PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY OMPLETED	
		345442	B. WING _	· · · · · · · · · · · · · · · · · · ·		09/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 280 SS=D	PARTICIPATE PLANI 483.10 (c)(2) The right to part and implementation or plan of care, including (i) The right to participate including the right to be included in the plan request meetings and revisions to the person (ii) The right to participate expected goals and or amount, frequency, and other factors related to plan of care. (iv) The right to receivance included in the plan of care. (v) The right to see the right to sign after sign of care. (c)(3) The facility sharing to participate in shall support the resign planning process must be planning process must	pate in the planning process, dentify individuals or roles to nning process, the right to I the right to request in-centered plan of care. pate in establishing the utcomes of care, the type, and duration of care, and any to the effectiveness of the ve the services and/or items of care. The care plan, including the difficant changes to the plan of the resident of the control of the control of the control of the control of the resident and/or ve. The care plan of the resident and/or ve. The control of the resident's control of the resident control of the res	F 2	80		10/13/17
ABORATORY	·	n developing goals of care. SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE		(X6) DATE

10/05/2017 **Electronically Signed**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345442	B. WING			9/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 280	Continued From page	e 1	F 28	30			
	483.21 (b) Comprehensive C	are Plans					
	(2) A comprehensive	care plan must be-					
	(i) Developed within 7 the comprehensive a	days after completion of days after completion of ssessment.					
	(ii) Prepared by an inincludes but is not lim	terdisciplinary team, that uited to					
	(A) The attending phy	vsician.					
	(B) A registered nurse resident.	e with responsibility for the					
	(C) A nurse aide with resident.	responsibility for the					
	(D) A member of food	I and nutrition services staff.					
	the resident and the r An explanation must medical record if the	eticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the					
		staff or professionals in inded by the resident's needs e resident.					
		vised by the interdisciplinary ssment, including both the juarterly review					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			D MANO				
		345442	B. WING			09/	14/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FORREST	OAKES HEALTHCARI	E CENTER			20 HEATHWOOD DRIVE		
				Α	LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	ne 2	F	280			
			200				
	by:	IT is not met as evidenced					
		eview and staff interview, the			1. On 10/2/17, a Quality Assurance		
		ew and revise the plan of care			Performance Improvement (QAPI)		
	1	e of five residents reviewed			meeting was conducted by the Executi	ve	
	for unnecessary me	edications (Resident #11) and			Director to complete a root cause analy		
	for nutrition for two			and to develop corresponding corrective			
	nutrition (Resident #			action to ensure residents' care plans f	or		
	included:				behaviors/mood and nutrition/hydratior	1	
					are reviewed and revised with changes		
		s admitted to the facility on			residents' condition to provide behavior		
	_	es that included dementia,			and nutritional care to meet the goals a		
	delusional disorder,	and depression.			needs of the resident. QAPI committee	;	
	The average Nimina	Data Cat (MDC)			members in attendance included the		
		num Data Set (MDS) 7/1/17 indicated Resident #11 '			Executive Director (QAPI Coordinator)		
		derately impaired. He was			Director of Clinical Services, MDS nurs Unit Manager, Dietary Manager, Socia		
	_	elusions, no hallucinations, no			Worker, Activities Director and Medical		
		ejection of care. Resident #11			Director.		
		chotropic medications.			Birodor.		
	mae met em amy pey				Through Root Cause Analysis and bas	ed	
	The plan of care for	Resident #11 included the			on the findings for Resident #11, it was		
	-	havior/Mood initiated on			determined that the facility failed to		
	12/23/16 and most	recently reviewed on 7/26/17.			implement a new intervention to addres	ss	
	He was indicated to	•			a new behavior to meet the care plan g	joal	
		viors, signs/symptoms of			for the patient. On 9/29/17, the Social		
		chological symptoms of			Worker updated Resident #11		
	*	stance to care. Resident #11			behavior/mood care plan to include a r	iew	
	_	nitive loss, insufficient safety			intervention to appropriately address		
		npliance with care or			residents' behaviors and meet the		
	-	ons of sorrow, refusing care,			residents' behavioral care goals.		
