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 _____	C 12/06/2018

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 000	INITIAL COMMENTS On 12/4/18 through 12/6/18, the survey team conducted a complaint investigation survey and cited tag F580, F656, and tag F660. On 01/22/19, the State Agency's Quality Improvement Committee reviewed tag F660. There was no change in the scope and severity but the tag was revised. The case was sent to CMS for remedy determination.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		1/3/19

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

Electronically Signed | 12/18/2018

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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to notify the family of a new pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #1). Finding included: Resident #1 was admitted to the facility on August 28, 2018 with diagnoses of hypertensive heart disease with heart failure, type 2 diabetes mellitus with hyperglycemia, presence of left artificial hip joint and cerebral infarction. A review of the admission Minimum Date Set (MDS) dated September 4, 2018 for Resident #1 revealed she had an unhealed pressure ulcer and	F 580	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 1/3/19. 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. The facility failed to notify the family	

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F 580	Continued From page 2 a surgical wound. Review of the comprehensive care plan dated September 12, 2018 for Resident #1 revealed an update dated September 17, 2018 that identified a pressure ulcer to the left buttocks that was unstageable. Review of a wound assessment report dated September 17, 2018 for Resident #1 revealed the wound was a pressure ulcer wound located on her left buttock. The wound was unstageable due to slough/eschar and measured 1.20 cm (centimeters) in length, 1.50 cm in width and no depth. The wound bed was 100% slough and there was a small amount of serous drainage. The wound assessment report indicated that on September 17, 2018 the family was not notified of the new pressure ulcer. A reviewed of medication administration record (MAR) dated September 17, 2018 revealed a treatment order for Allevyn Foam dressing to sacrum to be changed every 3 days and as needed and Santyl ointment for protection. During an interview with the Physician Assistant (PA) on December 4, 2018 at 7pm revealed Resident #1 was discharged home with family on September 28, 2018. The PA stated the resident needed assistance with all of her call needs. She added she had never spoken with the family, but was told that the family wanted Resident #1 home. The PA stated Resident #1 was weight bearing and had completed her therapy here. The PA was unaware that the family did not pick up Resident #1 on September 28, 2018. The PA stated nothing about Resident #1 new found pressure ulcer during this interview.	F 580	representative of a resident's new pressure ulcer. The treatment nurse found the pressure ulcer, completed the appropriate paperwork, treated the wound, but failed to notify the family. The treatment nurse was educated immediately. The facility will inform residents and resident representatives of any significant change of the resident immediately. The affected resident's representative is aware of the resident's pressure ulcer after completion of the facility survey. The facility will do a 100% audit of all current wounds to ensure resident representatives were notified and documented by 12/18/18. 100% of all nursing staff will be educated on notifying residents and resident representatives of any significant changes to the resident in accordance to regulation by 12/28/18. Nursing staff will be educated to document these notifications. The treatment nurse will also document in weekly notes who was notified of any resident skin changes during her treatment rounds. The treatment nurse will notify the Director of Nursing any time a resident representative cannot be reached. Wound audit tools will be used to ensure resident and family representatives are notified immediately for any significant changes daily x 4 weeks, weekly for 3 months and monthly x 1 year. The Director of Nursing will present the results of the audit tools to the Monthly QAPI	

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F 580	Continued From page 3 A review of discharge summary dated September 25, 2018 for Resident #1 revealed no documentation related to treatment of the residents pressure ulcer. The resident's family member (FM) was contacted on December 5, 2018 at 3:15pm. FM stated they were not notified that Resident #1 had a wound. They became aware of the wound when the facility dropped the resident off at home on October 4, 2018. The FM stated the only time the facility had called them was about discharging the resident. During an interview with the Treatment Nurse (TN) on December 6, 2018 at 11am revealed she was the one that found the pressure ulcer on September 17, 2018. She stated she completed the paperwork for the pressure ulcers. TN indicated that she forgot to call the family because, the facility had difficulty getting up with the family. TN revealed it was her responsibility to call families and let them know of new pressure ulcers. She added she had dropped the ball on this resident. During an interview with Director of Nurses (DON) on December 6, 2018 at 11:30 am she stated the TN was responsible for notifying the family of any changes. She stated it was her expectation that the regulations be followed regarding notification of pressure ulcers. An interview with the Administrator on December 6, 2018 11:45am revealed it was his expectation that staff follow the regulations for notification of change for all residents.	F 580	Committee monthly for 1 year. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Treatment Nurse will implement the above corrective actions.	

