STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		4/27/17

(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete a significant change assessment due to Resident #190 having significant weight loss and a stage 3 pressure ulcer for one of two sampled residents with significant changes.

The findings included:

Resident #190 was admitted to the facility on 7/20/16 with diagnosis of acute respiratory failure with hypoxia, placement of a tracheostomy, stroke, diabetes, and dysphagia.

Admission physician orders dated 7/20/16 included tube feedings of Diabetisource at 55 milliliters (ml) an hour continuous for 24 hours.

The care plan dated 11/1/16 included a problem of altered nutrition related to recent weight loss and feeding tube needed due to dysphagia. The stated goal included Resident #190 would have

Oak Forest Health and Rehabilitation requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 4/27/17. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.

A Significant change of Assessment for Resident #190 was completed on March 30, 2017 to include changes for weight loss and changes in skin condition.

A 100% audit was initiated by the MDS Nurse on March 30, 2017 to identify

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/21/2017

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F 274	Continued From page 1 adequate nutrition as evidenced by stable weight at 135 pounds (plus or minus 5 pounds) over the next 90 days. Interventions were to provide tube feedings and flushes as ordered, monitor weight, skin and labs, monitor tolerance of feedings, monitor adequacy of feedings, notify (medical doctor) MD, (certified dietary manager) CDM, and family of significant weight changes. The most recent Minimum Data Set (MDS), a Quarterly, dated 1/9/17 indicated Resident #190 had unplanned weight loss with a current weight of 128 pounds. Total nutritional needs were met by a feeding tube with continuous feedings. This MDS indicated he did not have pressure ulcers. Review of the weights from December 2016 to March 2017 were as follows: December weight was 124 pounds, January weight was 128 pounds, February weight was 129 pounds and March weight was 120 pounds. Record review revealed Resident #190 had developed a pressure ulcer (stage 3) on 2/24/17. Record review revealed the wound healed on 3/10/17 Review of the updated care plan dated 3/21/17 had not included the pressure ulcer, or that it resolved and did not include new interventions for weight loss. An interview was conducted with the Dietary Manager (DM) on 03/30/17 at 10:55 AM. Resident #190 had experienced weight loss at the time of the January MDS. She explained the resident had experienced vomiting issues. The DM was asked about a stage 3 pressure ulcer that was identified on 2/24/17 and was healed on	F 274	residents with weight loss, wounds, and use of indwelling urinary catheters to identify any significant change of condition that has not been previously addressed. The audit was completed on April 7, 2017. All identified residents with significant changes, received a Significant Change MDS Assessment by the MDS nurses with completion of the audit. 100% of the MDS Nurses received re-education on 4/18/2017 by the Regional Reimbursement Coordinator identifying a significant change of condition and then initiate a MDS Significant Change of Assessment. All newly hired MDS nurses will receive the education during orientation. Utilizing a Significant Change MDS Audit Tool, the MDS Nurses x 3 will complete the audit 5 days weekly based on the information from Medicare/Medicaid, clinical morning meetings, new orders, acute episodes, and updated resident health status information to identify the need to complete a Significant Change MDS Assessment. Monitoring will occur 5 days weekly x 2 weeks, then 3 times weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1 month. The Director of Nursing will review and initial the audit tools weekly x 8 weeks, then monthly x 1 for trends and concerns. The DON will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	

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F 274	Continued From page 2 3/10/17. She explained she was not aware he had a pressure ulcer. The MDS nurse was interviewed on 03/30/17 at 1:27 PM revealed she did not know about the weight loss. The MDS nurse is informed of changes in residents at the morning meetings and reviews the physician orders. Further interview revealed if she had known about the wound and weight loss, that would have prompted her to do a Significant Change MDS. An interview was conducted with the Director of Nursing on 03/30/17 at 1:36 PM. Interview revealed the MDS nurse and DM are in the Medicare and Medicaid meetings. Any changes in residents ' condition are discussed. The DON explained a significant change MDS should have been completed due to the two changes in Resident #190.	F 274		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 280		4/27/17