	-	control, cursing, crying, and The interventions included,			On 9/29/17 Resident #11's care plan w	20	
	,	ppropriate behaviors and wait			updated with new interventions including		
		refusing care or treatment.			Family removed knives from residents	.9	
					possession, plastic knives will replace		
	A nursing note date	d 9/3/17 written by Nurse #3			metal knives on meal trays, psychologi	cal	
	_	d Resident #11 had delusional			evaluation and treatment, and psychiat		
		nt #11 reportedly stated to a			evaluation and treatment.		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345442	B. WING			09/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
FORREST		OFNITED		62	0 HEATHWOOD DRIVE		
FORREST	OAKES HEALTHCARE	CENTER		ΑI	LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	fighting. Nurse #3 in redirect Resident #11 was safe at the facilit. A nursing note dated at 8:00 AM indicated,noticed that [Reside stuck down in front of stomach and the elas Resident #11 was ins was not permitted to was removed from hi was noted with delus asked Nurse #3 how himself from all the massured Resident #1 informed him that his locked up. The Direct reportedly informed of A nursing note dated at 1:03 PM indicated mental health provide behaviors. A nursing note dated at 1:29 PM indicated Responsible Party (Rand updated on Resident #11 's plan Behavior/Mood was updated #12 's plan	A) that he needed a himself because of all of the dicated she attempted to and assured him that he y. 9/3/17 written by Nurse #3 "[Nurse #3] to dining room ent #11] had an opened knife in his pants between his stic on his jogging pants." tructed by the nurse that he have the knife and the knife is possession. Resident #11 ional beliefs as he reportedly he was going to protect then going around. Nurse #3 if that he was safe and knife was going to be stor of Nursing (DON) was if Resident #11 's behaviors. 9/3/17 written by Nurse #3 a message was left with the er reporting Resident #11 's 9/3/17 written by Nurse #3 Resident #11 's	F	280	Through Root Cause Analysis and bas on the findings for Resident #9 and #73 was determined that nursing failed to communicate diet and supplement changes to the dietary department who resulted in the failure to update the residents' nutrition/hydration care plandate 9/29/17, the Dietary Manager updated Resident #73 nutrition/hydratic care plan to include current puree diet supplements per RD (Registered Dietitian) recommendations and physic orders. 2. On 10/4/17, the MDS (minimum data set)nurse and Social Worker completed QA (quality assurance) monitoring of 5 current facility residents' behavior/modicare plans to ensure that residents have appropriate interventions in place to address their behavioral care needs. Not discrepancies were identified. On 10/4/17, the MDS nurse, Director of Clinical Services and Dietary Manager completed a QA monitoring of 57 current facility residents' nutrition/hydration care plans to ensure that residents' diet order and current supplement recommendations/orders from 7/1/17-9/30/17 are included to address their nutritional needs. Any identified discrepancies were updated as appropriate. 3. On 10/2/17, the Regional Director of 10/2/17, the Reg	3, it ich On on and da 7 od re o f ers	
	problem of Resident	#11 noted to have had rotect himself. The goals			Clinical Services provided education to the Interdisciplinary Team (IDT) on		

OL. TILIT	O . O	WEDIO/ WE CEITTICE				U.V.D 110	2. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345442	B. WING			09/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 557	
					20 HEATHWOOD DRIVE		
FORREST	OAKES HEALTHCARE	CENTER			LBEMARLE, NC 28001		
(VA) ID	CLIMMADV CT	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	2 4	F:	280			
		id included, "[Resident #11]			Consulate policies and procedures of		
		es of keeping weapons on			reviewing and revising the residents' pl	an	
		revisions made to the			of care when a resident exhibits a new		
	interventions section				behavior, has a change in diet or RD		
		o p.a o. oa. o.			(registered dietitian) recommendations		
	An interview was con	ducted on 9/14/17 at 2:54			and/or physicians' orders to address		
	PM with the SW. The	e nursing notes dated 9/3/17			nutritional needs of the resident.		
