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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345284	A. BUILDING _____ B. WING _____	C 10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS	901 BETHESDA RD WINSTON SALEM, NC 27103

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and record review the facility failed to provide prompt incontinence care. The facility staff failed to apply barrier crème after incontinence care was provided. This was evident in 1of 3 residents in the survey sample who were dependent upon staff for care. Resident#5 Findings included: Review of the medical record revealed Resident#5 had cumulative diagnoses which included hypertension, Parkinson's disease, paralysis agitans, presenile dementia, lack of coordination and muscle weakness. Review of the current October 2012 physician orders revealed routine medications that included Clonidine HCL 0.2 mg (milligrams) twice a day and Metoprolol 25 mg in the am and 50 mg po at 5 p.m. These medications help to manage hypertension. Review of the (Minimum Data Set) MDS assessment dated 8/20/12 revealed the resident was severely cognitively impaired. Resident#5 was totally dependent on staff for all activities of	F 312	**The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies.** **To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.** **483.25 (a) (3) ADL Care Provided for Dependent Resident** **F Tag # 312** **This requirement will be met as follows:** **The facility has taken corrective action for the residents affected by this practice by:** • Resident #5 provided ADL care on October 30, 2012 and had no ill effect. • 24 hour report completed and sent to Health Care Registry. Investigation completed, found to be unsubstantiated. Employees counseled regarding general rounds, providing incontinent care, proper use of ADL terminology checking for incontinence versus providing incontinent care on November 2, 2012. **The facility will take corrective action for those residents having the potential to affected by the same deficient practice:** • All incontinent residents have the potential to be affected by this alleged practice. • Care plans will be reviewd by MDS nurses by November 26, 2012 and all residents requiring staff assistance with incontinent care and use of barrier cream/protective cream identified. • All nursing staff educated regarding appropriate ADL care. See below.	10-30-12 11-26-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Susan C. Hallett | Administrator | 11-23-12

A 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.

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F 312	Continued From page 1 daily living (bathing). The resident needed extensive assistance with 2 or more staff for bed mobility (turning side to side). The MDS indicated that the resident was always incontinent of urine and bowel movement. Review of the initial care plan dated 6/27/12 revealed a problem with incontinence of bowel and bladder. One of the goals was to keep the resident clean, dry and odor free. To accomplish this goal the facility developed interventions which included perineal care when resident was incontinent. This included perineal cleaning and application of a moisture barrier to the buttocks. Observation on 10/30/12 at 10:30 a.m. of Resident#5 ' s room revealed a strong offensive lingering odor that resembled urine. An observation on 10/30/12 at 10:37 am of NA#1 providing incontinence care to Resident#5 was conducted. These observations revealed Resident#5 was lying on 3 white colored cloth under pads, fitted sheet and 2 white colored draw sheets. Resident#5was covered with a top sheet and blanket. All were wet with progressive brown colored urine stains. Resident#5 was wearing white compression stockings on her legs. The white stockings were wet with progressive circles of golden colored stains that smelled of urine. NA#1 turned the resident on her right side with the assistance of the restorative aide (RA). When Resident#5 left buttocks was exposed a brown dried substance was noted on her left buttock that resembled feces. NA#1 at this time indicated this substance was indeed feces. The resident was bathed and a clean brief was applied. No barrier crème was applied to the	F 312	<u>The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur:</u> • An in-service was provided for all nursing staff (RN, LPN, NA, FT, PT, PRN). Training included general rounds, incontinent care, use of barrier cream/protective cream , use of ADL terminology, and review of job functions by Staff Development Coordinator (SDC) and will be completed by November 26, 2012. • Any in-house nursing staff that did not receive in-service training will not be allowed to work until training is completed. • ADL needs will be reviewed by MDS nurse on admission and quarterly and care planned accordingly. • This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. <u>The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:</u> • The ADL Care QA Survey Auditing Tool will be used to monitor care on 3 residents daily for two weeks then weekly for two months by DON and/or designee; see tool. • Any immediate concerns will be brought to the DON or Administrator for appropriate action. • Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Members include Administrator, DON, Nurse Unit Director, MDS Nurses, Social Workers, Dietary, & SDC.	11-26-12

