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	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of this complaint investigaton NC00119053 and NC00117043.	F 000		
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to promptly resolve grievances regarding the staff's response time to answer resident call lights that was documented in six of six months of Resident Council meeting minutes. The findings included: Review of the Resident Council meeting minutes for the last six months (March 2016-August 2016) revealed the following concerns regarding staff not answering resident call lights in a timely manner: 3/22/16-on first shift (7:00AM-3:00PM) residents waited too long for the CNA (nursing assistant) to answer the call lights. On third shift (11:00PM-7:00AM) it took 30-35 minutes for staff to answer a resident's call light. 4/25/16--it took too long for staff to answer resident call lights. 5/23/16--staff would turn the call light off but won't help you.	F 244	1 .Corrective Action was accomplished for the alleged deficient practice by the Activity Director capturing the concern on a concern forms and distributing to the appropriate department head. Executive Director met with alert and oriented residents by attending Resident Council Meeting on 9-26-16. No residents voiced grievances about call bells at this time, but voice that call bell timeliness had improved. Director of Clinical Services and Unit Manager conducted interview and observation of call light response for 5 different residents on each of the three shifts on 10/10/16, 10/11/16, and 10/12/16. Based on interviews and observations conducted, the resident's needs were met and call light response time varied between 2mins and 10mins. 2. On 9-26-16 a Resident Council Meeting	10/20/16

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

Electronically Signed | 10/14/2016

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F 244	Continued From page 1 6/27/16--too long for staff to answer resident call lights. 7/25/16--took as long as 30 minutes for someone to answer resident call lights from 8:00PM until the next morning. 8/22/16--call lights-it takes staff too long to answer resident call lights on second shift (3:00PM-11:00PM). A review of facility responses to the Resident Council's concerns regarding call bell response was conducted. A concern dated 3/22/16 stated residents complained that first shift took too long to answer call lights. Action taken: the nursing assistant was educated related to providing resident/ patient care according to the care plan. Licensed nursing staff was to increase rounding to ensure care was delivered. There were no responses by the facility to address the Resident Council's concerns voiced during the meetings in April, May, June, July and August 2016. On 9/21/16 at 8:30AM, an interview was conducted with Resident #14, the Resident Council President. The Resident Council President stated concerns were written down at each meeting but she never received a response back from the facility regarding the resolution of the concerns. The resident stated she had only been Resident Council President since last month but had been a resident at the facility over a year and went to almost all of the resident council meetings. The Resident Council President also stated they (the residents) just "let it go" and felt the concerns of the Resident Council were being ignored/ not followed up on by the facility. She stated the call light issue was ongoing and residents continued to voice concerns about at the monthly Resident Council meetings.	F 244	was held and concerns captured on a concern form. No residents voiced grievances about call bells at this time, but voice that call bell timeliness had improved. Director of Clinical Services and Unit Manager conducted interview and observation of call light response for 5 different residents on each of the three shifts on 10/10/16, 10/11/16, and 10/12/16. Based on interviews and observations conducted, the resident's needs were met and call light response time varied between 2mins and 10mins. 3. All staff, including, licensed, unlicensed, PRN staff, housekeeping, therapy, administrative staff, maintenance and dietary staff, will be re-educated by the Director of Clinical Services, Unit Manager, or Executive Director on timely response of call lights. The re-education will be completed by 10-20-16. The Director of Clinical Services, Unit Manager and or charge nurse will randomly observe and interview 5 residents weekly, including weekends and 3-11 and 11-7 shift, for 12 weeks then monthly for 3 months to verify call bell compliance, the results of this monitoring will be documented on the facility monitoring tool. The Resident Council President will be interviewed weekly for 4 weeks than monthly for 5 months by the Executive Director to ensure call bell compliance and resident concerns are being addressed. Opportunities will be corrected daily as identified by the Director of Clinical Services, Unit Manager, or Executive Director.	

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F 244	Continued From page 2 On 9/21/2016 at 9:05AM, an interview was conducted with the Activities Director (AD). She stated she went to the Resident Council meeting every month and wrote down the minutes of the meeting. The AD stated she took the grievances to the morning meeting and the grievances were reviewed. A copy of the grievances were given to the Administrator. The AD stated she reviewed the old business the next month, reviewed each concern by department and asked the residents if they would like anyone else to attend the meeting. She stated the problem regarding the resident call lights not being answered timely by staff was reoccurring. The AD stated during the monthly resident council meetings residents continued to complain that their call lights were not answered in a timely manner on 2nd and 3rd shift. The AD indicated the results of the follow-up to the concern was not discussed at the next monthly resident council meeting. On 9/21/16 at 9:10AM, an interview was conducted with the Director of Nursing (DON). The DON stated she had educated all the nursing staff (licensed and nursing assistants) about call bell response at least twice in the last month. The Director of Nursing stated management staff made rounds every day to make sure call bells were within reach and accessible. She stated the Registered Nurse (RN) on duty at night was monitoring call bell response. She stated an audit monitoring tool had not been done and the concern about call bell response had not been taken to the facility's Quality Assurance meeting. On 9/21/2016 at 9:39AM, an interview was conducted with the Administrator. He stated he received a copy of the grievances the day after	F 244	4. The results of these observations and interviews will be submitted to the QAPI Committee by the Director of Clinical Services or Unit Manager for review by Interdisciplinary Team members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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F 244	Continued From page 3 Resident Council and also was informed of the grievances at the stand-up meeting that was held every morning. He stated he gave the appropriate department the grievance for follow-up. After the department filled out their response, they returned the grievance form to him. He stated he expected each department to go to that particular resident with the results of their investigation. When asked regarding the concern about the call bells, he stated it was hard for them to address that issue beyond in-servicing staff and they needed more specificity so they could narrow in if it was a particular person who was not responding to the call bells. He stated he did not know if staff had responded to the Resident Council about what was being done to resolve the issue.	F 244		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interview the facility failed to maintain resident room and bathroom walls in good repair on 3 of 5 halls (Hall B: Rooms 111 and 112, Hall D: Rooms 117 and 122, and Hall E: Rooms 129 and 132) and failed to provide clean privacy curtains in resident rooms on 3 of 5 halls (Hall B: Rooms 111 bed A and 112 bed A and B, Hall D: Room 122 bed B and Hall E: Room 132 bed A and B). The findings included:	F 253	1. Corrective Action was accomplished for the alleged deficient practice by the Maintenance Director and or Housekeeping Supervisor by replacing/washing privacy curtains and repairing doors and walls. Room 111 bathroom: Wall adjacent to handrail and area near soap dispenser were repaired on 10/7/16. Room 112: areas identified on both A and B side were repaired on 10/12/16. Room 129: areas left of the bed	10/20/16