		nt #11 was found in the			Education included the roles and		
	dining room with a kn	ife tucked into the resident '			responsibilities of the Social Worker or	1	
	s waistband of his pa	nts was reviewed with the			documenting behavior/mood care plan		
	SW. She stated this	incident had occurred over			changes and the Dietary Manager on		
	the weekend and was	s discussed in the morning			documenting nutrition/hydration care p		
		5/17. She reported the			changes. The IDT members are inclus	sive	
		OON), Unit Manager (UM),			of, but not limited to, the Executive		
		IDS) Coordinator, Activities			Director, Director of Clinical Services,		
		nager, and Dietary Manager			Social Services Director, Activities		
		e at the clinical meeting.			Director, Dietary Manager and Minimul		
		3/17 Resident #11 had been			Data Assessment Nurse. Newly hired		
		e that she thought he had			members will be educated by the Direct	ctor	
		then. She indicated the staff			of Clinical Services upon hire.		
		t reported Resident #11			Licensed pures will decument resident		
	stated he wanted to p	notect minisen.			Licensed nurse will document resident		
	The interview with the	e SW continued. She stated			behaviors using behavior monitoring sheets, 24 HR report, or nurse's notes		
	it was the responsibil				The IDT to review residents' with new	•	
	-	neeting to develop new			behaviors during Daily Clinical Meeting	1	
	interventions for care				and as needed to determine an	,	
		ing the behavioral care			appropriate plan of care, including a ne	•w	
		she updated the plan of care			intervention to address the new behavi		
		wing the clinical meeting on			and meet the patients' care needs. The		
	9/5/17. The plan of c	-			Social Worker, or MDS coordinator in t		
		esident #11 was reviewed			absence of the social worker, is		
	with the SW. The up	dated problem of Resident			responsible for updating the		
		ons on him to protect			behavior/mood care plan with any		
		with the SW. The updated			revisions as appropriate. The Director	of	
	goal of Resident #11	having less episodes of			Clinical Service to review residents wit		
	keeping weapons on	him was reviewed with the			new behaviors during weekly Behavior		
		nterventions to this plan of			Risk meetings to monitor compliance v	vith	
	care for Resident #11	was reviewed with the SW.			updates to the residents' behavior/mod	od	

OL. VILLI	O T OIT MEDIO/ WILL O	MEDIO/ ND CERTIFICE				<u> </u>	7. 0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345442	B. WING			09/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FORREST		OFNITED		62	20 HEATHWOOD DRIVE		
FORREST	OAKES HEALTHCARE	CENTER		Α	LBEMARLE, NC 28001		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 280	Continued From pag	e 5	F	280			
		verified no new interventions were added to			care plan as appropriate.		
		sident #11 's behavior of			oure plan as appropriate.		
	having weapons in h				Licensed nurse will write physician order	er	
	3 1				and send communication form to dietar		
	An interview as cond	lucted was conducted with			manager. The IDT to review residents'		
	the DON on 9/14/17	at 3:05 PM. The nursing			with new nutrition/hydration changes		
		nat indicated Resident #11			during Daily Clinical Meeting to determ		
	was found in the dini			an appropriate plan of care, including a	1		
		vaistband of his pants was			new intervention to address the		
		ON. She stated the incident			nutrition/hydration changes and meet the	ne	
		kend and Nurse #3 had			patients' care needs. The Dietary		
		ncident by phone. She			manager, or MDS coordinator in the		
		butter knife that Resident			absence of the dietary manager, is		
	-	ssion. She reported she was knife it was, but it was not a			responsible for updating the nutrition/hydration care plan with any		
		ad obtained from the facility.			revisions as appropriate. The Director	nf	
		se #3 had removed the knife			Clinical Service to review residents with		
		dication cart for safety. She			new nutrition/hydration orders during	•	
		earched Resident #11 's			weekly weight meetings to monitor		
	·	were no other weapons.			compliance with updates to the resider	ıts'	
	The DON indicated s	she instructed Nurse #3 to			nutrition/hydration care plan as		
	contact Resident #11	I 's family to inform them of			appropriate.		
