 05		Director and Maintenance con	-
	_	n 7/21/21 at 12:25 p.m., the		kitchen walk through to ensure	
	Dietary Manager (DM			cold water switch, hole, and be	everage
	approximately one me	onth ago, he submitted a		gaskets had been repaired.	

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 / <b>23/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	0.020.	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	23/2021
TVAIVIL OF T	TOVIDER OR GOL I EIER						
THE OAKS	3				11 BETHESDA ROAD		
				w	INSTON 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From pa	ge 55	F 8	312			
	work order request	to the facility's maintenance					
		needed repair of the large hole			3. Systemic changes		
	in the wall in the kite				, ,		
					In-service education was provided to a	II	
	During an interview	on 7/21/21 at 2:34 p.m., the			full time, part time, and as needed staf		
		or stated he was informed			Topics included:		
	about the hole in the				'		
	approximately two	weeks prior. He revealed he			" Storage and dating policies and		
		repair the wall and the task			regulations.		
	had been added to	•			" Inspections on shifts to observe al	I	
					food to ensure they are labeled, dated,		
	2c. During an obse	rvation of the meal tray line			and stored properly.		
	service in the kitche	en on 7/21/21 at 12:15 p.m.,			" Submitting work orders and		
	the inside thermome	eter reading of the beverage			maintenance follow-up.		
	refrigerator was 38	degrees Fahrenheit but the					
		f the 3 sampled 8-ounce			This information has been integrated in	nto	
	cartons of milks tes	ted were above the minimum			the standard orientation training and in	the	
	requirement of 41 d	legrees Fahrenheit or below.			required in-service refresher courses for	or	
	The temperatures of	of the 3-sampled milks were			all staff and will be reviewed by the Qu	ality	
	45.7 degrees Fahre	enheit, 45.5 degrees			Assurance process to verify that the		
		2 degrees Fahrenheit,			change has been sustained.		
	respectfully. Dietary	staff were instructed by the					
		emaining milks from the			<ol><li>Quality Assurance monitoring</li></ol>		
		collect milk from the walk-in			procedure.		
		uring the meal tray line					
	_	t this meal service tray line			The Dietary Service Director or design		
		vere no milks served from this			will monitor procedures for proper food		
	beverage refrigerate	or.			procurement, store/prepare/serve, and		
	10.110.1				sanitation x 2 weeks then monthly x 3		
		5 p.m., the DM revealed he			months using the Dietary Quality		
		rder request to the facility's			Assurance Audit which will include	4 -	
		tment approximately 2-3			inspections on both AM and PM shifts	(O	
	•	the gasket of the refrigerator			observe that all food is labeled, dated,	_	
	would not seal whe	n ciosea.			stored properly and that equipment is i		
	D	7/04/04 at 0.04 at 1.			proper working condition. Reports will I	эe	
		on 7/21/21 at 2:34 p.m., the			presented to the weekly Quality	otor	
		or revealed that on 6/24/21			Assurance committee by the Administrate and a second committee by th	alor	
		airman informed him all 5-door			to ensure corrective action initiated as	arad	
	gaskets of the beve	rage cooler needed to be			appropriate. Compliance will be monitor	лeu	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE: COMPI			
	345284	B. WING		07/	23/2021
NAME OF PROVIDER OR SUPPLIER  THE OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 0772	23/2021
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812 Continued From page 56 replaced and returned apprago to remeasure the coole that time, the repairman toke until repaired, due to the ter cooler, it could only be used they should not put dairy pruntil it was repaired. The Mastated he also informed the repairman's recommendation recall the day.  3. During the tour of the kit 9:36a.m., there was an obsicardboard boxes stacked he floor. Throughout the kitcher observed to be dirty with a label During an interview on 7/19 Assistant DM revealed dietakitchen's floor at the end of before.  F 842 Resident Records - Identification CFR(s): 483.20(f)(5), 483.70 (ii) The facility may not release resident-identifiable to the president-identifiable to an accordance with a contract agrees not to use or disclose except to the extent the facility of the e	ar for the gasket. At all the dietary staff that imperature of the dietary staff that imperature of the dietary and juices; oducts in the cooler aintenance Director DM of the on but was unable to ochen on 7/19/21 at ervation of empty aphazardly on the en, the floor was brown film covering.  1/21 at 9:36 a.m., the eary staff mopped the the shift, the night eable Information 0(i)(1)-(5)  1/21 at 9:36 a.m., the eary staff mopped the the shift, the night eable Information that is guide.  2 information that is gent only in under which the agent set the information ility itself is permitted.	F 842	and ongoing auditing program reviewer the weekly Quality Assurance (QA) Meeting. The weekly QA Meeting is attended by the Administrator, Director Nursing, Minimum Data Set Coordinate Therapy, Health Information Manager, and the Dietary Manager	of or,	8/20/21

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C 07/23/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	1 01/20/2021
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 842	must maintain medithat are- (i) Complete; (ii) Accurately docur (iii) Readily accessil (iv) Systematically of §483.70(i)(2) The far all information contained are gardless of the forecords, except where (i) To the individual, representative where (ii) Required by Law (iii) For treatment, properations, as permoved with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial and law enforcement purposes, research medical examiners, a serious threat to help and in compliance §483.70(i)(3) The farecord information are unauthorized use. §483.70(i)(4) Medical for- (i) The period of times (ii) Five years from the there is no requirement in the serior of the contained are serior of the period of times (iii) Five years from the there is no requirement in the serior of the contained are serior of the period of times (iii) Five years from the there is no requirement in the serior of the period of times (iii) Five years from the there is no requirement in the period of times (iii) Five years from the period of times (iii) Five years from the there is no requirement in the period of times (iii) Five years from the period of times (iiii) Five years from the period of times (iiiii) Five years from the period of times (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	mented; ole; and organized  cility must keep confidential ained in the resident's records, or or storage method of the en release is- or their resident e permitted by applicable law; or; ayment, or health care itted by and in compliance 6; or activities, reporting of abuse, oviolence, health oversight d administrative proceedings, reposes, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512.  cility must safeguard medical against loss, destruction, or  all records must be retained e required by State law; or the date of discharge when tent in State law; or ears after a resident reaches	F 84:		