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F 280	Continued From page 3	F 280		

plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

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F 280	Continued From page 4 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to update the care plan to include the use of an indwelling urinary catheter for one of three sampled residents reviewed with urinary catheters. Resident #3. The findings included: Resident #3 was admitted to the facility on 1/11/17 with diagnoses that included congestive heart failure, diabetes and pressure ulcer. The admission Minimum Data Set (MDS) dated 1/18/17 indicated Resident #3 was incontinent of bowel and bladder and required total assistance	F 280	The care plan for Resident #3 was updated to include the use of an indwelling urinary catheter by MDS Nurse on March 29, 2017. A 100% audit of all residents with an indwelling urinary catheter was completed on April 6, 2017 by the Regional Reimbursement Coordinator to assure each resident had a care plan in place for a catheter use. All residents identified had an existing care plan in place. 100% of the MDS Nurses received re-education on 4/18/17 by the Regional Reimbursement Coordinator to ensure a	

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F 280	Continued From page 5 by two persons for toileting. The MDS indicated a pressure ulcer was present on admission. Review of the care plan dated 1/18/17 included a problem of a pressure ulcer and interventions for the pressure ulcer. Record review revealed an order dated 2/16/17 for use of an indwelling urinary catheter due to the pressure ulcer was now a stage 4. Review of a telephone order dated 3/6/17 to continue the use of the urinary catheter for two more weeks. Review of the care plan revealed it had not included an update for the use of the urinary catheter. Observations on 03/29/17 at 11:32 AM during observations of the wound care revealed Resident #3 had an indwelling urinary catheter. Interview with the unit manager on 03/30/2017 at 3:37 PM revealed Resident #3 was to continue the indwelling urinary catheter until the wound improved. The wound nurse would write the orders after making rounds with the wound physician. An interview with the MDS nurse on 03/30/17 at 3:46 PM revealed she was not aware Resident #3 had the urinary catheter. She explained the order for the urinary catheter was between the assessment periods, and they missed it.	F 280	resident who enters the facility with or receives new orders for an indwelling urinary catheter, that the catheter will be added to the resident's care plan. All newly hired MDS nurses will receive the education during orientation. Utilizing a Foley Catheter Audit QI Tool, the Unit Managers will identify all residents with catheters to assure a care plan was in place for the use of the catheter. The MDS Nurses x 3 will review the Audit QI Tool Weekly and update care plans as indicated by the audit ongoing. The DON will review and initial the Audit Tool weekly x 12 weeks for trends or concerns. The DON will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		4/27/17

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F 325	Continued From page 6 (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide interventions for identified weight loss for a resident who was receiving total nutrition by enteral feedings for one of one sampled residents with enteral feedings. (Resident #190). The findings included: Resident #190 was admitted to the facility on 7/20/16 with diagnosis of acute respiratory failure with hypoxia, placement of a tracheostomy, stroke, diabetes, and dysphagia. Admission physician orders dated 7/20/16 included tube feedings of Diabetisource at 55 milliliters (ml) an hour continuous for 24 hours. Review of the Admission Minimum Data Set (MDS) dated 8/8/16 indicated Resident #190 had	F 325	Resident #190 tube feeding formula was increased to Diabetisource at 60ml/hr. on 3/30/17. The resident's record was reviewed on 4/10/17 by the Registered Dietician with recommendations to increase Diabetisource AC to 65ml/hr. and was carried out on 4/10/17 and continued to be weighed weekly. Resident #190 experienced a change in condition on 4/10/17 and was transferred to the hospital and admitted. The resident was re-admitted to the facility on 4/17/17 with new orders for Nutren 2.0 at 35ml/hr. continuous via gastrostomy tube per hospital discharge orders. The resident will continue to be weighed weekly to monitor changes in weight and reviewed by the Weight Committee weekly and referred to the Registered Dietician as	