	the incident and to fir	nd out how Resident #11 had					
		She reported Nurse #3 had					
	_	e mental health provider and					
		a secured text messaging			4. The Director of Clinical Services to		
	system. The DON st				complete quality assurance monitoring		
	instructed to observe				5 random residents to ensure residents	3	
	frequently that day a				with new behaviors have a new		
	indicated this was for	eal trays that day. She			intervention updated on the residents' behavior/mood care plan and residents		
	maioaioa imo was ioi	one day only.			nutrition/hydration care plans have	•	
	A phone interview wa	as conducted with Nurse #3			accurate diet type and supplements as		
		M. She stated she had been			recommended and/or ordered. Monitor		
		for over three years. She			to be completed at a frequency of 3 da	-	
		orking on 9/3/17 when			per week for 4 weeks then, 1 time per	•	
		und in the dining room with a			week for 8 weeks, then monthly therea	fter	
		resident 's waistband of his			as determined by the Quality Assuranc		
	pants. Nurse #3 revi	iewed the events that			Performance Improvement (QAPI)		

PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR I	<u>MEDICARE & I</u>	MEDICAID SERVICES				<u>OMB NO</u>). 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		345442	B. WING _			09/	14/2017
NAME OF PROVIDER O	OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
FORDEST OAKES	UEALTUCADE (CENTER		62	20 HEATHWOOD DRIVE		
FORREST OAKES	HEALINGARE (JENIER		Α	LBEMARLE, NC 28001		
	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
occurre reporter noticed She statucked describ be fold stated blade for blade with the stated blade with the s	ed she went into a something unated she pulled into the waistbook the knife as ed to close the the knife was in tully out of the has approximated she asked Foodo with the kning around cu. She stated she gotten the knife er skinning knift did Resident #11 shot permitted ated she took to ked it in the mass searched Red two other "kitch infe", and a pailed these items exked them in the did she messager and physicial of the DON by pent #11 's family health provide build be seen the grand she was an responded. For came to the see the knives and stated the counter the see the knives and the see the knives and the was an responded.	ith Resident #11. She to the dining room and der Resident #11 's shirt. If up his shirt and saw a knife to and of his pants. She to a hunting knife that could blade into the handle. She to the open position with the to handle. She reported the to tely 4 inches long. Nurse Resident #11 what he was nife and he said, "the men tutting up people around to asked Resident #11 where the from and he said it was fe". She indicated she had to have a weapon on him. the knife from Resident #11 edication cart. She reported to have a weapon on him. the knife from Resident #11 edication cart. She reported to sident #11 's room and to have a weapon on him. The knife from Resident #11 edication cart. She stated she from Resident #11 's room the medication cart. Nurse #3 the dication cart. Nurse #3 the dication cart health to no the paging system, she thone, and she contacted ty member. She stated the the responded that Resident the next time they were in the tunable to recall what the Resident #11 's family facility later that afternoon to d pliers. The family we how Resident #11	F2	280	Committee to maintain compliance. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. 5. The Executive Director is responsible for the implementation and execution of this plan.	ad ass ttive t,	

The phone interview with Nurse #3 continued.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			9/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCAR	E CENTER	•	STREET ADDRESS, CITY, STATE, ZIP (620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 280	but this was the first type of weapons. Since the continuous of that do that information. Since the nurse is sobserved on a normal Resident #11 had in knife after the incidicated (9/3/17) there with the facility for own with Resident #11. Working on 9/3/17 with the dining room with Resident in the dining room with the hallways, the dissident #11 routing the hallways, the dissident #11 was a had calmed down the diditional incidents resident #11 was a his meals for the resident with resident #11 was a his meals for the resident #11 w	at #11 was delusional at times, at incident of him having any of the reported she thought the limit every 15 minutes for the ay (9/3/17), but she not sure of the indicated Resident #11 of his time in the hallways or tation so he was easily mal basis. Nurse #3 reported not said anything about the tent. She indicated since that were no new interventions	F 2	280			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTR	RUCTION		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			09	/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		620 HEATI	DDRESS, CITY, STATE, ZIP CODE HWOOD DRIVE ARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 280	9/14/17 at 4:15 PM. worked at the facility she was familiar with indicated she was av Resident #11 was for knife tucked into the pants. She confirme interventions implem incident. A follow up interview DON on 9/14/17 at 4 her expectation for crevised as needed. 