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F 312	Continued From page 2 resident ' s buttocks or perineal area. Further observation on 10/30/12 at 11:10 a.m. with the RA of the soiled linens from Resident#5 ' s bed revealed the blanket was soiled with progressive rings of brown urine stains. One draw sheet had dried stool and dark golden colored progressive rings that smelled like urine which measured approximately 11 inches by 22 inches at the largest ring. The second cloth draw sheet had multiple circles that measured approximately 23 inches at the largest ring. The cloth under the pad had a dried substance which resembled fecal matter with progressive brown colored stains that smelled like urine. The second under pad had dried stool and dark golden colored rings that smelled like urine. The third cloth underpad had multiple progressive golden colored wet stains that smelled of urine. The compression stockings were wet and had multiple golden colored stains from the top of the stocking to the foot area which resembled urine odor. Interview on 10/30/12 at 11:20 a.m. with NA#1 revealed she had not provided care to Resident#5 since she arrived on duty at 7 a.m. until 10:30 a.m. NA#1revealed Nurse#1 had received report at the time of shift change that the resident had not urinated all night during the 11 p.m.-7 am shift. NA#1 indicated that when she checked on the resident at 8:30 am-9 am the resident was soiled " just like we saw it today. The nurse told me that after feeding the residents (around 8-8:30 am) to not change Resident #5 but to provide care to another resident because it was that resident ' s birthday and the family would be in to visit. " NA#1 indicated that she would have provided care to resident#5 earlier than	F 312		

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F 312	Continued From page 3 10:00 am. This NA further indicated that the resident had a " stressful bladder " and if you push on her stomach, urine would start flowing. NA#1 indicated that she should have applied a barrier cream to the resident ' s buttocks but did not because the resident did not have any cream in her room. She further stated she did not want to leave the resident to obtain the cream. Continued interviewing with NA#1 revealed, " No way did the resident not void all night " because she was familiar with the resident. Interview on 10/30/23 at 2:50 p.m. with Nurse#1 revealed the night shift NA#2, , and Nurse#2 told her during change of shift report around 7:05 am, that the resident had not voided all night. Nurse#1 continued that NA#1came to her around 8:30 am-8:45 am and reported Resident#5 was left wet. She stated that she told NA#1, " Let ' s clean her up. " Nurse#1 continued that she told NA#1 to provide care to another resident first because the resident was going to have visits from the family and, " You know how they (referring to family members) are. " No explanation was provided. Interview via phone on 10/30/12 at 3:36 pm with Nurse#2 (on duty 10/29/12-10/30/12), revealed she observed the resident in bed asleep. She stated she did not witness incontinence care being provided to Resident#5. She further stated, " I saw NA#2 coming out of the resident ' s bathroom. She indicated that she last observed Resident#5 at 5:00 am but never looked at her linens. Nurse#2 stated NA#2 told her and was overheard by the oncoming nurse (Nurse#1) that Resident#5 had not voided all shift.	F 312		

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F 312	Continued From page 4 Interview with NA#2 via the phone on 10/31/12 at 9:19 am, revealed she clocked out of duty at 7:00 am, after telling the oncoming and off going nurses that Resident#5 had not voided all shift. She further indicated that she had checked the resident ' s brief at 5:30 am, but nothing was soiled. She stated, " I never changed her linens as there was not enough staff to perform all duties and that is why I need to start early (referring to the last round before 6 am "). Interview on 10/30/12 at 3:20 p.m. with the director of nurses (DON) revealed she expected residents to be provided incontinence care as soon as staff can provide care. An additional inquiry into the time span for providing care was done and the DON indicated that the staff should provide care within an every 2 hour window.	F 312		
F 322 SS=E	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to check for placement and/or residual for 3 of 3 residents observed during medication administration or	F 322	483.25 (g) (2) **NG Treatment Services- Restore Eating Skills** **F Tag # 322** **This requirement will be met as follows:** **The facility has taken corrective action for the residents affected by this practice by:** • Resident #6, 7 and 8 were checked for G-tube placement and residual on November 1, 2012. G-tube placement was appropriate. • Nurse #1,3, and 4 were educated by Staff Development Coordinator (SDC) beginning November 6, 2012. • Observations of care on November 21, 2012 by DON/designee indicated appropriate G-tube placement. **The facility will take corrective action for those residents having the potential to be affected by the same deficient practice:** • All G-tube residents were assessed on November 5, 2012 for appropriate tube placement and residual; all appropriate. • Physician or designee has reviewed G tube orders and orders obtained for G tube checks for placement and/or residual on November 22, 2012. **The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur:** • All Nurses will be in-serviced by SDC by November 25, 2012 regarding appropriate G-tube placement and residual checks. • Any in-house nursing staff who did not receive in-service training will not be allowed to work until training is completed. • This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	11-25-12