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F 253	Continued From page 4 1. On 9/19/16 at 12:11 PM the resident bathroom attached to Room 111 on B Hall was observed. The wall by the handrail for the toilet was noted to have an approximately 5 inch long x 2 inch wide area of sheetrock that had worn away from the wall. The sheetrock was also torn near the soap dispenser. On 9/19/16 at 1:14 PM and again on 9/19/16 at 3:43 PM Room 112 on B Hall was observed. One side of bed 112 A was pushed up against the wall with the ½ side rail up. The sheetrock was in disrepair along the entire length of the side rail. In addition near bed 112 B an approximately 10 inch x 6 inch area of sheetrock was noted to be chipped away from the wall. On 9/19/16 at 4:23 PM room 129 on E hall was observed. An approximately 2 foot long paint chip was on the wall on the left side of bed B. An approximately 1 foot long paint chip was at the left side of window. In addition an approximately 1 foot high x 2 inches wide area of sheetrock was chipped away from the corner of the wall to the right of the bathroom door. Resident #69 was interviewed at this time and stated at interview that the wall had been in that condition for months. The resident said she asked Maintenance about it and was told they would get around to it. On 9/19 at 4:58 PM Room 132 on E Hall was observed. The door to the resident bathroom was observed to have a punched in hole, on the bedroom side of the door that was approximately 3 inches in diameter. Also the paint was chipped on the left side of the window extending about 2 feet and on the right side of the window for approximately 3 inches.	F 253	and left of window were repaired on 10/10/16. The corner next to the bathroom was repaired on 10/3/16. Room 132: the hole in the bathroom door was repaired on 10/12/16. Area left of window was repaired on 9/22/16. Room 117: areas identified on both A and B sides of room were repaired on 10/11/16. Room 122: Corner next to bathroom repaired on 10/4/16. Bathroom door repaired on 10/12/16. Identified curtains in room 112 A and B were cleaned on 10/10/16. Identified curtains in rooms 111A and 122B were cleaned on 10/11/16. Identified curtains in room 132 A and B were cleaned on 10/17/16. 2. All walls, doors and privacy curtains were inspected by the Maintenance Director, Housekeeping Supervisor, and/or Executive Director for cleanliness and good repair by 10/14/16. Results of the inspection were documented on a maintenance audit form and a privacy curtain audit form. All items noted to be in need of repair/cleaning were repaired/cleaned by 10/20/16, and the repair/clean date was documented on the maintenance and privacy curtain audit forms. 3. The Executive Director will re-educate Maintenance Director on identifying walls and doors in need for repair, with the understanding of types of issues need to be resolved, by 10/14/16. The Executive Director will re-educate the Housekeeping Supervisor and housekeeping staff on identifying and replacing/cleaning of soiled	

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F 253	Continued From page 5 On 9/20/16 at 8:03 AM Room 117 on D Hall was observed. Sheetrock and paint was noted to be chipped and peeled off the wall at the head of both bed 117 A and bed 117 B. On 9/20/16 at 9:05 AM Room 122 on D Hall was observed. A 1 inch (length) x 12 inch (height) chunk of sheetrock was noted to be missing from the corner of the wall near the resident bathroom door. In addition, the door to the resident bathroom was observed to have a punched in hole, on the bedroom side of the door that was approximately 3 inches in diameter. On 9/22/16 at 10:50 AM the Maintenance Director was interviewed. He indicated that he had just been in the process of repairing sheetrock in a resident room but had been called away to complete another task. He said that he was unavailable to tour several resident rooms with the surveyor as he needed to attend to his work but that he was already aware of things that needed repair. The Maintenance Director provided a copy of his list on request. Review of the hand written list (undated) provided by the Maintenance Director revealed the following items for Skilled Nursing Areas: D Hall 121 - fix room 121 corner of bath 122 - corner of wall bath 124 - corner of wall bath Paint in hall E Hall 132 - hole in bath door 130- wall corner bath Paint in hall	F 253	or stained privacy curtains by 10/17/14. The Executive Director will complete 5 random observations of resident's privacy curtains, including different rooms and different halls, weekly for 12 weeks to ensure clean and in good repair. The Executive Director will complete 5 random observations of walls and doors, including different rooms and different halls, weekly for 12 weeks to ensure they are in good repair. The results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected as observed by the Maintenance Director or Housekeeping Supervisor as identified during these audits. 4. The results of these observations will be submitted to the QAPI Committee by Executive Director for review by the IDT members each month for 3 months. The QAPI Committee will evaluate and amend as needed.	

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F 253	Continued From page 6 On 9/22/16 at 10:55 AM the Administrator was interviewed. In regards to the list provided by the Maintenance Director he stated that they had not yet completed a comprehensive list of all the needed repairs. He indicated that the focus of the list was to identify damaged doors and wall corners that needed repair. In addition, he stated that he had told the Maintenance Director to take one hall at a time and one room at a time and get to needed repairs as he was able. The Administrator added that he was in the process of getting approval for a major renovation to the facility and had gotten a quote on 4 new doors to replace the ones that were in the greatest need of repair. He also acknowledged that in the meantime the walls and doors needed to be maintained in good repair to promote a homelike environment for residents. On 9/22/16 at 11:00 AM Room 132 on E Hall was observed with the Administrator. The door to the resident bathroom was observed to have a punched in hole, on the bedroom side of the door that was approximately 3 inches in diameter. Also the paint was chipped on the left side of the window extending about 2 feet and on the right side of the window for approximately 3 inches. The Administrator acknowledged the areas in disrepair and added that the bathroom door was one of the doors he was planning to replace after getting another quote and getting the order approved. On 9/22/16 at 11:03 AM Room 122 on D Hall was observed with the Administrator. A 1 inch (length) x 12 inch (height) chunk of sheetrock was noted to be missing from the corner of the wall near the resident bathroom door. In addition, the door to	F 253		

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F 253	Continued From page 7	F 253		

the resident bathroom was observed to have a punched in hole, on the bedroom side of the door that was approximately 3 inches in diameter. The Administrator acknowledged the areas in disrepair and added that the bathroom door was one of the doors he was planning to replace after getting another quote and getting the order approved.

On 9/22/16 at 11:05 AM Room 117 on D hall was observed with the Administrator. Sheetrock and paint was noted to be chipped and peeled off the wall at the head of both bed 117 A and bed 117 B. The Administrator acknowledged these areas were in disrepair.

On 9/22/16 at 11:10 AM Room 112 on B hall was observed with the Administrator. One side of bed 112 A was pushed up against the wall with the ½ side rail up. The sheetrock was in disrepair along the entire length of the side rail. In addition near bed 112 B an approximately 10 inch x 6 inch area of sheetrock was noted to be chipped away from the wall. The Administrator acknowledged these areas were in disrepair.

On 9/22/16 at 11:12 AM the resident bathroom attached to Room 111 on B Hall was observed. The wall by the handrail for the toilet was noted to have an approximately 5 inch long x 2 inch wide area of sheetrock that had worn away from the wall. The sheetrock was also torn near the soap dispenser. The Administrator acknowledged these areas were in disrepair.

2. On 9/19/16 at 12:11 PM Room 111 on B Hall was observed. The privacy curtain for bed A was noted to be soiled with multiple brown marks near the base of the curtain on the side facing the

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F 253	Continued From page 8	F 253		

resident ' s bed.

On 9/19/16 at 1:14 PM and again on 9/19/16 at 3:43 PM Room 112 on B Hall was observed. The privacy curtain for bed A was noted to have an orange stain of approximately 4 inches by 1 -2 inches near the base of the curtain facing the resident ' s bed. The privacy curtain for bed B was noted to have an approximately 2 inches x 3 inches yellowish mark 1/3 the way up the curtain on the side facing the resident ' s bed.

On 9/22/16 at 11:00 AM Room 132 on E Hall was observed with the Administrator. The privacy curtains for both beds A and B were observed to have multiple areas of apparent soiling with brown and yellowish marks. The Administrator acknowledged the privacy curtains appeared soiled.

On 9/22/16 at 11:03 AM Room 122 on D Hall was observed with the Administrator. The privacy curtain for bed B was observed to have multiple areas of soiling with brownish marks. The Administrator acknowledged the privacy curtain appeared soiled.