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 P	ROVIDER OR SUPPLIER	040204	<u> </u>	STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	23/2021
					BETHESDA ROAD		
THE OAK	S				NSTON SALEM, NC 27103		
				***	<u>`</u>		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ITATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From pag	ge 58	F 8	342			
	§483.70(i)(5) The m	edical record must contain-					
		tion to identify the resident;					
		esident's assessments;					
	(iii) The comprehens	sive plan of care and services					
	provided;	·					
	(iv) The results of ar	ny preadmission screening					
	and resident review						
	determinations cond						
	(v) Physician's, nurs						
	professional's progre						
		ology and other diagnostic					
		required under §483.50.					
		T is not met as evidenced					
	by:	view, resident and staff			The statements made on this plan of		
		ty failed to reflect the correct			correction are not an admission to and	do	
		s vascular access site in the			not constitute an agreement with the	uo	
	•••	of 1 resident reviewed for			alleged deficiencies.		
	dialysis (Resident #4	46).			To remain in compliance with all federa	al	
	``	•			and state regulations the facility has ta		
	The findings include	d:			or will take the actions set forth in this		
					plan of correction. The plan of correction	on	
		dmitted to the facility on			constitutes the facility□s allegation of		
		sis of end stage renal			compliance such that all alleged		
	disease with depend	dence on dialysis.			deficiencies cited have been or will be		
		D 4 0 4 (14D0)			corrected by the dates indicated.		
	A quarterly Minimum	, ,			F842		
		/21/21 revealed Resident #46			1. Corrective action for resident(s)		
	was cognitively intact. Resident #46 received dialysis during the look back period.				affected by the alleged deficient practic	æ.	
	dialysis during the ic	ook back period.			The order for the Resident #46 was		
	The care plan (date not recorded) revealed a				revised to reflect the correct dialysis		
		s with intervention to include			vascular access site by the Director of		
	,	or thrill and bruit and do not			Nurses on 07.26.2021.		
		plood pressure in arm with					
	shunt.	L			2. Corrective action for residents with	h	
					the potential to be affected by the alleg		
	The July 2021 physi	cian's orders revealed an			deficient practice.	•	
		k permacath for bleeding and			•		

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 _				23/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	_			90	01 BETHESDA ROAD		
THE OAK	5			W	VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From pages signs and symptoms adverse findings in nusecond active order for remain in place at all third active order for the permacath in right up.  A review of the July 2 Administration Recording and the findicate Resident #46 On 7/19/21 at 11:11 A conducted with Resident had a permacath and dialysis site. Resident had a permacath and dialysis.  On 7/21/21 at 2:09 Pt conducted with Nurse Resident #46 returned him his medications, anything, checked his and listened for bruit a knew he no longer had know why it wasn't chorders.  On 7/22/21 at 4:30 Pt conducted with the Distated the medical records.	of infection and document urse's notes every shift. A per permacath dressing to times was also noted and a pedbath only due to per chest until further notice.  O21 Medication derevealed documentation to that a permacath present.  MM, an interview was ent #46. He stated the staff eceive showers due to his that added he no longer now had a shunt for  MM, an interview was ent #46 added he no longer now had a shunt for  MM, an interview was ent #46 added he no longer now had a shunt for  MM, an interview was ent #46 added he no longer now had a shunt for  MM, an interview was ent who stated when deform dialysis, she gave that was ent who stated when deform dialysis, she gave that was ent who stated when deform dialysis site for bleeding and thrill. She stated she deform a permacath but didn't anged in the physician's		842	On 08.09.2021 the Director of Nurses/Evening Nurse Supervisor completed a 100% audit of all residents dialysis vascular access site to ensure that the accurate site was documented the resident record.  3. Measures /Systemic changes to prevent reoccurrence of alleged deficie practice:  On 07.23.2021, the DON, Treatment Nurse, Administrator, and the Quality Assurance Clinical Nurse Consultant reviewed the policy on nursing documentation. There were no change required for the policy. On 07.25.2021 the Director of Nurses/Staff Developme Coordinator began education of all full time, part time and as needed nurses a agency nurses on ensuring that all resident medical records are complete accordance with accepted professional standards and practices, the facility mu maintain medical records on each resident that are complete and accurat documented including the correct dialy vascular access site.  This information has been integrated in the standard orientation training and in required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training w	in nt es ent and in est ely sis to the or	
					not be allowed to work until training has been completed by 08.20.2021.	S	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345284	B. WING		C <b>07/23/2021</b>
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  901 BETHESDA ROAD  WINSTON SALEM, NC 27103	1 01123/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.
