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 10/23/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview the facility failed to follow through with a scheduled eye appointment for 1 of 1 sampled resident for left eye irritation. (#181) Findings included: Record review revealed Resident #181entered admitted to the facility on 2/5/14 with cumulative diagnoses which included diabetic retinopathy and anemia. Review of the medical record revealed admitting physician orders dated 2/8/14 revealed for ophthalmology care PRN (as needed). Review of the Minimum Data Set dated 7/13/14, revealed no long or short term memory problems. and adequate vision. Record review of the Care Area Assessment dated 02/12/2014, revealed visual field deficit of the eye with of diagnosis diabetic retinopathy and decreased visual acuity. Review of care plan dated 2/18/14, revealed in part, impaired vision and wears prescription	F 250	483.15 (g)(1) Provision of Medically Related Social Service F Tag #250 This requirement will be met as follows: The facility has taken corrective action for the residents affected by this practice by: " Resident #181□s eye appointment was re-scheduled for 10/29/2014; resident did go to the appointment and was accompanied by a family member. The facility will take corrective action for those residents having the potential to affected by the same deficient practice: " All outside appointments (10/23/2014-11/07/2014) were reviewed on 11/10/2014 by Administrator/designee to assure attendance and appropriate accompaniment by family or staff member. The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur: " Social Workers/Unit Secretary in-serviced by Administrator/designee on 11/14/2014 regarding appointment scheduling, contacting family and/or assignment of staff for appointments. " The Unit Secretary was in-serviced by	11/14/14

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

Electronically Signed | 11/07/2014

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F 250	Continued From page 1 eyeglasses. During an interview on 10/21/14 at 8:37 AM, Resident # 181 revealed "I am very angry by the last minute change of my eye appointment." She indicated the facility had canceled her eye appointment on 10/22/14. She indicated her left eye had been itching. During an interview on 10/22/14 at 10:11 AM, Social Worker indicated Resident #181 had an appointment for the eye doctor that was made on 10/20/14 and the transportation to and from the appointment was scheduled. During an interview on 10/22/14 at 10:41AM the Director of Nursing indicated they had tried to contact someone to go to the appointment with Resident #181. During an interview on 10/22/14 at 10:44AM the Administrator indicated Resident #181 was able to go unaccompanied. It was common practice for residents who were competent to go to appointments unaccompanied. The Director of Nursing indicated Resident #181 wasn't able to go on her appointment unaccompanied. The DON revealed " It was her mistake." She had misunderstood that the eye appointment was today (10/22/14) and had a chaperone available to accompany Resident #181. Her expectation was for residents to go to scheduled appointments and not miss them due to the lack of a chaperone.	F 250	DON on 11/14/2014 regarding procedures for engaging family members and alerting DON if family unable to accompany resident. " DON/designee to assign staff member to accompany resident to appointments if family unable. " This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan□s effectiveness by: " Facility will monitor compliance reviewing three appointments a week for attendance to appointments and appropriate accompaniment. This will be done weekly for 4 weeks then monthly for 3 months. " 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. Date of Compliance: 11/14/14	
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	F 312		11/14/14

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F 312	Continued From page 2 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, interview with residents and interviews with staff the facility failed to provide assistance with toe nail care for 1 of 4 sampled residents (#141).The facility failed to trim facial hair and provide the shower for 1 of 4 sampled residents reviewed for Activities of Daily Living (# 23). Findings included: Review of the Policy Title: Nails, Care of (Fingers and Toes) dated 10/01/2001 revealed in part, " Basic responsibility: Licensed Nurse Performs the procedure on high risk residents. Nursing assistants may perform the procedure if the resident is not a risk for complications of infection. A podiatrist may perform the procedure on residents per facility policy. " Resident #141 was admitted on 10/14/13, with the diagnoses of hypertension, anemia and heart failure. She required oxygen via a nasal cannula at all times. Review of the annual Minimum Data Set (MDS) 9/10/14 revealed no long or short term deficit and she required supervision and physical help with bathing and hygiene. Review of the care plan dated 10/15/13 revealed in part, Self-Care Deficit r/t (related to) Activity	F 312	483.25 (a)(3) ADL Care 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 #141□s toenails were trimmed on 10/24/2014 and #181□s were trimmed on 11/07/2014. " Resident #23□s facial hair shaved on 10/23/2014. " Resident #23 showered on 10/23/14. " C N A #2 was counseled and educated by the DON on 10/23/2014 on the need to provide showers as scheduled. The facility will take corrective action for those residents having the potential to affected by the same deficient practice: " All residents were interviewed and assessed for facial hair, toenail length, and shower preference/immediate needs 11/04/2014 - 11/11/2014 by LPN Support Nurse and Nurse Manager/designee. " Residents identified with facial hair were shaved/preference not to be shaved honored. " Residents identified with long toenails were trimmed or referred to the podiatrist. " Immediate shower needs provided and preferences honored. The following measures/systemic	