On 9/22/16 at 11:10 AM Room 111 on B Hall was observed. The privacy curtain for bed A was noted to be soiled with multiple brown marks near the base of the curtain on the side facing the resident ' s bed. The Administrator acknowledged the privacy curtains appeared soiled.

On 9/22/16 at 11:12 AM and Room 112 on B Hall was observed with the Administrator. The privacy curtain for bed A was noted to have an orange mark of approximately 4 inches by 1 -2 inches

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F 253	Continued From page 9	F 253		

near the base of the curtain facing the resident ' s bed. The privacy curtain for bed B was noted to have an approximately 2 inches x 3 inches yellowish mark 1/3 the way up the curtain on the side facing the resident ' s bed. The Administrator acknowledged the privacy curtains appeared soiled.

On 9/22/15 from 11:15 - 11:23 a tour of the following rooms and interview was conducted with the Housekeeping and Laundry Manager (HLM):

Room 132 on E hall - the HLM stated that the markings on the privacy curtain for bed A appeared to be soiling and he would put it on the list to be washed. He said that the markings on the privacy curtain for bed B were stains that would not come out. He added that the facility did not have any replacement privacy curtains.

Room 122 on D hall - the HLM said that the privacy curtain for bed B needed to be washed. He stated that since he did not have any replacement curtains he needed to wash privacy curtains and then put them back up in the same day as soon as they were dry because residents were without a curtain in the meantime.

Room 118 on hall - the privacy curtain for bed A was observed to be removed. The resident was out of bed and not in the room. The HLM stated that the Housekeeping Aide on D hall had told him that morning that the privacy curtain was soiled so he was in the process of washing it and would rehang it when dry.

Room 111 on B hall - the HLM indicated the privacy curtain for A bed appeared soiled and also had some stains on it. He stated it needed to be

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F 253	Continued From page 10	F 253		

washed.

Room 112 on B hall - the HLM indicated that the orange mark on the bed A privacy curtain and the yellow mark on the bed B privacy curtain were both stains. He said they had already been washed and he could wash them again but the stains would not come out. The HLM added that the privacy curtains needed to be replaced but there were no replacements available in the facility so he did the best he could.

Further interview with the HLM at this time revealed that the Housekeeping Department was under contract with the facility, so he and the staff in the department were employed by another company, not by the facility. He said that he expected the Housekeeping Aids to let him know when privacy curtains were soiled and he would add them to his Privacy Curtain Log and ensure they got washed. The HLM stated he did not have any replacement privacy curtains for the privacy curtains that were stained but that they should be replaced. He added that it was his understanding that the facility was responsible for purchasing privacy curtains and he did not know why this had not been done. The Privacy Curtain Log for 7/21/16 through 9/22/16 was provided by the HLM at this time and reviewed. There were 13 privacy curtains for skilled nursing beds on the list including room 112 (reported and washed 7/25/16) and rooms 118 and 119 (reported 9/22/16).

On 9/22/16 at 11:25 AM Housekeeping Aide #1 who was working on D hall was interviewed. She stated that when she noticed soiled privacy curtains she reported it to the HLM. She acknowledged that there were privacy curtains

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F 253	Continued From page 11 that were stained that she did not report as the stains would not come out in the wash. She added that she had just told her Manager that morning about soiled privacy curtains in room 118 and room 119. On 9/22/16 at 12:40 PM the Administrator was interviewed. He stated that he had been unaware that there were stained and soiled privacy curtains in use within the facility and that that there were no replacements available. He indicated that there had been a breakdown in communication and that there may have been some misunderstanding of who was responsible for purchasing privacy curtains, due to the housekeeping service being a contract provider. He added that the facility was responsible for purchasing privacy curtains and now that he was aware he would ensure sufficient numbers of privacy curtains were available.	F 253		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278		10/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 278	Continued From page 12 willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to code the Minimum Data Set (MDS) assessment accurately for Preadmission Screening and Resident Review (PASRR) level II (Resident #21), life expectancy (Residents #21 and #67), hospice care (Resident #21), medications (Residents #27, #76, and #8), and pressure ulcers (Resident #16) for 6 of 17 sampled residents. The findings included: 1a. Resident #21 was initially admitted to the facility on 6/15/07 and readmitted on 11/10/09 with multiple diagnoses that included schizophrenia. Resident #21's annual Minimum Data Set (MDS) dated 4/16/16 indicated a "No" to question A1500 which asked if Resident #21 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. An interview with the Social Worker (SW) was	F 278	1. The MDS for Resident #21 with ARD 4-16-16 and 7-17-16 was corrected on 9-27-16 by the MDS Coordinator to accurately reflect the PASRR level II and life expectancy. Resident #67 no longer resides at the facility. The MDS for Resident #27 with ARD 9-1-16 was corrected on 10-7-16 by the MDS Coordinator to accurately reflect medication antianxiety. The MDS for Resident #76 with ARD 8-11-16 was corrected on 9-27-16 by the MDS Coordinator to accurately reflect medication antidepressant. The MDS for Resident #8 with ARD 7-19-16 was corrected on 9-23-16 by the MDS Coordinator to accurately reflect medication anticoagulant. The MDS for Resident #16 with ARD date 9-10-16 was corrected on 9-24-16 by the MDS Coordinator to accurately reflect pressure ulcer.	

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	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

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F 278	Continued From page 13 conducted on 9/21/16 at 2:25 PM. She indicated Resident #21 had a PASRR level II. An interview with the Director of Nursing (DON) was conducted on 9/21/16 at 4:28 PM. She indicated she expected the MDS to be completed accurately. An interview was conducted with MDS Nurse #1 on 9/21/16 at 4:30 PM. She indicated she started working at the facility about a month ago. She stated the previous MDS Nurse (MDS Nurse #2) was on medical leave. The 4/16/16 annual MDS for Resident #21 was reviewed with MDS Nurse #1. She wrote down the information and indicated she was going to review the medical record for verification of the MDS information. A follow up interview with MDS Nurse #1 on 9/22/16 at 9:22 AM revealed the 4/16/16 MDS for Resident #21 was coded inaccurately for PASRR level II. She indicated the 4/16/16 MDS should have indicated Resident #21 had a PASRR level II. 1b. Resident #21 was initially admitted to the facility on 6/15/07 and readmitted on 11/10/09 with multiple diagnoses that included Alzheimer's disease and failure to thrive. A Nurse Practitioner (NP) note dated 1/5/16 indicated Resident #21 was on hospice care. The quarterly MDS dated 1/15/16 indicated Resident #21 had significant cognitive impairment and was on hospice care. Section J, the Health Conditions section, indicated Resident #21's life expectancy was not less than six months (question J1400).	F 278	2. The MDS Coordinator, the Regional Director of MDS and or Director of Clinical Services will complete an audit of all current residents MDS for PASRR level, life expectancy, hospice care, medications and pressure ulcers to validate the most recent comprehensive MDS assessment have been coded accurately to reflect the status of the resident. This audit will be completed by 10-18-16. Audits identified 6 corrections related to section N of the MDS, and corrections were made on 10/19/16 by the Director of Clinical Services. 3. The Regional MDS Coordinator will re-educate all MDS staff including those working as needed by 10-20-16 on the accurate completion of the MDS. The Regional MDS Coordinator or Director of Clinical Services will randomly review 5 completed MDS assessments weekly for 12 weeks to verify accurate completion, the results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected daily by the MDS Coordinator as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the MDS Coordinator for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 278	Continued From page 14	F 278		

An interview with the DON was conducted on 9/21/16 at 4:28 PM. She indicated she expected the MDS to be completed accurately.