2. Resident #9 was in on 8/22/08 and most 2/7/15 with multiple of dementia. The annual Minimum 10/17/16 indicated R severely impaired. Sassistance of one stawas on a mechanica swallowing concerns significant weight los The Care Area Asses Nutrition for the 10/2 #9 's diet texture was A physician 's order downgrade to Reside mechanical soft to put A diet order and comments.	She indicated she had for about 3 to 4 months and a Resident #11. She ware of the 9/3/17 when und in the dining room with a resident 's waistband of his d there were no new ented after the 9/3/17 was conducted with the :45 PM. She indicated it was are plans to be reviewed and initially admitted to the facility recently readmitted on diagnoses that included in Data Set (MDS) dated resident #9 's cognition was the required the extensive aff for eating. Resident #9 lly altered diet, she had no and was assessed with no second in the company of	F 2	280				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 280	focus category of Nu of care was initiated recently reviewed on included, in part, a management of the dietime the care plan was resident #9. An interview was corn Assistant (NA) #2 on stated she was family reported Resident #9. An interview was corn Nursing (DON) on 9/1/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	Resident #9 included the trition/Hydration. This plan on 10/14/16 and was most 7/13/17. The interventions techanical soft diet for adducted with Nursing 9/14/17 at 10:22 AM. She iar with Resident #9. She is was on a pureed diet. Inducted with the Director of 14/17 at 10:35 AM. She Manager (DM) was wing and revising care plans and the diet order and dated 6/16/17 that indicated exture was changed from ureed was reviewed with the elated to Nutrition for	F 2	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			9/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•	 	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 280	on 9/14/17 at 11:15 dated 6/14/17 and communication for Resident #9 's diet mechanical soft to DON. The care pla Resident #9 that in mechanical soft die She verified this caresponsibility of the current DM began 7/17/17. She state plans to be reviewed.	was conducted with the DON 5 AM. The physician 's order	F2	280			
	4/25/17 and readm diagnoses included swallowing) and gather An Admission Minimindicated resident Supervision was rewas documented at A Care Area Assest dated 5/1/17 stated some episodes of cregular mechanical thin liquids. Residemeals in the dining herself without suptriggered due to the elevated BMI (body mechanically altered A Quarterly MDS diesident #73 was a limited assistance with the swallow and the same and the	itted on 8/9/17. Cumulative I dysphagia (difficulty Istroesophageal reflux disease. Inum Data (MDS) dated 5/2/17 It 73 was cognitively intact. It quired with eating. Weight Is 147 pounds. Is ment (CAA) for nutrition I Resident #73 was alert with I Resident #73 was alert with I confusion. She received a I soft no added salt diet and I soft no added salt diet and I with the confusion of the could feed I with the confusion. The CAA was I was erapeutic diet as well as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345442	B. WING _			09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	revealed an order fo 60 cubic centimeters day for nutritional sure A review of the Augur Record (MAR) indicated Pass 2.0 60 cc three times daily from A care plan was initiated to a reviewed 8/9/17 for an and eating less than Resident #73 would status as evidenced no signs or symptom Interventions include facility protocol. Sna specified. Assign sea and serve diet (no di intervention for the ucare plan. A Registered Dieticia stated, in part, Residloss over 3 months. Dounds. Weight had last 3 months. Weigweekly. Resident #7 related to a readmissi Weight on readmissisi	ician orders for August 2017 r Med Pass 2.0 (supplement) s (2 ounces) three times a pport. Ist Medication Administration ated Resident #73 received (cubic centimeters) 2 ounces m 8/1/17 through 8/5/17. Intended on 5/12/17 and last nutrition due to poor intake 25% of meals. Goals stated maintain adequate nutritional by maintaining weight with	F 2	80			