F 842	Continued From page		F 84	The facility will review this information their clinical meeting and discuss any issues at least weekly for the next 3 months unless the Quality Assurance Committee feels this issue has been resolved sooner.  4. Monitoring Procedure to ensure the plan of correction is effective and the specific deficiency cited remains correction in compliance with regulatory requirements.  The DON or designee will monitor compliance utilizing the F842 Quality Assurance Tool weekly x 4 weeks ther monthly x 3 months. The DON will monitor compliance to ensure that all dialysis residents have the correct dial vascular access site documented in the resident record. Reports will be present to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly Meeting is attended by the Administrated Director of Nursing, Minimum Data Secoordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.	nat hat cted  ysis e nted  dy QA or,
SS=E	CFR(s): 483.80(a)(1)(	(2)(4)(e)(f)			
	§483.80 Infection Cor	ntroi			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345284	B. WING _			C 07/23/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	<b>I</b>	01/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 61	F 8	80		
	The facility must es infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program.  The facility must es and control progran a minimum, the followard for the facility must estaff, volunteers, visproviding services a arrangement based conducted accordinaccepted national services for the put are not limited to (i) A system of survention program accepted national services in the facility of the persons in the facility of the pe	tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions.  In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements:  Item for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment in the same and the same				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345284	B. WING			C <b>7/23/2021</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 901 BETHESDA ROAD WINSTON SALEM, NC 27103		7720/2021
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	least restrictive poss circumstances.  (v) The circumstance must prohibit employ disease or infected s contact with resident contact will transmit (vi)The hand hygiene by staff involved in d §483.80(a)(4) A systidentified under the f corrective actions tal §483.80(e) Linens. Personnel must hand transport linens so as infection.  §483.80(f) Annual re The facility will condul IPCP and update the This REQUIREMEN' by:  Based on observation interviews the facility signage and implemed Precautions as record Disease Control and directed by the facility admitted residents wagainst COVID-19 on was unknown (Resider 11, #114, #420, #417, #114, #420, #418)	at the isolation should be the lible for the resident under the less under which the facility lees with a communicable kin lesions from direct so or their food, if direct the disease; and exprocedures to be followed irect resident contact.  The for recording incidents acility's IPCP and the library in the facility.  The facility is IPCP and the sen by the facility.  The facility is IPCP and the sen by the facility.  The facility is IPCP and the sen by the facility of the spread of library in	F 88	The statements made on the correction are not an admission to constitute an agreement alleged deficiencies.  To remain in compliance with and state regulations the factor will take the actions set for plan of correction. The plan constitutes the facility salled compliance such that all alled deficiencies cited have been corrected by the dates indicated.	sion to and do with the  h all federal cility has taken orth in this of correction egation of eged n or will be	

PREFIX TAG    Cach deficiency must be preceded by full rag   Prefix tag	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	COMP	(X3) DATE SURVEY COMPLETED	
THE OAKS  STREET ADDRESS, CITY, STATE, ZIP CODE  901 BETHESDA ROAD  WINSTON SALEM, NC 27103  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 880  Continued From page 63  Review of CDC guidance titled, "Infection Control for Nursing Homes" with a Summary of Recent  STREET ADDRESS, CITY, STATE, ZIP CODE  901 BETHESDA ROAD  WINSTON SALEM, NC 27103  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMP DEFICIENCY)  F 880  1. How corrective action will be accomplished for those residents found to have been affected by the deficient			345284	B. WING		ı	
PREFIX TAG    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DEFICIENCY					901 BETHESDA ROAD		23/2021
1. How corrective action will be accomplished for those residents found to have been affected by the deficient	PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