An interview was conducted with MDS Nurse #1 on 9/21/16 at 4:30 PM. She indicated she started working at the facility about a month ago. She stated the previous MDS Nurse (MDS Nurse #2) was on medical leave. The 1/15/16 quarterly MDS for Resident #21 was reviewed with MDS Nurse #1. She wrote down the information and indicated she was going to review the medical record for verification of the MDS information.

A follow up interview with MDS Nurse #1 on 9/22/16 at 9:22 AM revealed the 1/15/16 MDS for Resident #21 was coded inaccurately for life expectancy. She indicated the 1/15/16 MDS should have indicated Resident #21 had a life expectancy of less than six months.

1c. Resident #21 was initially admitted to the facility on 6/15/07 and readmitted on 11/10/09 with multiple diagnoses that included Alzheimer's disease and failure to thrive.

A Nurse Practitioner (NP) note dated 4/1/16 indicated Resident #21 was on hospice care.

The annual MDS dated 4/16/16 indicated Resident #21 had significant cognitive impairment and was on hospice care. Section J, the Health Conditions section, indicated Resident #21's life expectancy was not less than six months (question J1400).

An interview with the DON was conducted on 9/21/16 at 4:28 PM. She indicated she expected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

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FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 278	Continued From page 15	F 278		

the MDS to be completed accurately.

An interview was conducted with MDS Nurse #1 on 9/21/16 at 4:30 PM. She indicated she started working at the facility about a month ago. She stated the previous MDS Nurse (MDS Nurse #2) was on medical leave. The 4/16/16 annual MDS for Resident #21 was reviewed with MDS Nurse #1. She wrote down the information and indicated she was going to review the medical record for verification of the MDS information.

A follow up interview with MDS Nurse #1 on 9/22/16 at 9:22 AM revealed the 4/16/16 MDS for Resident #21 was coded inaccurately for life expectancy. She indicated the 4/16/16 MDS should have indicated Resident #21 had a life expectancy of less than six months.

1d. Resident #21 was initially admitted to the facility on 6/15/07 and readmitted on 11/10/09 with multiple diagnoses that included Alzheimer's disease and failure to thrive.

A Nurse Practitioner (NP) note dated 7/5/16 indicated Resident #21 was on hospice care.

The quarterly MDS dated 7/17/16 indicated Resident #21 had significant cognitive impairment. Section J, the Health Conditions section, indicated resident's life expectancy was not less than six months (question J1400).

An interview with the DON was conducted on 9/21/16 at 4:28 PM. She indicated she expected the MDS to be completed accurately.

An interview was conducted with MDS Nurse #1 on 9/21/16 at 4:30 PM. She indicated she started

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

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FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 278	Continued From page 16	F 278		

working at the facility about a month ago. She stated the previous MDS Nurse (MDS Nurse #2) was on medical leave. The 7/17/16 quarterly MDS for Resident #21 was reviewed with MDS Nurse #1. She wrote down the information and indicated she was going to review the medical record for verification of the MDS information.

A follow up interview with MDS Nurse #1 on 9/22/16 at 9:22 AM revealed the 7/17/16 MDS for Resident #21 was coded inaccurately for life expectancy. She indicated the 7/17/16 MDS should have indicated Resident #21 had a life expectancy of less than six months.

1e. Resident #21 was initially admitted to the facility on 6/15/07 and readmitted on 11/10/09 with multiple diagnoses that included Alzheimer's disease and failure to thrive.

A Nurse Practitioner (NP) note dated 7/5/16 indicated Resident #21 was on hospice care.

The quarterly MDS dated 7/17/16 indicated Resident #21 had significant cognitive impairment. Section O, the Special Treatments and Programs section, indicated Resident #21 had not received hospice care while a resident at the facility and within the last 14 days (question O0100K).

An interview with the DON was conducted on 9/21/16 at 4:28 PM. She indicated she expected the MDS to be completed accurately.

An interview was conducted with MDS Nurse #1 on 9/21/16 at 4:30 PM. She indicated she started working at the facility about a month ago. She stated the previous MDS Nurse (MDS Nurse #2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

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F 278	Continued From page 17	F 278		

was on medical leave. The 7/17/16 quarterly MDS for Resident #21 was reviewed with MDS Nurse #1. She wrote down the information and indicated she was going to review the medical record for verification of the MDS information.

A follow up interview with MDS Nurse #1 on 9/22/16 at 9:22 AM revealed the 7/17/16 MDS for Resident #21 was coded inaccurately for hospice care. She indicated the 7/17/16 MDS should have indicated Resident #21 received hospice care while a resident at the facility and within the last 14 days.

2. Resident #27 was admitted to the facility on 8/25/16 with multiple diagnoses that included anxiety disorder.

The admission MDS dated 9/1/16 indicated Resident #27 had moderate cognitive impairment. Section N, the Medications section, indicated Resident #27 was administered antianxiety medications on 4 of 7 days during the MDS look back period.

A review of the Medication Administration Record (MAR) for the look back period of Resident #27's 9/1/16 MDS indicated she was administered Buspar, an antianxiety medication, on 7 of 7 days (8/26/16 through 9/1/16).

An interview with the DON was conducted on 9/21/16 at 4:28 PM. She indicated she expected the MDS to be completed accurately.

An interview was conducted with MDS Nurse #1 on 9/21/16 at 4:30 PM. She indicated she started working at the facility about a month ago. She stated the previous MDS Nurse (MDS Nurse #2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 278	Continued From page 18	F 278		

was on medical leave. The 9/1/16 admission MDS for Resident #21 was reviewed with MDS Nurse #1. She wrote down the information and indicated she was going to review the medical record for verification of the MDS information.

A follow up interview with MDS Nurse #1 on 9/22/16 at 9:22 AM revealed the 9/1/16 MDS for Resident #27 was coded inaccurately for antianxiety medications. She indicated the 9/1/16 MDS should have indicated Resident #27 was administered antianxiety medication on 7 of 7 days.

3. Resident #76 was admitted to the facility on 4/28/16 with multiple diagnoses that included depression.

The quarterly MDS dated 8/11/16 indicated Resident #76 had moderate cognitive impairment. Section N, the Medications section, indicated Resident #76 was administered antidepressant medications on 7 of 7 days during the MDS look back period.

A review of Resident #76's MAR revealed he was not administered an antidepressant medication during the look back period of the 8/11/16 MDS (8/5/16 through 8/11/16).

An interview with the DON was conducted on 9/21/16 at 4:28 PM. She indicated she expected the MDS to be completed accurately.

An interview was conducted with MDS Nurse #1 on 9/21/16 at 4:30 PM. She indicated she started working at the facility about a month ago. She stated the previous MDS Nurse (MDS Nurse #2) was on medical leave. The 8/11/16 quarterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

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F 278	Continued From page 19	F 278		

MDS for Resident #76 was reviewed with MDS Nurse #1. She wrote down the information and indicated she was going to review the medical record for verification of the MDS information.

A follow up interview with MDS Nurse #1 on 9/22/16 at 9:22 AM revealed the 8/11/16 MDS for Resident #76 was coded inaccurately for antidepressant medications. She indicated the 8/11/16 MDS should have indicated Resident #76 was administered antidepressant medication on 0 of 7 days.

4. Resident #8 was admitted to the facility 1/9/15. Resident #8 had a diagnosis of atrial fibrillation (irregular heart rate).