	approximately 129.5 discharged to hospit with lunch meal and	nission weight on 8/9/17 was pounds. Resident #73 was all prior to frozen treat starting med pass 2.0 60 cc three restarted on readmission					

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345442	B. WING		,	09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 280	to monitor weight par Recommend restart times daily and add every day. A physician order day 2.0 60 cc. three time order for frozen treatray daily. On 9/14/17 at 10:18 conducted with the the Food Service Dinitiating and updati. On 9/14/17 at 11:18 conducted with the stated she was responding and updation. She state nutrition care plan by the she would make the occurred. She state frozen treats should plan. On 9/14/17 at 11:29 conducted with the she expected the careviewed and revised 3. b. Resident #73 4/25/17 and readmidiagnoses included swallowing) and gas An Admission Minimindicated resident #	w mechanical soft. Continue attern weekly until stabilized. To fined pass 2.0 60 cc three a frozen treat to lunch meal atted 9/7/17 stated Med Pass as daily. There was also an att (supplement) on her lunch at AM, an interview was a most of the nutrition care plan. AM, an interview was a food Service Director who consible for the care plans for a fifther were changes to the netween care plan meetings, as changes at the time they at the Med Pass 2.0 and the land have been added to the care at AM, an interview was a director of Nursing who stated are plan to be followed and at as needed. Was admitted to the facility on ted on 8/9/17. Cumulative dysphagia (difficulty stroesophageal reflux disease. The most and the stroes of the stroesophageal reflux disease. The most and the stroesophageal	F 28				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345442	B. WING			9/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001		<u> </u>	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 280	dated 5/1/17 stated some episodes of coregular mechanical thin liquids. Resident meals in the dining therself without superingered due to the elevated BMI (body mechanically altered A Quarterly MDS da Resident #73 was colimited assistance with documented as 130 or gain. A care plan was initial reviewed 8/9/17 for and eating less than Resident #73 would status as evidenced no signs or symptom Interventions include facility protocol. Sna specified. Assign se	ment (CAA) for nutrition Resident #73 was alert with onfusion. She received a soft no added salt diet and int #73 liked to receive her room where she could feed ervision. The CAA was rapeutic diet as well as mass index) and id diet. Proceed to care plan. Inted 7/23/17 indicated ognitively intact. She required with eating. Weight was pounds with no weight loss Inted on 5/12/17 and last mutrition due to poor intake in 25% of meals. Goals stated maintain adequate nutritional by maintaining weight with ins of malnutrition. The determinant weight sper marks-no specific snacks were ating at meal time. Provide	F 28				
	intervention for the care plan. Weekly with the care plan. On 9/14/17 at 10:18 conducted with the lithe Food Service Di initiating and updation. On 9/14/17 at 11:18 conducted with the lithe food service Di initiating and updation.	iet specified). There was no use of supplements on the weights were not indicated on AM, an interview was MDS Coordinator who stated rector was responsible for any the nutrition care plan. AM, an interview was Food Service Director who consible for the care plans for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345442	B. WING _			09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER	•	STREET ADDRESS, CITY, STATE, 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 280	nutrition. She stated nutrition care plan be she would make thosoccurred. She stated have been added to On 9/14/17 at 11:29 conducted with the Dishe expected the car reviewed and revised. 3. c. Resident #73 v. 4/25/17 and readmitt diagnoses included of swallowing) and gast An Admission Minimulated resident #7 Supervision was required as A Care Area Assess dated 5/1/17 stated F some episodes of coregular mechanical sthin liquids. Resident meals in the dining reself without super triggered due to the elevated BMI (body mechanically altered A Quarterly MDS dat Resident #73 was colimited assistance wi	if there were changes to the etween care plan meetings, se changes at the time they diveckly weights should the care plan. AM, an interview was birector of Nursing who stated re plan to be followed and dias needed. Was admitted to the facility on ed on 8/9/17. Cumulative dysphagia (difficulty troesophageal reflux disease. Jum Data (MDS) dated 5/2/17 as was cognitively intact. Juired with eating. Weight 147 pounds. The CAA) for nutrition Resident #73 was alert with infusion. She received a oft no added salt diet and the transport of the community of the com	F 2	280			