Changes (updates dated 3/29/21) for managing new admissions and readmissions read in part:  "In general, all other new admissions and readmissions should be placed in a 14 day quarantine even if they have a negative test upon admission. Exceptions include residents within 3 months of a SARS-CoV-2 (COVID-19) infection and fully vaccinated residents."  Review of a facility policy titled, "COVID19 Program V 25" (Effective July 2021) addressed Resident Care. This policy read in part:  "1. Admissions d. New admission and readmission placement  i. Unvaccinated new admissions and readmission are to be enhanced precautions for at least 14 days unless discharged to home or another location prior to the completion of the 14 days. See exception below for past positive patients.  ii. Readmission/readmissions that have tested positive for COVID-19 in the past 90 days and do not have active signs or symptoms of COVID-19 on the quire 14 days of enhanced precautions. However, they must have completed the requirements for discontinuation of isolation, or they must be admitted to a COVID-19 unit.  iv. Fully vaccinated new admission or readmissions are not required to quarantine and may be placed in semi-private rooms.  v. Vaccination status should be	F 880	Review of CDC guid for Nursing Homes" Changes (updates of new admissions and "In general, all other readmissions should quarantine even if the admission. Exception months of a SARS-dand fully vaccinated Review of a facility program V 25" (Effer Resident Care. This "1. Admissions d. New admissions d. New admission are to be at least 14 days unleanother location priced days. See exception patients.  ii. Readmission and the seed procedure of the seed positive for Cand do not have act COVID-19 do not reprecautions. However, and the requision of the procedure of of the	dance titled, "Infection Control with a Summary of Recent dated 3/29/21) for managing direadmissions read in part: In new admissions and dibe placed in a 14 day ney have a negative test upon ons include residents within 3 CoV-2 (COVID-19) infection residents."  Poolicy titled, "COVID19 ective July 2021) addressed in part: on and readmission  ted new admissions and one enhanced precautions for ess discharged to home or or to the completion of the 14 in below for past positive  cons should be placed on ones in a private room when sions in a private room when sions of equire 14 days of enhanced over, they must have rements for discontinuation of last be admitted to a COVID-19 in the past 90 days in t	F 88	1. How corrective action will be accomplished for those residents have been affected by the deficie practice:  Resident #415, #419, #413, #417 #420, #422, & #421 were not affethe deficient practice. On 07.20 Assistant Director of Nurses (ADensured that each resident had a Enhanced Droplet Isolation Sign door.  No residents were identified as a On 07.20.2021, the Director of N audited to assure appropriate iso signage for enhanced droplet prehad been placed on the doors of #415, #419, #413, #417, #114, #422, & #421 and educated the sworking on the Enhanced Drople Hall that day ensuring that Enhar Droplet Precaution signs are mai on doors for the required residen precautions.  2. How the facility will identify cresidents having the potential to affected by the same deficient processing the same deficient processing and to observe staff compliance of appropriate hand hygiene practic Personal Protective Equipment (I when entering and exiting residents)	s found to ent  7, #114, ected by 2021, the ON) an on their   ffected. urses plation ecautions rooms 420, staff et Isolation ecautions intained intained its on   other be eactice: pment ecte to lent doors with ecte and PPE)	

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 DE	ROVIDER OR SUPPLIER	343204	B: Willo	STREET ADDRESS, CITY, STATE, ZIP CODE	0	7/23/2021
NAIVIE OF PI	ROVIDER OR SUPPLIER					
THE OAKS	8			901 BETHESDA ROAD		
				WINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	Continued From page	≘ 64	F 88	0		
	documented in PCC (the electronic medication record) on admission."  1-a) Resident #415 was admitted to the facility on 7/9/21 and resided on the 100 Hall. The resident's cumulative diagnoses included Parkinson's dementia.			The Director of Nurses (DON), ensure that every resident will h	nave their	
				vaccination status entered within of admission to identify the residual isolation status.	dents	
	no documentation or	nt's medical record revealed there was ntation or evidence of his COVID-19 status upon admission to the facility.		<ol> <li>Address what measures wi place or systematic changes made ensure that the deficient practic reoccur:</li> </ol>	ade to	
	An observation conducted on 7/19/21 at 9:55 AM of the 100 Hall revealed only one resident's room (not Resident #415's) had signage to indicate the resident was on Enhanced Droplet Precautions. There was no signage placed on or near Resident #415's doorway to indicate this resident was on Enhanced Droplet Precautions.			Education:  On 07.26.2021, the DON, Admi and the Quality Assurance Clini Consultant reviewed the policy COVID-19 Program. There wer changes required for the policy.	cal Nurse on the re no On	
	AM with Medication A assigned to work on the Med Aide confirm	ducted on 7/19/21 at 10:00 side #1. Med Aide #1 was the 100 Hall. Upon inquiry, ed only one resident on the tage placed by her door) was Precautions.		07.25.2021, the Director of Nursand the Assistant Director of Nursand the Assistant Director of Nursand the Assistant Director of Nursand (ADON) who are all Infection Properties of the Control via NC SPICE initiated for all full time, part time, PRN sagency staff on the Center for EC Control □s (CDC) recommended	reventionist n Infection education staff, and Disease	