Physician orders were reviewed and revealed Resident #8 had an order for Plavix (anti-platelet medication) 75 milligrams by mouth daily.

A Quarterly Minimum Data Set (MDS) dated 7/19/16 indicated Resident #8 was cognitively intact. Medications administered during the seven day look back period (7/13/16 through 7/19/16) indicated Resident #8 received seven (7) days of anticoagulant medication.

A review of the July 2016 Medication Administration Record (MAR) revealed Resident #8 did not receive any anticoagulant medication during the assessment period of 7/13/16 through 7/19/16.

On 9/21/16 at 4:22PM, an interview was conducted with the Director of Nursing who stated her expectation was for the MDS to be accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 278	Continued From page 20	F 278		

On 9/21/16 at 4:30PM, an interview was held with MDS Nurse #1. She stated she had been in that position for approximately one month. She reviewed the MDS dated 7/19/16 and the MAR for July and stated she would not have coded Plavix as an anticoagulant and the MDS was incorrect.

On 9/22/16 at 9:22AM, a follow up interview was conducted with MDS Nurse #1 who stated the MDS dated 7/19/16 was inaccurate for the coding of the anticoagulant medication.

5. Resident #67 was admitted to the facility 9/28/15 with last admission 8/3/16. Cumulative diagnosis included hepatic encephalopathy, hepatic failure and ascites related to chronic liver disease. Resident #67 was under hospice care on 8/3/16.

A Significant Change Minimum Data set (MDS) dated 8/9/16 indicated Resident #67 was cognitively intact. Hospice care was checked as being received during the assessment period. J1400 Prognosis was checked as "No" for life expectancy of less than 6 months.

On 9/21/16 at 4:22PM, an interview was conducted with the Director of Nursing who stated her expectation was for the MDS to be accurate.

On 9/22/16 at 9:22AM, an interview was conducted with MDS Nurse #1 who stated the MDS dated 8/9/16 (J1400) should have been checked "Yes" for life expectancy of less than 6 months.

6. Resident #16 was readmitted to the facility on 8/27/16. Cumulative diagnoses included peripheral vascular disease and diabetes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 278	Continued From page 21	F 278		

Medical record review revealed a nursing admission assessment dated 8/27/16 which indicated Resident #16 was readmitted to the facility with a pressure ulcer on her left heel. The area measured 4.6 centimeters in width and 4.0 centimeters in length.

A review of the pressure ulcer record dated 8/27/16 for Resident #16 stated she had an unstageable pressure ulcer (suspected deep tissue injury in evolution) to her left heel that measured 4.0 centimeters in length x 4.6 centimeters in width. The area was red/ black in color with the wound edges red in color. The area was mushy and boggy.

An Admission Minimum Data Set (MDS) dated 9/2/16 indicated Resident #16 was cognitively intact. Section M for skin conditions indicated she was at risk for pressure ulcers. It was checked " No " for unhealed pressure ulcers and no pressure ulcers were documented.

A Pressure Ulcer record dated 9/5/16 stated Resident #16 had an unstageable pressure ulcer on the left heel that measured 4.0 centimeters in length and 4.2 centimeters in width. The area was noted as being red/ black in color, mushy, boggy and noted as a blister.

A 14 day MDS dated 9/10/16 was reviewed. Section M for skin conditions indicated Resident #16 did not have any pressure ulcers.

On 9/21/16 at 11:05AM, an interview was conducted with Nurse #4. She stated she readmitted Resident #16 on 8/27/16. Nurse #4 stated, at the time of re-admission, there was a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 278	Continued From page 22 pressure ulcer on her left heel that was purplish in color and spongy. On 9/21/16 at 4:22PM, an interview was conducted with the Director of Nursing who stated her expectation was for the MDS to be accurate. On 09/21/2016 at 4:36PM, an interview was conducted with MDS Nurse #1. She stated she reviewed the nursing admission assessment, the forms for non-pressure ulcer and pressure ulcers, checked the treatment record, physician ' s orders and physician progress notes when she coded section M for skin condition. She stated she also reviewed any wound physician notes if the resident was being seen by the wound doctor. MDS Nurse #1 stated the error on coding for the pressure ulcer was found yesterday when the assessment was reviewed by someone from corporate and a significant correction was started yesterday. She stated she did not know how the error occurred. She stated she had just started working in that position about a month ago. There had been a lot of assessments to do and it was human error for the Admission assessment and for the 14 day assessment. On 9/22/16 at 9:22AM, a follow up interview was conducted with MDS Nurse #1 who stated both the Admission assessment dated 9/2/16 and the 14 day assessment dated 9/10/16 were coded inaccurately for pressure ulcers.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		10/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 279	Continued From page 23 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to develop a care plan for a resident who expressed suicidal thoughts and ideations (Resident #50) for one of one residents reviewed for choices. The findings included: Resident #50 was admitted to the facility 7/21/16. Cumulative diagnoses included, in part, dementia and history of cerebrovascular accident (CVA). An Admission Minimum Data Set (MDS) dated 7/28/16 indicated Resident #50 was severely impaired in cognition. Resident Mood interview indicated resident #50 had thoughts that he would be better off dead or hurting himself in some way and was documented as having occurred 2-6 days. Verbal behavioral symptoms directed	F 279	1. A Behavior Care Plan reflecting resident's suicidal thoughts and ideations with current interventions was initiated for Resident #50 by the MDS Coordinator and Social Services Director on 9-21-16. 2. The MDS Coordinator and Social Services Director will complete an audit of all Residents with suicidal thoughts and or ideation to validate a Care Plan is in place that reflects current interventions. This audit will be completed by 10-14-16, and no residents were identified to be exhibiting suicidal thoughts or ideation. 3. The Interdisciplinary Team, which includes the Director of Clinical Services, Unit Manager, MDS Coordinator, Activities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 279	Continued From page 24 towards others was noted as occurred 4-6 days. Rejection of care occurred 1-3 days. A Care Area Assessment (CAA) for behavioral symptoms stated Resident #50 had a diagnosis of unspecified Alzheimer's dementia. His mood may have been impaired due to Resident #50 having to remain in the long term care facility. His family was aware of his diagnosis but Resident #50 was unable to completely understand his family's decision of leaving him in a long term care facility. Behaviors would be addressed in the care plan. No referrals were needed at that time. The CAA did not address Resident #50's verbalizations regarding wanting to die. A psychiatric consultation dated 7/15/16 and obtained while Resident #50 was in the hospital stated Resident #50 had a history of dementia and stroke. He was brought to the hospital secondary to increased agitation and anger outbursts especially towards his wife. The consultation stated Resident #50's granddaughter had noted that Resident had become increasingly angry and irritable. He had voiced feelings of hopelessness with suicidal ideation and threatened to kill himself if he could not get his way at home. He was not on any psychotropic medications. Trileptal (an anti-epileptic medication that can also be described to treat mood disorders) was initiated in the hospital ad he had great improvement in his agitation. Diagnostic impression stated the following: vascular dementia, major cognitive disorder, vascular type with behavioral disturbances, vascular type dementia. A hospital discharge summary dated 7/21/16	F 279	Director, Dietary Manager and Social Services Director, will be re-educated by the Regional MDS Coordinator by 10-20-16 related to the development of Comprehensive Care Plans, including the requirement for Care Planning related to suicidal thoughts and ideations. Social Services will be responsible for initiating and completing care plan for suicidal thoughts and ideation. The MDS Coordinator, Unit Manager or Director of Clinical Services will randomly observe 5 residents and review the Resident Care Plans weekly for 12 weeks then quarterly to validate care plans are in place for residents with suicidal thoughts and ideations as required, the results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected daily by the MDS Coordinator as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the MDS Coordinator for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

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F 279	Continued From page 25	F 279		

stated, in part, per wife and granddaughter, over the past year patient had been having worsening memory, increasingly agitated, not allowing his wife to take care of him at home with activities of daily living, showing progression throwing objects across the room. Resident #50 had also been expressing ideations of suicide.

