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 06/10/2016

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 000	INITIAL COMMENTS	F 000		
F 431 SS=E	F 253 D deleted in IDR 7/18/16 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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.	F 431		6/27/16

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

Electronically Signed | 06/24/2016

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F 431	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to dispose of expired medications and safely store medications in 2 of 5 medication carts. Findings included: On 6/8/16 at 10:25 am, during observation of the 500 hall medication cart revealed, there were 4 insulin pens that were not dated when they were opened. Two insulin vials that were not dated when they were opened. A generic box of acid control medication that was expired on 5/2016. There was an amber medication bottle with a white cap containing red round pills, a piece of tape was applied and " multivitamin " had been hand written on the tape. A bottle of generic multivitamins with an expiration date of 5/2016. The second drawer contained several various pills in the bottom drawer. During interview Nurse #1 indicated the third shift was responsible for cleaning out the medication cart. On 6/8/16 at 11:05 am during observation of the 400 hall medication cart revealed, a Humalog pen that had expired on 5/8/16 and another that had expired on 4/10/16. A bottle of Lantus insulin with a label to refrigerate. An inhaler opened 4/8/16 with a label that read, " Good for 30 days after being removed from the original pouch." There were multiple loose pills observed in the second drawer. During an interview Nurse #2 indicated it was every nurse ' s responsibility to clean out the medication cart and discard expired medications. On 6/9/16 at 1:22 pm, the Director of Nursing indicated the pharmacy consultant came to the facility at least once per month to do the cart audit, and they notified the nurse the medication was expired. It was her understanding the	F 431	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. F431 DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS Corrective Action: Any insulin that was not dated or initialed when opened was immediately discarded. Any Medication that was expired was immediately discarded. All Medications were immediately secured properly. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. Audits were done June 20, 2016 by the Director of Nursing, Staff Development Coordinator, and Nurse Manager on all medication and treatment carts, and also any areas where medication was securely stored to ensure that there were no medications that were expired, and also to ensure that there were, no expired, undated or not initialed, open insulin by the nurse. Their findings were no other medications that were expired and also	

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F 431	Continued From page 2 11:00pm-7:00am nursing staff were to check for expired medication and returned them to the pharmacy.	F 431	there were no other insulin that were open and expired, undated or not initialed by the nurse. Systemic Changes: Director of Nursing and /or Designee in serviced all nursing staff (RNs, LPNs, full time, part time, and PRN) that 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. This in service was completed by 6/27/2016. Any nursing staff member (RNs, LPNs, full time, part time, and PRN) 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. Monitoring: To ensure compliance, Administrator, Director of Nursing or designee will monitor this issue using the QA survey tool. Facility will also observe all medication and treatment carts and any other area where insulin is securely stored for expired, undated and not initialed, open insulin's by the nurse. Facility will also observe all medication and treatment carts and all areas where medication is securely stored for any expired medication. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Support Nurse, Unit	

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F 431	Continued From page 3	F 431	Manager, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality 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. Date of Compliance: 6/27/2016	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair corridor hand railings on 3 of 5 corridor halls observed. An observation with the Maintenance Director (MD) on 6/6/16 at 11:30 am revealed on the 400 hall corridor, the hand rail corner was missing and a nail was exposed, the 100 hall revealed 4 corners of the handrails were missing and the 200 hall had 1 corner of the handrail missing. An interview was conducted with the MD on 6/6/16 at 11:30 am. The MD reported he was aware of the missing wood on the corners of the	F 465	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.	6/27/16

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F 465	Continued From page 4 rails and indicated he needed to get a specific saw to replace the hand rail corners. An observation on 6/8/16 at 3:30 pm revealed on the 400 hall a nail was observed protruding one centimeter out from the missing section of the handrail. The area around the nail was rough to touch and the corner section was missing. An additional observation was made on the 400 hall again of the same area on 6/9/16 at 9:37 am. The MD was made aware of the observation. The MD indicated there was no routine schedule to check the corridor rails in the facility. He reported he fixed things when he saw them. An interview with the Administrator on 6/9/16 at 3:30 pm revealed that her expectation of the MD was to address and repair concerns when he became aware of the concern.	F 465	F465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT Corrective Action: Maintenance Director repaired the hand railings on the 400, 100, and 200 hallways. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by the alleged practice. An audit was completed by Maintenance Director on 6/24/16 of all handrails in the facility. Any handrails found in need were repaired. Systemic Changes: Maintenance Director will check hand rails during daily rounds and repair as needed. Administrator in-serviced Maintenance Director 6/24/16 regarding process. Noted repairs for the hand rails will be reported by others using a work request process. Administrator-in-Training, Staff Development Coordinator, Maintenance Director, and Environmental Services Director in serviced all staff (nursing and ancillary staff) regarding new process for logging needed work requests which include handrails. As needed work items are found staff will log the item in the Maintenance Log book. Log books are located at each nursing station, and the business office. The Maintenance Director or designee will check the log book in the AM and PM Monday – Friday. The weekend nursing supervisor will check the Maintenance logs Saturday and Sunday and will contact the Administrator or designee if a work request is needed	

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F 465	Continued From page 5	F 465	prior to Monday. The Maintenance Log contains date, location, description of work needed, and the name of person requesting work. This in service was completed by 6/27/16. The Maintenance Director will then log the work item into the DSSI TELs electronic web based system which contains the following: work order number, priority level, due date, title (description), room/area, category (i.e. general maintenance, HVAC, electrical, etc), status (open, closed), initiated by, and closed date. 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. This in service was completed by 6/27/2016. Any staff members who did not receive in-service training will not be allowed to work until training is completed. Monitoring: To ensure compliance, Administrator or Maintenance Director or designee will monitor this issue using the QA survey tool. This will be done on weekly basis for 4 weeks then monthly for 3 months by the Maintenance Director, Administrator, or designee. Reports will be presented to the weekly QA Committee by the Administrator or designee to assure corrective action initiated as appropriate. Any immediate concerns will be brought to the Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly	

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F 465	Continued From page 6	F 465	QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 6/27/2016	