	PM as the facility's S <sub>I</sub> (SLP) carried a meal room. There was no the resident's doorwa	conducted on 7/19/21 at 1:29 beech-Language Pathologist tray into Resident #415's signage placed on or near by to indicate he was on		on donning/doffing of PPE, han policy, and re-education on ens isolation signage is in place at a enhanced droplet precaution ro	uring all times on	
	SLP was wearing a m eye protection, a gow the room. A review o record included an SI	ecautions at that time. The nask but was not wearing in, or gloves upon entering f Resident #415's medical P note dated 7/19/21 which was treated for swallowing al function. The note		On 07.26.2021 the Administrate and ADON-Infection Control Pre implemented Infection Control r ensure the presence of appropre enhanced droplet isolation signations for those residents on endaroplet precautions.	eventionist ounds to iate age on all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG		3) DATE SURVEY COMPLETED	
		345284	B. WING _		0.	C 7/ <b>23/2021</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		7/23/2021	
				901 BETHESDA ROAD			
THE OAKS	3			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 ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From pag	ne 65	F 8	80			
	bedside on 7/19/21 oprovided. The estim 40 minutes.	415 was fed in his room at with total feeding assistance ated time for treatment was		This information has been the standard orientation trabe reviewed by the Quality process to verify that the classical process to verify that the classical process to verify that the classical process to verify the classical process.	aining and will Assurance hange has		
	again revealed there	e on 7/20/21 at 7:55 AM was no signage on or near way to indicate the resident roplet Precautions.		been sustained. As of 08.2 staff who does not receive in-service training will not b work until training has beel	scheduled be allowed to		
	PM with the facility's the SLP was asked i Resident #415 was o Precautions when sh 7/19/21. The SLP reaware of this. Howe	nducted on 7/20/21 at 3:20 SLP. During the interview, f she had been aware on Enhanced Droplet ne fed him his lunch meal on eported she had not been ever, she stated she did see et Precautions sign was		The facility will review this their clinical meeting and d issues at least weekly for the months unless the Quality Committee feels this issue resolved sooner.  Root Cause Analysis:	liscuss any he next 3 Assurance		
	precautions.  1-b) Resident #419 on 7/9/21 and resideresident's cumulative history of diabetic ke	7/20/21) to alert staff to the was admitted to the facility and on the 100 Hall. The ediagnoses included a stoacidosis (a serious etes that occurs when lid up in the blood).		A Root Cause Analysis was 08.13.2021 to discuss the analysis of this event when Signage for residents on E Droplet Precautions were rathe team members participe Root Cause Analysis included following staff members: A	root cause e the Isolation nhanced not it place. pating in the ded the		
	The resident's medic no documentation or vaccination status up A physician order wa resident to be placed Precautions for a pe An observation cond of the 100 Hall revea room (not Resident #	cal record revealed there was evidence of his COVID-19 con admission to the facility. as received on 7/9/21 for the don Enhanced Droplet		DON, ADON, Staff Develop (SDC), Licensed Practical Nursing Assistant, Environ Director, and the Medical Eteam identified that lack of the staff assisting in the rod distraction from various this the facility contributed to the practice. A follow up meet weekly to discuss ongoing address the root cause for least 6 months unless the	pment Nurse Nurse, Certified mental Service Director. The knowledge of om moves and ngs going on in ne deficient ing will be held solutions to a period of at		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE COMP	SURVEY PLETED	
		345284	B. WING			1	C <b>23/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	0.1020.	1	S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	23/2021
NAME OF T	NOVIDER OR SOLT LIER				01 BETHESDA ROAD		
THE OAKS	5				VINSTON SALEM, NC 27103		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 880	Continued From page	e 66	F	380			
	near Resident #419's resident was on Enha	vas no signage placed on or doorway to indicate this anced Droplet Precautions.			Assurance (QA) Committee deems it c end before the 6 months. The follow u root cause analysis meeting will be attended by the Administrator, DON,	p	
	AM with Medication A assigned to work on t the Med Aide confirm	ducted on 7/19/21 at 10:00  ide #1. Med Aide #1 was  he 100 Hall. Upon inquiry,  ed only one resident on the  age placed by her door) was  Precautions.			ADON, Minimum Data Set Nurse (MDS Health Information Manager, Dietary Manager, Environmental Service Direct and the Business Office Manager, all of who are members of the facility Quality Assurance and Performance Committee	etor, of / ee.	