A nursing note dated 7/22/16 stated Resident #50 had threatened to hit staff when staff were changing his brief. Family stated Resident #50 would throw socks and shoes at times.

A nursing note dated 7/27/16 stated Resident #50 expressed anxiety due to family leaving him to go home for the night. He stated to just call the funeral home because he was just going to die if he could not go home.

A Social Service Progress Review note dated 7/28/16 stated Resident #50 was able to respond and make himself understood. Current mood status had the following checked as present: "states that life isn't worth living, wished for death or attempts to harm self". Information was obtained from the clinical record. Referral status indicated referrals would be made as needed.

A nursing note dated 8/3/16 at 10:15PM stated Resident #50 said he wanted to drink some poison. He said to give him some arsenic and he wanted to die.

A nursing note dated 8/12/16 at 5:30AM stated Resident #50 said "Let me die. I want to die."

A nursing note dated 8/20/16 at 9:30PM stated Resident #50 asked the nurse to give him some arsenic. The nurse told him he could not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 279	Continued From page 26	F 279		

arsenic and he said he would find some.

A nursing note dated 8/21/16 at 10:30PM stated Resident #50 was asking again for arsenic.

A nursing note dated 9/3/16 at 10:45AM stated Resident #50 was verbally abusive to staff. He tried to hit his nursing assistant and tried to leave the facility via the fire exit on a hall.

A review of the care plan for Resident #50 revealed there was not a care plan in place for Resident #50's verbalizations about wanting to die and/or wanting arsenic.

On 9/21/2016 at 2:33PM, an interview was conducted with the Social Worker. She stated she completed the Social Service Progress Review on 7/28/16. She stated the documentation was correct regarding Resident #50 had said he would be better off dead or hurting himself in some way. The Social Worker stated he said that because he found out he was going to be at the facility long term and his family wasn't going to take him home. She stated she did not know why she checked "Yes" for referrals on the CAA, then stated no referrals were needed. The Social Worker stated when she indicated "Yes" for a referral, she would let the nursing staff know so the physician could make a referral for psychiatric services. The Social Worker stated Resident #50 had changed and was more receptive of his placement. She stated weekly meetings were held with the Director of Nursing or one of the nursing staff, MDS nurse, Activity staff, dietary staff and herself. At the meeting, they discussed any residents that exhibited behaviors that were totally different for the normal and/or residents that were not acting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 279	Continued From page 27 like themselves. She stated she was not aware of any behaviors that had occurred within the last month and had not been informed of any behaviors since July 2016. She indicated, if she had been informed of Resident #50's verbalizations about wanting to die/ wanting arsenic since July, the behaviors would have been care planned and the team would have had a meeting about the behaviors. On 9/21/2016 at 3:34PM, an interview was conducted with the Director of Nursing. She stated, if a resident had a behavior problem, nursing staff would communicate it through the 24 hour report, document the behavior in the resident's medical record and on the nursing assistant report for suggestions on how to work with the resident and approaches to use in dealing with the behavior. The Director of Nursing stated she had not been informed by anyone that Resident #50 had made statements regarding wanting arsenic or making statements about wanting to die, etc. She stated she was only aware of Resident #50 being aggressive with his family. She said Resident #50 should have had a care plan developed for his verbalizations about wanting to die.	F 279		
F 319 SS=E	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced	F 319		10/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 319	Continued From page 28 by: Based on medical record review, staff interview, physician and nurse practitioner interviews, the facility failed to identify and provide treatment for a resident who displayed mental and psychosocial adjustment difficulty for one of one residents reviewed for choices (Resident #50) which resulted in Resident #50's continued verbalizations of wanting to die. The findings included: Resident #50 was admitted to the facility 7/21/16. Cumulative diagnoses included, in part, dementia and history of cerebrovascular accident (CVA). A psychiatric consultation dated 7/15/16 and obtained while Resident #50 was in the hospital stated Resident #50 had a history of dementia and stroke. He was brought to the hospital secondary to increased agitation and anger outbursts especially towards his wife. The consultation stated Resident #50's granddaughter had noted that Resident had become increasingly angry and irritable. He had voiced feelings of hopelessness with suicidal ideation and threatened to kill himself if he could not get his way at home. He was not on any psychotropic medications. Diagnostic impression stated the following: vascular dementia, major cognitive disorder, vascular type with behavioral disturbances, vascular type dementia. Recommendations included: Add Trileptal (anti-epileptic medication that can also be described to treat mood disorders) to help with mood control, as well as agitation control. A hospital discharge summary dated 7/21/16 stated, in part, per wife and granddaughter, over the past year patient had been having worsening	F 319	1. An order was obtained on 9-21-16 for resident #50 for psychological consult. An order was obtained on 10-4-16 for Zoloft 50mg by mouth daily for depression and Buspar 10mg by mouth daily for anxiety by the medical director Dr. Kepp. Resident #50 was seen by Dr. Christopher Runge, PhD, Licensed Psychologist on 10/17/16. Resident #50 has a scheduled follow up visit with OnSite psychiatric services for 10/20/16. 2. All residents will be reviewed/evaluated by the Social Services Director, MDS Coordinator, Director of Clinical Services and/or Unit Manager using section D Mood of the MDS to identify any psychosocial needs by 10-14-16. Upon review and evaluation no residents exhibited suicidal thoughts or ideation. 3. The Interdisciplinary Team, which includes the Director of Clinical Services, Unit Manager, MDS Coordinator, Activities Director, Dietary Manager and Social Services Director, will be re-educated by the Regional MDS Coordinator by 10-20-16 related to identifying psychosocial needs as related to the MDS. The Regional Director of Nursing will re-educate the Director of Clinical Services and Unit Manager by 10-20-16 on identifying and addressing psychosocial needs. The Director of Clinical Services will re-educate all nursing staff, including weekend and PRN nursing staff, on facility policy of “To ensure the safety of any resident that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