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F 656	Continued From page 4	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		1/3/19

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F 656	Continued From page 5 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to develop a care plan for 1 of 3 residents reviewed for discharge (Resident #1). Findings included: Resident #1 was admitted to the facility on August 28, 2018 and diagnoses included hypertensive heart disease with heart failure, type 2 diabetes mellitus with hyperglycemia, presence of left artificial hip joint, and cerebral infarction. A review of the admission Minimum Date Set (MDS) dated September 4, 2018 indicated Resident #1 was not cognitively intact. A review of Section Q of the MDS dated September 4, 2018 revealed discharge plan was coded as 1 for yes. An interview with Social Worker (SW) on December 6, 2018 at 9am revealed she remembered Resident #1. She stated she had completed section Q of the MDS and Resident #1 was not able to make her needs known. The SW added she had not spoken with the family about Resident #1 being discharged home. She stated the Discharge Planner and MDS Nurse were responsible for care planning a resident's discharge. Review of the Social Worker Notes for Resident #1 revealed no documentation related to her discharge plan.	F 656	The facility failed to develop a discharge care plan for a resident. The Social Worker completed section Q to show resident's discharge plan was to discharge from the facility. The MDS Nurse failed to identify this in the comprehensive care plan. The affected resident is currently residing in another facility at the time of the plan of correction. However, the MDS Nurses were educated on the affected resident discharge care plan immediately. The facility will ensure residents' comprehensive care plan identifies residents' discharge plans. The facility will do a 100% audit of all current resident comprehensive care plans to ensure discharge plans are included by 12/21/18. 100% of all MDS nurses, Social Worker, and Discharge Planner will be educated on discharge comprehensive care plans in accordance to the regulation by 12/28/18. The MDS Nurses, Social Worker, and Discharge planner will update the discharge comprehensive care plan to reflect residents' discharge plans after completion of Section Q of MDS, care plan meetings and/or after completion of interdisciplinary assessment of resident preferences and potential for future discharge from facility.	

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F 656	Continued From page 6 An interview with the MDS Nurse on December 6, 2018 at 9:30 am revealed she forgot to care plan Resident #1's discharge plan on her comprehensive care plan. An interview with the Director of Nurses (DON) on December 6, 2018 at 10 am indicated it was her expectation that the MDS Nurse would have developed a discharge care plan for Resident #1. An interview with the Administrator on December 6, 2018 11:45am revealed it was his expectation that staff follow the regulations for development of discharge care plans.	F 656	A comprehensive care plan audit tool will be used to ensure discharge care plans are included in the comprehensive care plan daily x 4 weeks, weekly x 3 months and monthly x 1 year. The Director of Nursing will present the results of the audit tool to the Monthly QAPI Committee monthly for 1 year. The Director of Nursing, Assistant Director of Nursing, MDS nurses, Staffing Development Coordinator, Social Worker, and Discharge Planner will implement the above corrective actions.	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of	F 660		1/3/19

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F 660	Continued From page 7	F 660		

developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and

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F 660	Continued From page 8 data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record reviews, family member and staff interviews the facility failed to address Resident #1's care needs (medications, activities of daily living, and pressure sore management), the type of caregiver support and the logistics of assuring that the resident had the equipment and support required. The facility did not have a care plan that addressed discharge. The facility discharged Resident #1 to home despite failing to address and acknowledge family members' voiced concerns of being unable to care for Resident #1 at home. This was evident in 1 of 3 residents reviewed for discharge planning (Resident #1). Findings included: Resident #1 was admitted to the facility on August 28, 2018 with diagnoses of hypertensive heart disease with heart failure, type 2 diabetes mellitus with hyperglycemia, presence of left artificial hip joint and cerebral infarction. A review of the admission Minimum Date Set	F 660	The facility failed to implement an effective discharge plan for a resident discharged from the facility. The discharge planner failed to involve the family representative with the discharge planning process. The family representative did not have knowledge of the resident's wound and treatment for the wound. The nurse failed to provide and review a medication list and medication scripts with family representative. Family training and documentation was not completed. The affected resident is currently residing in another facility at the time of the plan of correction. However, the discharge planner and nurse were educated immediately on the deficiencies made with the affected resident's discharge plan. The facility will complete a 100% audit of all resident discharges within the last two weeks from the facility by 12/17/18 to ensure the facility implemented an	

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F 660	Continued From page 9 (MDS) dated September 4, 2018 indicated Resident #1 had impaired cognition and Section Q was coded yes for a discharge plan. Resident #1 was total dependent on staff for bed mobility, locomotion on the unit and bathing. Resident #1 only need one person physical assist with eating. Walking had not taken place during this look back period. A review of the comprehensive care plan dated September 12, 2018 did not include a care plan for discharge planning. A review of the treatment progress note dated September 17, 2018 revealed Resident #1 had a newly identified unstageable pressure sore to her left buttock. An unstageable pressure sore has full thickness tissue loss in which the base of ulcer is covered by slough and eschar in the wound bed. Review of a departmental note dated September 28, 2018 revealed Resident #1 was scheduled to be discharged home on September 28, 2018 with her family. Home health had been arranged, no equipment was determined to be needed and the family was to arrange for a follow up visit with her primary care physician. An interview with the Discharge Planner (DP) on December 3, 2018 at 4 pm revealed Resident' #1's family was very difficult to reach however she had contacted them on September 21, 2018. The family indicated they would pick up Resident #1 from the facility on September 28, 2018. The DP stated she had contacted 3 home health agencies and 2 of the agencies would not be able to provide services for Resident #1. She explained 2 agencies came to the facility to	F 660	effective transition to post-discharge care. 100% of all nursing staff and discharge planner will be educated on effective discharge planning for residents in accordance to the regulation by 12/28/18. The discharge planner will involve the resident and resident representative in the discharge planning process and document resident discharge preferences involving the interdisciplinary team. The discharge planner will complete a discharge assessment for resident preferences and needs for discharging back to the community. The nursing staff will document the discharge instructions given to resident and/or resident representative upon discharge. A discharge audit tool and discharge planning audit tool will be used to ensure effective discharge plan is established daily x 4 weeks, then weekly x 3 months then monthly x 1 year. The Director of Nursing and Assistant Administrator will present the results of the audit tools to the Monthly QAPI committee for 1 year. The Director of Nursing, Nurse Managers, and Assistant Administrator will implement the above corrective actions.	