	again revealed there	on 7/20/21 at 7:55 AM was no signage on or near way to indicate the resident oplet Precautions.			This Root Cause Analysis will be a par our ongoing Performance Improvemen Process.  4. Monitoring Procedure to ensure the plan of correction is effective and the plan	that	
		vas admitted to the facility ed on the 100 Hall. The diagnoses included			specific deficiency cited remains correct and/or in compliance with regulatory requirements:	cted	
	no documentation or vaccination status up A physician order was	al record revealed there was evidence of her COVID-19 on admission to the facility. It is received on 7/16/21 for the on Enhanced Droplet od of 14 days.			The Director of Nursing or designee wi monitor compliance utilizing the F880 Quality Assurance Tool weekly x 4 weethen monthly x 3 months. The DON or designee will monitor for compliance will isolation signage being in place for any residents on Enhanced Droplet	eks - rith /	
	of the 100 Hall reveal (not Resident #413's) resident was on Enha There was no signage Resident #413's door was on Enhanced Dro	way to indicate this resident			Precautions. Monitoring will be conduct across all three shifts and include weekends. Reports will be presented the weekly Quality Assurance (QA) committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitor and the ongoing auditing program reviewed at the weekly Quality Assurant Meeting. The weekly QA Meeting is	to	
	AM with Medication A	he 100 Hall. Upon inquiry,			attended by the Administrator, Director Nursing, Minimum Data Set Nurse,	of	

Facility ID: 923497

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345284	B. WING _			C 07/23/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CI 901 BETHESDA ROA WINSTON SALEM,	D	01123/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRI DEFICIENCY)	
F 880	hallway (with the sign on Enhanced Drople on Enhanced Drople An observation of R on 7/19/21 at 3:44 F signage to indicate Droplet Precautions #413 was conducter room as she laid slemember at bedside conducted with the #413's room at that recertification proceobserved to be weawith no other PPE value of the Nesident #413's downwas on Enhanced Ending the Nesident #417 on 7/12/21 and resident's cumulative saddle embolus of the blood clot where the branches off into early occurrent of the 100 Hall reversity on Enhanced Ending the Nesident's median of the 100 Hall reversity on Enhanced Ending the Nesident's median of the 100 Hall reversity on Enhanced Ending the Nesident's median of the 100 Hall reversity on Enhanced Ending the Nesident's median of the 100 Hall reversity on Enhanced Ending the Nesident's median of the 100 Hall reversity on Enhanced Ending the Nesident's median of the Nesident's mediant of the Nesident's medi	med only one resident on the gnage placed by her door) was et Precautions.  desident #413's doorway made PM revealed there was no the resident was on Enhanced at An observation of Resident don 7/19/21 at 3:44 PM in her deping in her bed with a family at An interview was also family member in Resident time as part of the facility's ass. The family member was ring a surgical face mask only worn.  de on 7/20/21 at 7:55 AM are was no signage on or near forway to indicate the resident proplet Precautions.  If was admitted to the facility ded on the 100 Hall. The rediagnoses included a he pulmonary artery (a large a main pulm	F 8	Therapy Mana Health Informa Dietary Manag Directed Plan Date: 08.20.20	ager, Unit Support Nurse ation Manager, and the ger. of Correction Complianc	
	no documentation of vaccination status upon the status of the 100 Hall reverse (not Resident #417' resident was on Enland There was no signal	or evidence of her COVID-19 upon admission to the facility.  ducted on 7/19/21 at 9:55 AM				

	C
345284 B. WING 07	7/23/2021
NAME OF PROVIDER OR SUPPLIER  THE OAKS  STREET ADDRESS, CITY, STATE, ZIP CODE  901 BETHESDA ROAD  WINSTON SALEM, NC 27103	7/20/2021
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880  Continued From page 68 was on Enhanced Droplet Precautions.  An interview was conducted on 7/19/21 at 10:00 AM with Medication Aide #1. Med Aide #1 was assigned to work on the 100 Hall. Upon inquiry, the Med Aide confirmed only one resident on the hallway (with the signage placed by her door) was on Enhanced Droplet Precautions.  An observation of Resident #417's doorway made on 7/19/21 at 2:45 PM revealed there was no signage to indicate the resident was on Enhanced Droplet Precautions. An observation and interview were conducted on 7/19/21 at 2:45 PM with Resident #417 in her room as part of the facility's recertification process.  An observation made on 7/20/21 at 7:55 AM again revealed there was no signage on or near Resident #417's doorway to indicate the resident was on Enhanced Droplet Precautions.  1-e) Resident #114 was admitted to the facility on 7/18/21 and resided on the 100 Hall. The resident's cumulative diagnoses included a recent history of a right closed ankle fracture.  The resident's medical record revealed there was no documentation or evidence of her COVID-19 vaccination status upon admission to the facility. A physician order was received on 7/18/21 for the resident to be placed on Enhanced Droplet Precautions for a period of 14 days.  An observation conducted on 7/19/21 at 9:55 AM of the 100 Hall revealed only one resident's room (not Resident #114's) had signage to indicate the	

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			C 07/23/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103		7172372021
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	An interview was company and the Med Aide confirmed assigned to work or the Med Aide confirmed assigned to work or the Med Aide confirmed assigned to work or the Med Aide confirmed again revealed their Resident #114's downwas on Enhanced Interview was on Enhanced Interview was on Enhanced Interview was on Enhanced Interview was no documental COVID-19 vaccinate the facility.  An observation composition of the 100 Hall reversident was on Enhanced Interview was on Enhanced Interview was on Enhanced Interview was company assigned to work or the Medication assigned to work o	orway to indicate this resident Droplet Precautions.  Onducted on 7/19/21 at 10:00 Aide #1. Med Aide #1 was In the 100 Hall. Upon inquiry, Imed only one resident on the Ignage placed by her door) was Interested to the facility on the diagnoses included a Interested to the facility on the too Hall. The too H	F 88			

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 07/23/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103	•	01/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From page	ge 70	F 8	80		
	hallway (with the sig on Enhanced Dropl	gnage placed by her door) was et Precautions.				