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F 312	Continued From page 3 Intolerance associated with being short of breath. Goal: I will improve current level of function in Bed Mobility, Transfers Dressing, Toilet Use and Personal Hygiene, through the next 90 days. Interventions were: Check nail length and trim and clean as necessary. Report any changes to the nurse. {NA}(Nursing assistant) was responsible to carry out the nail clipping. Review of the current podiatry list dated 10/14/14 of residents scheduled to see the podiatrist on 11/20/14. Resident #141 did not meet the qualifications to be on the podiatry list. Review of the shower schedule (not dated) for Resident #141 revealed showers were scheduled on Wednesday and Saturday evenings. Review record of nail care from 10/1-23/14, revealed (unspecified) nail care was documentation on 10/4/14 at 11:00PM. Review of the medical record of Resident #141 revealed no documentation of the condition of the toe nails. During an interview on 10/21/2014 at 10:37:28AM. Resident #141 indicated cutting toe nails was a part of her regular hygiene. She was unable to reach her toes to clip her nails. She indicated she had long toe nails and had asked that they be trimmed. They were snagging her socks and were hurting. She removed her socks and demonstrated her difficulty to reach her toes. Observation on 10/21/14 -at 10:37AM of Resident #181 revealed jagged toe nails that extended ¼ of an inch beyond each toe.	F 312	changes will be put in place to ensure that the deficient practice does not occur: " The Nursing staff (C N As and Nurses both part time and full time) were in-serviced by Staff Development Coordinator on 11/07/2014-11/15/2014 regarding facial hair, toenail care, and showering. " This included the procedure, policy, scheduled times offering showers twice weekly and providing showers for those who request nonscheduled shower time. Also staff was educated on resident right to refuse a shower and the responsibility to notify the nurse when a resident refuses. " Nail care has been added to C N A electronic medical record for documentation and diabetic nail care will be offered by the Nurse weekly on shower day. The Podiatrist provides in house services quarterly for any resident with special needs including diabetics for toenail care. " Resident schedules for showers entered into the electronic medical record for documentation for C N A. " 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. The facility will monitor its performance to	

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F 312	Continued From page 4 During an interview on 10/22/14 at 8:54 AM, Resident #141 indicated she still had not had her toe nails clipped and they were really bothering her. During an interview on 10/22/14 at 9:16 AM, Aide #1 indicated residents were offered a shower day twice a week. Toe nails were trimmed routinely on shower days. The shower documentation was reviewed and no showers were documented for Resident #141 Wednesday or Saturday's. Aide #1 indicated all residents required some amount of assistance. Some needed to be set up for bathing and assisted with finger nail and toe nail clipping. Finger and toe nails were checked daily for length and cleanliness. The nursing aides trimmed the finger and toe nails of resident who were not diabetic. Continued interview with Aide #1 revealed scheduled shower days were the preferred day to cut nails. Nurses trimmed the finger and toe nails of diabetic residents. Diabetic patients were also seen by a podiatrist. During an interview on 10/22/14 at 4:52 PM, Aide #2 indicated nail care was done on the schedule shower day. Aide #2 indicated nursing assistants trimmed the nails of resident who did not have diabetes, and nurses or podiatrist trimmed the nails of diabetic residents. During an interview on 10/23/14 at 8:30 AM, Aide #3 removed the socks of resident #141 and indicated the toe nails were too long and needed to be trimmed. Aide #3 indicated he would report the long nails to the nurse. Aide #3 indicated Resident #141 was independent with her hygiene and required oxygen at all times. When Resident #141 was	F 312	ensure that solutions are achieved and sustained. The facility will evaluate the plan□s effectiveness by: " Facility will monitor compliance by observing 5 residents weekly for facial hair, toenails, and showers. " This will be done weekly for 4 weeks then monthly for 3 months by the Support Nurse and Unit Manager/designee. " 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. Date of Compliance: 11/14/2014	

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short of breath she would ask for help. She was set up each day for her hygiene and she was able to take care of herself. Resident #141 clipped her toe nails herself. The nurses and podiatrist cut the toe nails of residents. Residents who are total care had nails assessed by the nurses during skin assessment.