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F 319	Continued From page 29 memory, increasingly agitated, not allowing his wife to take care of him at home with activities of daily living, showing progression throwing objects across the room. Resident #50 had also been expressing ideations of suicide. A review of admission physician orders dated 7/21/16 revealed an order for Trileptal 150 milligrams by mouth twice daily. A nursing note dated 7/22/16 stated Resident #50 had threatened to hit staff when staff were changing his brief. Family stated Resident #50 would throw socks and shoes at times. A nursing note dated 7/27/16 stated Resident #50 expressed anxiety due to family leaving him to go home for the night. He stated to just call the funeral home because he was just going to die if he could not go home. A Social Service Progress Review note dated 7/28/16 stated Resident #50 was able to respond and make himself understood. Current mood status had the following checked as present: "states that life isn't worth living, wished for death or attempts to harm self" . Information was obtained from the clinical record. Referral status indicated referrals would be made as needed. An Admission Minimum Data Set (MDS) dated 7/28/16 indicated Resident #50 was severely impaired in cognition. Resident Mood interview indicated resident #50 had thoughts that he would be better off dead or hurting himself in some way and was documented as having occurred 2-6 days. Verbal behavioral symptoms directed towards others was noted as occurred 4-6 days. Rejection of care occurred 1-3 days.	F 319	expresses the desire to harm themselves. The Director of Clinical Services and the Executive Director are to be notified immediately of any resident that expresses the desire to harm themselves" and facility procedure of "Once a resident expresses the desire to harm themselves, a staff member will remain with the resident until a physician or qualified psychologist evaluates the resident and documents that Resident is not suicidal or at risk for harming self, or until resident is transferred to higher level of care. The nurse will be notified immediately. The nurse will notify the physician and responsible party of the resident's condition. The nurse will notify the Director of Clinical Services and the Executive Director. The nurse will prepare the resident for transfer and ensure a safe transfer to the Emergency Room if ordered" by 10-20-16. The MDS Coordinator, Social Services Director, Unit Manager or Director of Clinical Services will randomly observe 5 residents and review section D on the MDS for 12 weeks then monthly for 3 months to validate any psychosocial needs are identified and addressed. The results of this monitoring will be documented on the facility monitoring tool. Opportunities will be corrected daily by the Social Services Director as identified during these audits. 4. The results of these reviews will be submitted to the QAPI Committee by the Social Services Director for review by IDT members each month for 3 months. The QAPI Committee will evaluate the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 319	Continued From page 30 A Care Area Assessment (CAA) for behavioral symptoms stated Resident #50 had a diagnosis of unspecified Alzheimer's dementia. His mood may have been impaired due to Resident #50 having to remain in the long term care facility. His family was aware of his diagnosis but Resident #50 was unable to completely understand his family's decision of leaving him in a long term care facility. Behaviors would be addressed in the care plan. No referrals were needed at that time. A nursing note dated 8/3/16 at 10:15PM stated Resident #50 said he wanted to drink some poison. He said to give him some arsenic and he wanted to die. A nursing note dated 8/12/16 at 5:30AM stated Resident #50 said "Let me die. I want to die." A nursing note dated 8/20/16 at 9:30PM stated Resident #50 asked the nurse to give him some arsenic. The nurse told him he could not arsenic and he said he would find some. A nursing note dated 8/21/16 at 10:30PM stated Resident #50 was asking again for arsenic. A nursing note dated 9/3/16 at 10:45AM stated Resident #50 was verbally abusive to staff. He tried to hit his nursing assistant and tried to leave the facility via the fire exit on a hall. A review of physician's orders for August and September 2016 for Resident #50 revealed no orders for a psychiatric consult. A review of the care plan for Resident #50	F 319	effectiveness and amend as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

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F 319	Continued From page 31	F 319		

revealed there was not a care plan in place for Resident #50's verbalizations about wanting to die and/or wanting arsenic.

On 9/21/2016 at 2:33PM, an interview was conducted with the Social Worker. She stated she completed the Social Service Progress Review on 7/28/16. She indicated the documentation was correct regarding the statement that Resident #50 said he would be better off dead or hurting himself in some way. The Social Worker said he said that because he found out he was going to be at the facility long term and his family wasn ' t going to take him home. She stated she did not know why she checked "Yes" for referrals on the CAA, then stated no referrals were needed. The Social Worker, during the interview, revealed when she indicated "Yes" for a referral, she would let the nursing staff know so the physician could make a referral for psychiatric services. The Social Worker indicated Resident #50 had changed and was more receptive of his placement. She stated weekly meetings were held with the Director of Nursing or one of the nursing staff, MDS nurse, Activity staff, dietary staff and herself. At the meeting, they discussed any residents that exhibited behaviors that were totally different for the normal and/or residents that were not acting like themselves. She revealed, during the interview, that she was not aware of any behaviors that had occurred within the last month and had not been informed of any behaviors since July 2016. If she had been informed of Resident #50's verbalizations about wanting to die/ wanting arsenic since July, the behaviors would have been care planned and the team would have had a meeting about the behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 319	Continued From page 32	F 319		

On 9/21/2016 at 3:34PM, an interview was conducted with the Director of Nursing. She stated, if a resident had a behavior problem, nursing staff would communicate it through the 24 hour report, document the behavior in the resident's medical record and on the nursing assistant report for suggestions on how to work with the resident and approaches to use in dealing with the behavior. If it was a suicidal ideation, she expected the nurses to notify the family, the physician, the Administrator and herself. The Director of Nursing, during the interview, revealed that she had not been informed by anyone that Resident #50 had made statements regarding wanting arsenic or making statements about wanting to die, etc. She said she was only aware of Resident #50 being aggressive with his family and he should have had a psychiatric evaluation when the first episode occurred on 7/27/16.

On 9/21/2016 at 4:02PM, an interview was conducted with Nurse # 1. She stated when a resident exhibited behaviors that were harmful, she documented the behaviors in the resident's medical record and on the 24 hour report record and would notify the physician. She revealed that Resident #50 would sometimes make the statements about wanting arsenic and wanting to die in from of his wife. When he made those statements, nursing staff would keep checking on him and there was not any way he could get arsenic in the facility. He would tell her later on the next day that he really didn't want to harm himself but he was upset. He told her he said stuff like that so his wife would be told and she would stay with him longer. Nurse #1, during the interview, said she guessed she should have charted about his comments that he really didn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 319	Continued From page 33	F 319		

want to harm himself. In her nursing judgment, she did not think he would do anything to cause the family pain. Nurse #1 revealed she was not aware that he had not been seen by psychiatric services. She indicated she did write the information down on the 24 hr. report on 8/3/16 and 8/21/16 and may have put the information down for the physician but she did not call the physician.

On 9/21/2016 at 5:45PM, an interview was conducted with Resident #50's physician. He stated he did not pay any attention to the discharge summary from the hospital. He said Resident #50 did have a psychiatric consult when he was in hospital and Resident #50 did become distraught in August. He spoke to Resident #50 who told him he was homesick and just wanted to go home. Arrangements were made for family discharge planning on 8/9/16 and Resident #50 was scheduled to go home on 8/13/16 but the family refused to take Resident #50 home. The physician indicated he spoke to the Social Worker who informed him that the family said they could not care for Resident #50 at home. The physician said he had some talks with Resident #50 and he felt that the talks helped Resident #50. The physician revealed that he was aware of Resident #50 stating he wanted arsenic one time and was not aware of the pattern of how frequently he made those comments. If he had been made aware of the frequency of the comments, he would have ordered a psychiatric consult.