		ated on 5/12/17 and last autrition due to poor intake					

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
	345442	B. WING		0	9/14/2017	
OAKES HEALTHCARE	CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•		
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	
and eating less than 2 Resident #73 would r status as evidenced to no signs or symptoms Interventions included restorative dining produced for a restorative dining produced for a restorative dining as a resident needed a for a restorative dining complete a form requirestorative dining associated for the resident for a restorative dining associated for the resident #73 for restorative dining. On 9/14/17 at 10:18 A conducted with the M the Dietary Manager nutrition care plan on employed at the facili unaware that the restorative dining. On 9/14/17 at 11:29 A conducted with the D she expected the care reviewed and revised 483.25(d)(1)(2)(n)(1)-4 and 12.20 A conducted with the D she expected the care reviewed and revised 483.25(d)(1)(2)(n)(1)-6 and 12.20 A conducted with the D she expected the care reviewed and revised 483.25(d)(1)(2)(n)(1)-6 and 12.20 A conducted with the D she expected the care reviewed and revised 483.25(d)(1)(2)(n)(1)-6 and 12.20 A conducted with the D she expected the care reviewed and revised 483.25(d)(1)(2)(n)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	25% of meals. Goals stated naintain adequate nutritional by maintaining weight with a of malnutrition. d, in part, to assess for a gram (undated). all record revealed there in that an assessment was rative dining program. M, an interview was beech therapist. She stated, an assessment completed go program, nursing would esting therapy for a essment and what would be interested to be safe with dining. The remember assessing porative dining and, to her and the first and the				10/13/17	
HAZARDS/SUPERVI	SION/DEVICES					
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC' REGULATORY OR LETT.) Continued From page and eating less than 2 Resident #73 would no status as evidenced to no signs or symptoms. Interventions included restorative dining programmer of the medical was no documentation completed for a restorative dining as for a restorative dining as for a restorative dining associated with the Spif a resident needed as for a restorative dining complete a form requirestorative dining associated with the Spif are sident #73 for restorative dining. On 9/14/17 at 10:18 A conducted with the M the Dietary Manager of the needed at the prestorative dining. On 9/14/17 at 10:18 A conducted with the M the Dietary Manager of the needed at the facilial unaware that the restorative dining. On 9/14/17 at 11:29 A conducted with the Dietary Manager of the needed at the facilial unaware that the restorative dining. On 9/14/17 at 11:29 A conducted with the Dietary Manager of the present of the prese	CORRECTION 345442 ROVIDER OR SUPPLIER OAKES HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 and eating less than 25% of meals. Goals stated Resident #73 would maintain adequate nutritional status as evidenced by maintaining weight with no signs or symptoms of mainutrition. Interventions included, in part, to assess for a restorative dining program (undated). A review of the medical record revealed there was no documentation that an assessment was completed for a restorative dining program. On 9/14/17 at 8:48 AM, an interview was conducted with the Speech therapist. She stated, if a resident needed an assessment completed for a restorative dining program, nursing would complete a form requesting therapy for a restorative dining assessment and what would be needed for the resident to be safe with dining. She said she did not remember assessing Resident #73 for restorative dining and, to her knowledge, resident #73 was never assessed for restorative dining. On 9/14/17 at 10:18 AM, an interview was conducted with the MDS Coordinator who stated the Dietary Manager who had completed the nutrition care plan on 5/12/17 was no longer employed at the facility. She said she was unaware that the restorative dining assessment had not been done. On 9/14/17 at 11:29 AM, an interview was conducted with the Director of Nursing who stated she expected the care plan to be followed and reviewed and revised as needed. 