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F 660	Continued From page 10	F 660		

assess the resident and determined they would not be able to provide services for the resident. The DP did not indicate why the agencies couldn't take the resident. The DP stated she had initially spoken with Resident #1's grandson's wife and then the residents grandson returned her call on September 21, 2018. The grandson indicated that he would pick up Resident #1 on September 28, 2018.

During a second interview with the DP on December 4, 2018 at 3 pm she revealed the family had not been involved with Resident #1's care (no specific care issues were identified). The DP stated the family had not attended any care plan meetings or spoken with the medical doctor about her care needs during her stay at the facility. She stated Resident #1 was not picked up on September 28, 2018 as scheduled. The DP explained when she spoke with the grandson, he indicated he would not be able to pick up Resident #1 from the facility due to a transportation issue.

An interview with the Physician Assistant (PA) on December 4, 2018 at 7pm revealed Resident #1 was discharged home with her family on September 28, 2018. The PA stated the resident needed assistance with all of her care needs (activities of daily living). She added she had not spoken with the family, but was told by staff (did not identify staff member) that the family wanted Resident #1 home. The PA stated Resident #1 was weight bearing and had completed her therapy here. The PA was unaware that the family did not pick up Resident #1 on September 28, 2018.

A review of discharge paper work dated

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F 660	Continued From page 11	F 660		

September 28, 2018 for Resident #1 revealed no documentation related to treatment of the resident's pressure ulcer or information about the prescribed medications.

Review of a departmental note authored by the DP dated October 3, 2018 at 4:53pm stated "Called (family) and left message that I (DP) needed to speak with family as soon as possible that the patient was not picked up on discharge date and that we will be transporting patient home soon so they needed to call my personal cell #/am."

Ongoing interview with the DP on December 5, 2018 at 1pm revealed the grandson of Resident #1 contacted her (DP) on October 3, 2018 and indicated the family needed help with transportation home for the resident. She added the family made arrangements and the resident was discharged home on October 4, 2018.

An interview via phone with a family member of Resident #1 on December 5, 2018 at 3:15pm revealed the DP called them on September 21, 2018 requesting that they pick up the resident on September 28, 2018. She stated she was unsure of the date of that call. The family member indicated that during that call she had informed the facility that they had no means to take care of Resident #1. She stated on October 4, 2018 the facility called again and the next thing we knew Resident #1 was drop off by a van. The family member indicated they had no medication except insulin for the resident and they had no knowledge that the resident had a pressure sore on her buttock. The family member stated the facility just dumped Resident #1 off without any instructions on how to take care of her. She

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 _____	C 12/06/2018

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 660	Continued From page 12	F 660		

added adult protection services were called for help and the resident was placed in another nursing home.

An interview on December 6, 2018 at 2pm with Nurse #10 revealed she had completed the discharge paper work on October 4, 2018 for Resident #1. She stated she discharged the resident to no one and was told to complete the paper work. Nurse #10 stated she never saw a medication list or prescriptions to send home with the resident. She added home health was scheduled to be in the home the next day. Nurse #10 indicated October 4, 2018 was the only day she had worked with this resident and she really didn't know much about her. She stated normally when she discharged a resident there was a family member present and she would review all of the medications and appointments with them. Nurse #10 added she didn't see any treatment orders for Resident #1's pressure sore. She stated this was not the normal process for discharging a resident.

An interview on December 6, 2018 at 11am with the transportation company (TC) that transported Resident #1 home on October 4, 2018 revealed the family had contacted them for a price to transport the resident home. The family indicated the price was too high. The TC was contacted by the facility and they made arrangements for the resident to be transported home on October 4, 2018.

An interview with Director of Nurses (DON) on December 6, 2018 at 11:30am revealed the family wanted Resident #1 out of the facility as soon as possible. She stated she did expect the regulations to be followed for residents when they

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F 660	Continued From page 13 were discharged. An interview with the Administrator on December 6, 2018 11:45am revealed it was his expectation that staff follow the regulations for discharging residents home.	F 660		