On 9/22/2016 at 8:05AM, an interview was conducted with the Nurse Practitioner. She stated she had reviewed Resident #50's record when he was admitted on 7/21/16 and had seen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 319	Continued From page 34 Resident 50 only once or twice since his admission. She indicated he had denied any suicidal thoughts or that he would hurt himself when she spoke to him. She revealed that the facility had not communicated to her any concerns regarding Resident #50 and she was not aware of any of the times that Resident #50 had verbalized he was going to harm himself.	F 319		
F 431 SS=E	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	F 431		10/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

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(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 431	Continued From page 35 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 observation, manufacturer's instructions and staff interviews, the facility failed to discard a single dose vial of Cyanocobalamin (Vitamin B12) and date an opened vial of Lantus insulin in one of three medication carts (medication cart for B/E halls). The facility also failed to dated opened foil packets of Budesonide inhalation vials in three of three medication carts. The findings included: 1. On 9/22/16 at 11:02AM, an observation of the C/D hall medication cart was conducted with Nurse #3. There was an opened foil pack of Budesonide inhalation (used to prevent symptoms of asthma) observed with four (4) vials inside of the foil pack. The opened foil had no date of opening. Manufacturer's instructions on the box read "Once the foil/ envelope is opened, use the vial/ ampule within two (2) weeks." On 9/22/16 at 11:02AM, Nurse #3 stated she did not open the foil pouch and the foil pouch should have been dated when it was opened. On 9/22/16 at 11:41AM, an interview was conducted with the Director of Nursing who stated she expected nursing staff to date the Budesonide foil pouch when it was opened.	F 431	1. Single dose vial of Cyanocobalamin, opened vial of Lantus insulin not dated and Budesonide inhalation not dated was discarded by the Director of Clinical Services on 9-22-16. 2. An audit of all medication carts and medication room was performed by the Director of Clinical Services to ensure all mediations are in date and dated when opened on 10/14/16. No expired medications were found as a result of the audit. 3. The Director of Clinical Services or Unit Manager will re-educate Licensed Nursing staff regarding expired medications to include dating of medications when opened, and that 11-7 licensed nurses are responsible for checking med carts and med room daily by 10/20/16. The Director of Clinical Services or Unit Manager will randomly audit all 3 medication carts and the medication room 2 times per week for 12 weeks then monthly for 3 months to validate no expired medications and medications required are dated when opened. Opportunities will be corrected by the Director of Clinical Services or Unit Manager as identified during these audits.	

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	345442	A. BUILDING _____ B. WING _____	C 09/22/2016

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F 431	Continued From page 36 2. a. On 9/22/16 at 11:05AM, an observation of the B/E hall medication cart was conducted with Nurse #2. There was an opened foil pack of Budesonide inhalation (used to prevent symptoms of asthma) observed with four (4) vials inside of the foil pack. The opened foil had no date of opening. Manufacturer's instructions on the box read "Once the foil/ envelope is opened, use the vial/ ampule within two (2) weeks." On 9/22/16 at 11:05AM, Nurse #2 stated she did not open the foil pouch and was unaware that the Budesonide foil pouch was supposed to be dated when it was opened. On 9/22/16 at 11:41AM, an interview was conducted with the Director of Nursing who stated she expected nursing staff to date the Budesonide foil pouch when it was opened. 2. b. On 9/22/16 at 11:05AM, an observation of the B/E hall medication cart was conducted with Nurse #2. There was a single dose vial of Cyanocobalamin that was opened with a small amount of the medication still in the vial. On 9/22/16 at 11:05AM, Nurse #2 stated the Cyanocobalamin was a single dose vial that should be used one time and then discarded. She stated the vial should have been discarded. O 9/22/16 at 11:41AM, an interview was conducted with the Director of Nursing who stated the Cyanocobalamin was a single dose vial and should have been discarded.	F 431	4. The results of these reviews will be submitted to the QAPI Committee by the Director of Clinical Services for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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F 431	Continued From page 37	F 431		

2. c. On 9/22/16 at 11:05AM, an observation of the B/E hall medication cart was conducted with Nurse #2. There was a vial of Lantus insulin that was opened and undated.

A review of the pharmacy recommendations dated September 29, 2014 revealed that all insulin vials should be dated when opened and discarded 28 days after opening except Levemir, Novolin R, Novolin N and Novolin 70/30 which can be used up to 42 days after opening and Humulin which can be used up to 31 days after opening.

On 9/22/16 at 11:05AM, Nurse #2 stated the Lantus insulin should have been dated when it was opened.

On 9/22/16 at 11:41AM, an interview was conducted with the Director of Nursing who stated the Lantus insulin should have been dated when it was opened.

3. On 9/22/16 at 11:27 AM the Medication Cart for A and F Halls was observed with Nurse #4. A box of Budesonide inhalation medication was present and inside the box there was an opened foil package containing two individual doses of Budesonide. There was no opened date written on the foil package. Further inspection of the foil package revealed the following " Once the foil envelope is opened, use the vials within two weeks. Date Opened _____ " (the space for the date was blank).
On 9/22/16 at 11:29: AM interview with Nurse #4 revealed that the Nurse who opened the Budesonide was responsible for dating it. She acknowledged it was not possible to know when the Budesonide should be discarded after

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F 431	Continued From page 38 opening, without the opened date present on the foil package. Nurse #4 also indicated she had been unaware it was undated. On 9/22/16 at 11:41 AM the Director of Nursing (DON) was interviewed. She indicated that it was her expectation that Nurses date the Budesonide when they opened it.	F 431		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520		10/20/16

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F 520	Continued From page 39 Based on medical record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and to monitor the interventions the committee put into place following the 10/11/15 recertification survey. This was for two deficiencies which were recited during the facility's 9/22/16 recertification survey in the areas of Assessment Accuracy (F278) and Develop Comprehensive Care Plans (F279). The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. a. F278 Assessment Accuracy: Based on record review and staff interview the facility failed to code the Minimum Data Set (MDS) assessment accurately for Preadmission Screening and Resident Review (PASRR) level II (Resident #21), life expectancy (Residents #21 and #67), hospice care (Resident #21), medications (Residents #27, #76, and #8) and pressure ulcers (Resident #16) for 6 of 17 sampled residents. During the 10/11/15 recertification survey the facility had a F278 citation for failing to accurately code the MDS assessments under the area of smoking and for actual height and weight. b. F279 Develop Comprehensive Care Plans: Based on medical record review and staff interviews, the facility failed to develop a care plan for a resident who expressed suicidal thoughts and ideations (Resident #50) for one of one residents reviewed for choices. During the 10/11/15 recertification survey the	F 520	1. The Executive Director held a Quality Assurance Performance Improvement meeting on 10-17-16 with the Interdisciplinary Team including the Director of Clinical Services, Social Services, Dietary Manager, Admissions Director, MDS Coordinator, Activities Director, Medical Records Director and Business Office Manager focusing on the citations of MDS accuracy and Developing of Care plans. The facility Quality Assurance reviewed the new plan of correction for maintaining compliance in these areas. During the quality meeting the committee reviewed audits completed in relation to F278. Audits identified 6 corrections related to section N of the MDS, and corrections were made on 10/19/16 by the Director of Clinical Services. Committee also reviewed audits completed in relation to F279. Audit was completed 10/14/16, and no residents were identified to be exhibiting suicidal thoughts or ideation. Plan of Correction was reviewed and approved by the Quality Assurance Committee. 2. During the Quality Assurance Performance Improvement on 10-17-16 the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of any identified deficiency to assure compliance and quality are maintained. 3. The Quality Assurance Performance Improvement Committee will continue to meet on at least a monthly basis	

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F 520	Continued From page 40 facility had a F279 citation for failing to develop a care plan for care areas identified as needing a care plan on the most recent Care Area Assessment, failed to care plan smoking and failed to care plan behaviors. During interview with the Administrator on 9/22/16 at 12:40 PM he stated that he felt the recurrent deficiencies of F278 and F279 had to do in part with changes of the staff completing the MDS and care plans. He added that he had recently hired a new Director of Nursing that had a strong background in MDS and care planning and that he had hired her in part for that skill set so the repeat deficiencies could be addressed.	F 520	identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Regional Vice President of Operations and or the Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for 6 months then quarterly for 2 quarters for validation. Opportunities will be corrected as identified by the Executive Director. 4. The results of theses reviews will be submitted to the Quality Assurance Performance Committee by the Executive Director for review by Interdisciplinary members each month for 6 months then quarterly for 2 quarters. The Quality Assurance Performance Committee will evaluate the effectiveness and amend as needed.	