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F 325	Continued From page 7 long and short term memory problems, and severe impairment of cognitive skills for daily decision making abilities. This MDS included he was totally dependent on staff for all activities of daily living. Nutrition was provided by a tube feeding and he weighed 136 pounds and had lost weight that was unplanned in the last 30 days. At the time of the Admission MDS Resident #190 had a stage 2 pressure ulcer. Review of the Care Area Assessments (CAAs) dated 8/12/16 included the areas of nutrition and pressure ulcers. Review of the Nutrition CAA revealed Resident #190 had a diagnosis of protein malnutrition. The analysis of this care area revealed the resident was to receive nothing by mouth (NPO) and the tube feeding was Diabetisource. The resident tolerated the feedings, was within ideal body weight range with a normal BMI at 21.8. The CAA included Resident #190 was admitted with a pressure ulcer on the left heel. The care plan dated 11/1/16 included a problem of altered nutrition related to recent weight loss and feeding tube needed due to dysphagia. The stated goal included Resident #190 would have adequate nutrition as evidenced by stable weight at 135 pounds (plus or minus 5 pounds) over the next 90 days. Interventions were to provide tube feedings and flushes as ordered, monitor weight, skin and labs, monitor tolerance of feedings, monitor adequacy of feedings, notify (medical doctor) MD, (certified dietary manager) CDM, and family of significant weight changes. Review of the monthly weights from 8/16 to 10/16 were as follows: August weight was 143 pounds,	F 325	appropriate. A 100% weight audit for a 6 month look back was completed for all residents dependent on enteral feedings on March 31, 2017 by the Director of Nursing to identify any resident with a significant weight loss. Residents identified with significant weight loss of 5% in 30 days or 10% in 6 months were reviewed by the Weight Committee on April 7, 2017 to include the Director of Nursing, Assistant Director of Nursing, Therapy representative, MDS Coordinator and Dietary Manager. Interventions were developed during the meeting and carried out. The residents with enteral feedings with significant weight loss will be weighed weekly to monitor the effectiveness of the interventions. Once the resident's weight stabilizes x 4 weeks, the resident will be moved to monthly weights. Weekly Weight Committee meetings will be held and a 100% weight audit for a 6 month look back will be completed for all residents dependent on enteral nutrition to identify any residents with significant weight loss. Those residents identified will be reviewed weekly by the Weight Committee for interventions and monitoring until their weight stabilized. On April 4, 2017, the Director of Nursing provided education to 100% of Restorative Nursing Assistants to include notification to the Unit Manager of any weight change of >/<3lb in one week or >/<5lb in 1 month. Any new restorative	

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F 325	Continued From page 8 September weight was 136 pounds and October weight was 131 pounds. A progress note by the CDM dated 11/1/16 identified weight loss for Resident #190. The note documented a 12 pound weight loss (8.3%) in 3 months (from 8/16 to 10/16) and a 5 pound weight loss in 1 month from 9/16 to 10/16. Review of this note indicated an intervention was provided that included the tube feeding was increased from 55 ml/hour to 58 ml per hour. There were no pressure ulcers noted during this assessment. Review of a telephone order dated 11/1/16 indicated the Diabetisource tube feeding was increased from 55 ml/hour to 58ml/hour. The most recent MDS, a Quarterly, dated 1/9/17 indicated Resident #190 had unplanned weight loss with a current weight of 128 pounds. Total nutritional needs were met by a feeding tube with continuous feedings. This MDS indicated he did not have pressure ulcers. The care plan was reviewed with no new interventions for weight loss. Review of the weights from December 2016 to March 2017 were as follows: December weight was 124 pounds, January weight was 128 pounds, February weight was 129 pounds and March weight was 120 pounds. A progress note by the CDM dated 1/18/17 identified weight loss for Resident #190. He remained NPO and received Diabetisource at 58 ml/hour continuous. There were no recent labs for review. The January weight was weight 128.2	F 325	Nursing Assistants will receive the education during orientation. 100% of the weight committee was provided education of F325 regulation on April 4, 2017. The DON will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	

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F 325	Continued From page 9	F 325		

pounds. This note indicated Resident #190 had a stable weight since December, but had a weight loss of 14.8 lbs (10.3%) in 6 months. The CDM calculated he was at the low end of IBW with a normal BMI at 20.7. Speech informed the CDM to continue with the tube feedings due to the resident did not tolerate a diet. He would vomit when trialed with food. The CDM did not increase feedings at that time as his caloric needs were met and his weight had been more stable.

The Registered Dietician (RD) progress note dated 1/24/17 revealed the current nutritional plan would be continued.

Record review revealed Resident #190 weighed 129 pounds on 2/10/17 and 120 pounds on 3/9/17.

Review of a nutritional note by the CDM dated 3/21/17 revealed the note addressed questionable weight loss. Resident #190 was tube fed and received Diabetisouce at 58 ml per hour with 40 ml per hour of water flush and continued NPO. The March weight was 120 pounds. This was a loss of 9.4 pounds a 7.2% in one month. He was also down 16 pounds an 11.7% in 6 months. The CDM documented his weights had been fairly stable from October to February. The tube feedings were providing over his needs and there were 3 instances of vomiting last week. The plan indicated his weights would be monitored and weekly weights would be requested for four weeks.