	again revealed there	de on 7/20/21 at 7:55 AM e was no signage on or near orway to indicate the resident Droplet Precautions.				
	on 7/12/21 and resi	was admitted to the facility ded on the 100 Hall. The de diagnoses included chronic dry disease.				
	no documentation of vaccination status under the Aphysician order w	cal record revealed there was or evidence of her COVID-19 upon admission to the facility. as received on 7/12/21 for the d on Enhanced Droplet eriod of 14 days.				
	of the 100 Hall reve (not Resident #422' resident was on Enl There was no signa	ducted on 7/19/21 at 9:55 AM aled only one resident's room s) had signage to indicate the hanced Droplet Precautions. ge placed on or near orway to indicate this resident Droplet Precautions.				
	AM with Medication assigned to work or the Med Aide confirm	onducted on 7/19/21 at 10:00 Aide #1. Med Aide #1 was In the 100 Hall. Upon inquiry, Immed only one resident on the Ignage placed by her door) was Interested the second of the process of				
	again revealed there	de on 7/20/21 at 7:55 AM e was no signage on or near orway to indicate the resident Oroplet Precautions.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		OMPLETED	
		345284	B. WING _			C 07/23/2021
NAME OF PR	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI 901 BETHESDA ROAD WINSTON SALEM, NC 27103		01723/2321
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	Continued From pag	ne 71	F 8	380		
	on 7/10/21 and resident's cumulative history of a subdural	was admitted to the facility led on the 100 Hall. The e diagnoses included a hematoma (aa type of bleed in the skull of head but ain tissue).				
	was no documentation COVID-19 vaccination the facility. A physic 7/9/21 for the resident	ical record revealed there on or evidence of her on status upon admission to ian order was received on nt to be placed on Enhanced for a period of 14 days.				
	of the 100 Hall revea (not Resident #421's resident was on Enh There was no signaç	rway to indicate this resident				
	AM with Medication assigned to work on the Med Aide confirm	nducted on 7/19/21 at 10:00 Aide #1. Med Aide #1 was the 100 Hall. Upon inquiry, ned only one resident on the nage placed by her door) was the Precautions.				
	again revealed there	e on 7/20/21 at 7:55 AM was no signage on or near way to indicate the resident roplet Precautions.				
	PM with the facility's (ADON). The ADON	nducted on 7/20/21 at 12:57 Assistant Director of Nursing I was identified as the nurse tion Control. During the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		\ , ,	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		0	C <b>7/23/2021</b>	
NAME OF PROVIDER OR SUPPLIER  THE OAKS			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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	VE ACTION SHOULD BE COMPLETION DATE		
F 880	were intended to be Precautions. The nuresidents on the 100 Droplet Precautions were no active COV this time. The ADON the facility, an order electronic medical reposted at the reside Enhanced Droplet P the resident's vaccin document he/she was for Enhanced Droplet Giscontinued. The nure Droplet Precautions Personal Protective upon entering the reface shield (eye protouring the interview regarding only one renhanced Droplet P7/19/21 and the morn member(s), visitor(sunaware of the need upon entering 8 of the were intended to be Precautions.  Accompanied by the made of the 100 Halthat time, an Enhance was posted at the docincluding Residents #422 and #421). Hoplaced on or near Reference in the solution of the 100 Halthat time, an Enhance was posted at the docincluding Residents #422 and #421). Hoplaced on or near Reference intended to be precautions was posted at the docincluding Residents was posted on or near Reference intended to be placed in the placed on or near Reference intended to be placed in the placed on or near Reference intended to be placed in the placed i	was asked which residents on Enhanced Droplet urse reported nine (9). Hall were on Enhanced She also reported there ID-19 cases in the facility at I stated upon admission to was put into the resident's ecord (EMR) and a sign of the doorway to initiate recautions for 14 days. Once ation card was received to as fully vaccinated, the order of the Precautions would be urse reported Enhanced required the following Equipment (PPE) to be worn sident's room: N95 mask, ection), gown and gloves. If the concern was expressed esident's room having an recautions sign posted on oning of 7/20/21. Staff (a), and surveyor(s) had been a for the one Enhanced Droplet (Precautions sign posted on the necessary PPE of the 9 residents' rooms who on Enhanced Droplet (Precautions sign porway of 7 residents' rooms who on Enhanced Droplet (Precautions sign porway of 7 residents' rooms who on Enhanced Droplet (Precautions enthanced Droplet Precautions. In Enhanced Droplet Precautions. In Enhanced Droplet Precautions. In Enhanced Droplet Precautions.	F 88				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345284	B. WING		C 07/23/2021	