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F 322	Continued From page 5 water flushes via gastrostomy tubes. (Residents # 6, Ressident #7 and Resident #8). Findings include: Facility Policy titled " Enteral Nutritional Therapy (Tube Feeding), Policy#NUP-309 " with an issue Date of October 1, 2001 read in part: " 3. Remove plug from end of feeding tube, check position of tube, and attach barrel of syringe to end of tubing. 4. Check position of tube by: C. Placing stethoscope over stomach and instill a small amount of air into Enteral feeding tube. Listen for air to enter the stomach. To Check Residual/Stomach Contents 2. Insert feeding syringe into feeding tube and aspirate stomach contents, gently. 3. The amount of residual may determine the amount of current feeding. Use the following guidelines unless otherwise instructed. a. Fifty cc ' s (cubic centimeters) or less is usually returned to the stomach, disregarded and feeding administered as ordered. b. Fifty to one hundred cc ' s is usually returned to the stomach, subtracted from amount of feeding to be administered. C. One hundred cc ' s and over is usually returned to the stomach and the tube feeding held. Notify physician as ordered. " 1. During an observation of a medication pass with Resident #6 on 10/30/12 at 3:45 PM, the nurse (nurse #3) prepared the medications at the medication cart (two acetaminophen 500 mg (milligrams) each crushed and Promod nutritional supplement). Nurse #3 entered the room, positioned the resident, removed the tubing	F 322	**The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:** • Using the QA Survey Auditing Tool, G-tube placement and residual checks will be monitored by DON and/or designee by observing care of 1 G- tube resident daily, Monday-Friday, for two weeks then weekly for two months; see audit tool. • Any immediate concerns will be brought to the DON or Administrator for appropriate action. • Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Members include Administrator, DON, Nurse Unit Director, MDS Nurses, Social Workers, Dietary, SDC.	

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F 322	Continued From page 6 running to the bottle of enteral feeding, opened the port to the gastrostomy tube (g-tube), poured in 50 cc of water, then the medications, then 50 cc of water. She recapped the tubing to the gastrostomy tube, started the pump at 60 ml/hour, washed her hands and left the room. Nurse #3 did not check for g-tube placement or residual before medication administration. In an interview with the Director of Nursing on 10/31/12 at 9 AM, she provided the corporate policy for gastrostomy feedings. She stated that she had contacted the Medical Director and Nurse practitioner and they stated their expectations were that a g-tube is checked for placement with a stethoscope, and air bubble and residual checks be done before any medication or fluid was administered through the g-tube. During an interview with the Staff Development Coordinator on 10/31/12 at 9:45 AM, she stated that skills checks were part of new hires training but she did not require new hires to do return demonstrations of gastrostomy feedings. 2. During an observation of g-tube flushing at 4:05 PM on 10/30/12, nurse #4 did use a stethoscope to check for g-tube placement on Resident # 7 but did not check for residual. When asked why she did not check for residual, she stated because it was a continuous feeding and she would always have residual. In an interview with the Director of Nursing on 10/31/12 at 9 AM, she provided the corporate policy for gastrostomy feedings. She stated that she had contacted the Medical Director and Nurse practitioner and they stated their	F 322		

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F 322	Continued From page 7 expectations were that a g-tube is checked for placement with a stethoscope, and air bubble and residual checks be done before any medication or fluid was administered through the g-tube. During an interview with the Staff Development Coordinator on 10/31/12 at 9:45 AM, she stated that skills checks were part of new hires training but she did not require new hires to do return demonstrations of gastrostomy feedings. 3. During an observation of a medication pass with nurse #1 on 10/30/12 at 4:30 PM, she prepared the Medication at the cart and entered Resident #8 room. She provided privacy, washed her hands and draped the resident. She accessed the port end of the gastrostomy tube and submerged it in a glass of water. Bubbles came out of the tube. She did not check for residual and did not use the piston syringe with air to check for placement. She did flush the tube and administered the medications and then used a final flush. When asked why she did not use a stethoscope to check for placement or residual, she stated that submerging the port of the gastrostomy tube in water was the method she was taught. Review of the corporate policy revealed that this was the method to use to check for placement with nasogastric tubes and not gastrostomy tubes. In an interview with the Director of Nursing on 10/31/12 at 9 AM, she provided the corporate policy for gastrostomy feedings. She stated that she had contacted the Medical Director and Nurse practitioner and they stated their	F 322		

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F 322	Continued From page 8 expectations were that a g-tube is checked for placement with a stethoscope, and air bubble and residual checks be done before any medication or fluid was administered through the g-tube. During an interview with the Staff Development Coordinator on 10/31/12 at 9:45 AM, she stated that skills checks were part of new hires training but she did not require new hires to do return demonstrations of gastrostomy feedings.	F 322		