Interview with the RD on 3/30/17 at 10:30 AM revealed she did not review the residents with tube feedings on a regular basis. She explained

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she would be aware of weight loss when the facility informed her.

An interview was conducted with the Certified Dietary Manager (CDM) on 03/30/17 at 10:55 AM. The CDM explained she was responsible for reviewing residents with tube feedings. Resident #190 had experienced weight loss at the time of the January MDS. She explained the resident had experienced vomiting issues. The speech therapist (ST) was treating the resident and he received a tray of food along with the tube feedings. The CDM had met with the ST to discuss a plan for the tube feedings. The ST had told her not to decrease the feedings and that the resident was not tolerating the meals. She had put Resident #190 on weekly weights beginning on 3/21/17 due to weight loss from February to March. The CDM explained the resident needed 1500 calories and he was getting 1600 calories. The CDM was asked about a stage 3 pressure ulcer that was identified on 2/24/17 and was healed on 3/10/17. She explained she was not aware he had a pressure ulcer. Further explanation revealed she had not received a wound report for Resident #190. The CDM reported the process of obtaining and reporting weights was as follows: The restorative aides obtained the weights. The charge nurses were informed of the weights. During the interview, she explained she did not think the restorative aides knew if a resident had a weight change from the previous month's weight. The physician or his assistant would inform her of a weight change. The DM explained she received a weight report at the end of the month. There were weight meetings but due to schedule conflicts she had not attended.

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F 325	Continued From page 11 Interview with the physician on 03/30/17 at 11:58 AM revealed the resident had gradual weight loss and somehow he (Resident #190) slipped through the cracks. He explained weights were usually reviewed by both the physician and the Physician's Assistant (PA) but somehow missed the weight loss. The unit manager followed weight variances for daily weights or weights obtained 2 to 3 times a week. Due to the wound he could have had some protein loss, but the wound was now healed. The physician stated he did not have a clinical reason for the weight loss and would need to obtain labs and review for possible causes. Interview with the Director of Nursing on 03/30/17 at 1:36 PM revealed there were Medicare and Medicaid meetings with the MDS nurse in attendance. Resident #190 had stable weights for several months. She explained it was just this month weight loss had become an issue for this resident. She did not know how the CDM was not aware of the pressure ulcer, as the information was in the computer (electronic chart). Interview with the administrator on 03/30/17 at 4:32 PM revealed he would have expected someone to have caught that weight loss on March 9, 2017. He did not know how the weight loss was missed. He stated the staff did have weight meetings, and talked about weights in the daily morning meetings.	F 325		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 431		4/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 12 §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		

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F 431	Continued From page 13 (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to secure a locked box of narcotics by having it permanently attached inside the refrigerator for one of one medication refrigerators. The findings included: Observations of the medication room on 3/30/17 at 9:10 AM revealed a metal locked box sitting on the refrigerator shelf. The box was easily removed from the shelf. Nurse # 3 opened the metal box and reconciled the narcotic antianxiety medications for two residents. The medications were liquid. The metal box was locked and replaced on the shelf in the refrigerator. The nurse explained it was double locked by the medication room door was locked and the box was locked. Interview with the Director of Nursing on 03/30/17 at 9:37 AM revealed she was not aware it was to be stationary inside the refrigerator.	F 431	The locked narcotic box was permanently attached to the refrigerator on C Wing by the Maintenance Director on March 29, 2017. All locked narcotic boxes were inspected for compliance. All were permanently attached and locked appropriately. The Regional Clinical Manager provided an in-service education to the Director of Nursing on 4/14/17 to assure the narcotic lock box is permanently secured to the refrigerator. In the event the refrigerator is changed or an additional locked narcotic box is added, the Maintenance Director will be notified to secure the box before medication can be stored. Using a Narcotic Box Secure QI Audit Tool, the Assistant Director of Nursing will observe the narcotic box on the C Wing weekly x 4 weeks, then monthly x 2 months to assure the box is secured to the refrigerator. The DON will review and initial the audit tool weekly x 4, then monthly x 2 for trends or concerns. The DON will present the results of the	

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F 431	Continued From page 14	F 431	monitoring to the Executive Quality Assurance Committee monthly x 3 for trends and the need for continued monitoring.	