During observation on 10/23/14 at 8:33AM, Resident #141 indicated she had not had her toe nails trimmed in over a month.

During an interview on 10/23/14 at 8:50 AM, Nurse # 1 indicated on the scheduled shower days all residents were assisted by the aide who would observe for nail care. Diabetic residents who needed nail care were reported to the nurse. The nurse was expected to do a skin assessments and this included nail assessment on Wednesday night. Diabetic residents who required podiatrist care were reported to the social worker and added to the podiatrist list.

During an interview on 10/23/14 at 10:02, Administrator indicated the aide was responsible for nail care. The facility podiatrist came every 90 days. A list of residents and the current podiatry letter was reviewed. Resident # 141 was not on the list.

During an interview on 10/23/14 at 10:05, Social Worker #2 indicated the Administrator kept the current list of residents who required toes nails trimmed by the podiatrist. The nursing staff referred residents who required podiatry care.

During an interview on 10/23/14 at 1:39PM, the Director of Nursing (DON) expectations were for the aides to report long toe nails to her, and for

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the nurses to clip long toe nails unless the resident was on the podiatry list.
During an interview on 10/23/14 at 3:40PM Aide #4 indicated she was assigned to Resident #141 and had not provided Resident #141 a shower or nail care. Residents were expected to ask to have their nails trimmed.

2. Review of the policy title: Shaving the Resident
Issuing Date: October1, 2011
Purpose:To remove facial hair and improve the resident ' s appearance and morale.

Resident #23 was admitted to the facility on 5/1/11 with the diagnoses of cerebrovascular disease, aphasia and hypertension.

Review of the Minimum Data Set (MDS) dated 9/15/14, revealed she had long and short term memory problems with physical impairment of movement with her upper and lower extremities. She was rarely understood and her speech was unclear. Resident #23 was totally dependent for bathing and personal hygiene.

Review of the care plan dated 10/17/14 revealed in part, Resident #23 required extensive assistance with bathing, dressing, grooming, turning /pulling up in bed, transferring, eating and toileting. Interventions were in part were to anticipate Resident#23 needs, to assist her with bathing and personal hygiene. The nursing assistant was responsible to carry out these interventions.

Review of the shower list (no date) revealed the scheduled shower days for Resident #23 was Wednesday and Saturday evening.

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F 312	Continued From page 7 Review of the Personal Care log documentation dated 10/1-23/2014 revealed one shower was documented on 10/15/14. On the remaining evening shower days a bed bath was given on 10/1, 11, and 22. The remaining evening shower days 10/4, 8, 18 there was no documentation of any type of shower, bed bath, or tub bath. During observation on 10/20/14 at 1:30 PM revealed Resident # 23 hair was greasy and uncombed. Resident#23 had long, white facial hair covering her chin that measured approximately ½ inch. During an interview on 10/1-23/2014 a family member revealed he stayed with Resident #23 the majority each day and she hadn't received a shower. This family member voiced concern of her dirty hair and the facial hair. He indicated she no longer went to the beauty salon. During an interview on 10/22/14 at 9:16AM, Aide #1indicated all residents have two (2) shower days a week. The shower list was reviewed and confirmed Resident #23 was scheduled on Wednesday and Saturday evenings. On shower days aides were to wash the hair and trim facial hair. Residents who did not want hair washed in the shower also had the option to use a microwavable shower cap to wash and condition the hair. Some residents preferred the beauty salon for hair care. During an interview on 10/22/14 at 4:52PM Aide #2 indicated every morning residents received a bed bath. Shower days were scheduled 2 days per week. The hair was washed in the shower or in the beauty salon. Facial hair would be trimmed	F 312		

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F 312	Continued From page 8 on a shower day and when needed. She indicated there was enough time to complete showers on the evening shift 3:00PM- 11:00PM. During an interview on 10/23/24 at 8:40 AM, Aide #3 observed Resident #23 had ¼ " - ½ " long white chin hairs. He indicated the hairs on her chin were very long and should have been removed on the shower day. Aide #3 indicated he would remove the chin hair. During an interview on 10/23/14 at 4:11PM, Aide #4 was assigned to give the evening shower and revealed she had not given Resident #23 a shower last evening. She helped another aide and did not have the time to shower Resident#23. She indicated she gave her a bed bath.She had not washed her hair or removed the facial hair. During an interview on 10/23/14 at 4:11PM, Director of Nursing indicated she expected scheduled showers to be completed, if the aide was running behind the nurse was to be notified to get the help to complete the shower.	F 312		