NAME OF PROVIDER OR SUPPLIER  THE OAKS			9	TREET ADDRESS, CITY, STATE, ZIP CODE 01 BETHESDA ROAD VINSTON SALEM, NC 27103	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESCRIPTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 880	these residents.  On 7/20/21 at 1:10 For residents who we Enhanced Droplet Patotal of nine (9) resincluded Residents: #114, #420, #422 ar A follow-up interview ADON on 7/21/21 ar interview, the nurse Hall had been move the week prior to the signs for Enhanced put in the PPE draw and visible upon entshe stated Resident on 7/16/21 and the some Droplet Precautions reported the nurse to Resident #413 was the signage for her Energy and with the facility's An interview was confident to the signage for her Energy and with the facility's and the signage for her Energy and with the facility's and the signage for her Energy and with the facility's and the signage for her Energy and t	PM, the ADON provided a list re currently intended to be on recautions. This list included sidents on the 100 Hall and #415, #419, #413, #417, and #421.  If was conducted with the experience of the 2:02 PM. During this reported residents on the 100 down around with room changes a survey. She stated the Droplet Precautions had been the error instead of being posted the error the room. However, #413 was recently admitted signage for her Enhanced was missed. The ADON that was on the hall when admitted should have posted	F 880	DEFICIENCY)		
	changes on the 100 Enhanced Droplet P taken down. She st done doing that." W staff were going in a point since they wer Droplet Precautions confirmed only one	I there had been a lot of room Hall and most of the recautions signs had been ated, "I wondered if we were I'hen asked, she reported her nd out of the rooms at that e not aware the Enhanced were in place. The Manager Enhanced Droplet d two PPE carts were on the				

NAME OF PROVIDER OR SUPPLIER  THE OAKS  STREET ADDRESS, CITY, STATE, ZIP CODE 90 SETHESDA ROAD WINSTON SALEM, No. 27103  (X4) ID PROVIDER TYPO OF CORRECTION PREFIX TAG  Continued From page 74 hall as of 7/19/21 (the date of the survey entry). The Manager reported more signs have since been posted and that she herself placed three or four additional PPE carts on the 100 Hall during the mid to late morning of 7/20/21.  An interview was conducted on 7/22/21 at 3:19 PM with the facility's Director of Nursing (DON) with regards to the failure of the facility to post signage and observe Enhanced Droplet Precautions for 8 of the 9 residents on the 100 Hall. The DON reported she had noticed on 7/20/21 there were fewer signs for Enhanced Droplet Precautions than she had previously seen. When asked, the DON stated her expectation would be for the staff to leave the signage in place until the leadership team evaluated whether the resident could come off of the precautions in accordance with their facility policy.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  THE OAKS  STREET ADDRESS, CITY, STATE, ZIP CODE 901 BETHESDA ROAD WINSTON SALEM, NC 27103  WINSTON SALEM, NC 27103  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 880  Continued From page 74 hall as of 7/19/21 (the date of the survey entry). The Manager reported more signs have since been posted and that she herself placed three or four additional PPE carts on the 100 Hall during the mid to late morning of 7/20/21.  An interview was conducted on 7/22/21 at 3:19 PM with the facility's Director of Nursing (DON) with regards to the failure of the facility to post signage and observe Enhanced Droplet Precautions for 8 of the 9 residents on the 100 Hall. The DON reported she had noticed on 7/20/21 there were fewer signs for Enhanced Droplet Precautions than she had previously seen. When asked, the DON stated her expectation would be for the staff to leave the signage in place until the leadership team evaluated whether the resident could come off of the precautions in accordance with their facility			345284	B. WING				
F 880  Continued From page 74 hall as of 7/19/21 (the date of the survey entry). The Manager reported more signs have since been posted and that she herself placed three or four additional PPE carts on the 100 Hall during the mid to late morning of 7/20/21.  An interview was conducted on 7/22/21 at 3:19 PM with the facility's Director of Nursing (DON) with regards to the failure of the facility to post signage and observe Enhanced Droplet Precautions for 8 of the 9 residents on the 100 Hall. The DON reported she had noticed on 7/20/21 there were fewer signs for Enhanced Droplet Precautions than she had previously seen. When asked, the DON stated her expectation would be for the staff to leave the signage in place until the leadership team evaluated whether the resident could come off of the precautions in accordance with their facility	NAME OF PROVIDER OR SUPPLIER				901 BETHESDA ROAD	l	07/23/2021	
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	F 880	hall as of 7/19/21 (the The Manager reported been posted and that four additional PPE of the mid to late mornion. An interview was content with regards to the fasignage and observed Precautions for 8 of Hall. The DON reported Trecautions seen. When asked, expectation would be signage in place until evaluated whether the precautions in accordance.	e date of the survey entry). ed more signs have since it she herself placed three or carts on the 100 Hall during ing of 7/20/21.  Inducted on 7/22/21 at 3:19 Director of Nursing (DON) callure of the facility to post the Enhanced Droplet the 9 residents on the 100 Interest on the 100 I	F 8	80			