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT	A BUILDING 345442 ROVIDER OR SUPPLIER OAKES HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 and eating less than 25% of meals. Goals stated Resident #73 would maintain adequate nutritional status as evidenced by maintaining weight with no signs or symptoms of malnutrition. Interventions included, in part, to assess for a restorative dining program (undated). A review of the medical record revealed there was no documentation that an assessment was completed for a restorative dining program. On 9/14/17 at 8:48 AM, an interview was conducted with the Speech therapist. She stated, if a resident needed an assessment completed for a restorative dining program, nursing would complete a form requesting therapy for a restorative dining grogram, nursing would complete a form requesting therapy for a restorative dining. She said she did not remember assessing Resident #73 for restorative dining and, to her knowledge, resident #73 was never assessed for restorative dining. On 9/14/17 at 10:18 AM, an interview was conducted with the MDS Coordinator who stated the Dietary Manager who had completed the nutrition care plan on 5/12/17 was no longer employed at the facility. She said she was unaware that the restorative dining assessment had not been done. On 9/14/17 at 11:29 AM, an interview was conducted with the Director of Nursing who stated she expected the care plan to be followed and reviewed and revised as needed. 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT 5 26	CORRECTION Satisfied Sati	A BUILDING 345442 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEPICIENCIES CARD REPOWDERS PLAN OF CORRECTION PREFIX FEBRUATORY OR LSC IDENTIFYING INFORMATION) FE 280 COntinued From page 15 A BUILDING CONTINUED OF THE APPROPRIATE CARD REPOWDERS PLAN OF CORRECTION FREEDY CARD REPOWDERS PLAN OF CORRECTION TAG CONTINUED OF THE APPROPRIATE F 280 F	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/14/2017		
		345442	B. WING				
	ROVIDER OR SUPPLIER OAKES HEALTHCAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 323	(2) Each resident reand assistance dev (n) - Bed Rails. The appropriate alternation bed rail. If a bed or must ensure correct maintenance of bed to the following eler (1) Assess the reside from bed rails prior (2) Review the risks the resident or resident	sure that - vironment remains as free rds as is possible; and eceives adequate supervision ices to prevent accidents. e facility must attempt to use rives prior to installing a side or reside rail is used, the facility t installation, use, and d rails, including but not limited ments. dent for risk of entrapment to installation. s and benefits of bed rails with dent representative and obtain rior to installation. bed's dimensions are resident's size and weight. NT is not met as evidenced ions, record reviews, and dent, family, staff,	F 323	,	g		
	Based on observatinterviews with resign psychologist, and in practitioner, the face 's safety when an improperly positions when transferred by lift. The improper pachair tipping backwithe chair onto the flisized hematoma to	dent, family, staff, nental health nurse ility failed to ensure a resident mmobile resident was ed in a geriatric (geri) chair		Performance Improvement (QAPI) meeting was conducted by the Execu Director to complete a root cause analysis and to develop correspondin corrective action to ensure immobile	g ance sfers of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345442	B. WING _	B. WING		09/14/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	0.4450.115.41.5110.455	05)1550		6	20 HEATHWOOD DRIVE		
FORREST	OAKES HEALTHCARE	CENTER		Α	LBEMARLE, NC 28001		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	e 17	 F:	323			
	. •				Coordinator), Director of Clinical Service	es.	
	The findings included	l:			MDS nurse, Unit Manager, Dietary	,	
	J				Manager, Social Worker, Activities		
	Resident #2 was initia	ally admitted to the facility on			Director and Medical Director.		
	9/27/10 and most red	ently readmitted on 7/31/17					
	with multiple diagnos	es that included history of			Through Root Cause Analysis and bas	ed	
	stroke, seizure disord	ler, contracture of			on the findings for Resident #2, it was		
	unspecified joint, and	dementia.			determined that the facility failed to ens		
					that a nursing assistant followed the pla		
		Data Set (MDS) dated			of care related to providing two-person		
		sident #2 ' s cognition was			assist with a mechanical lift during		
		he was assessed with no			resident transfer for an immobile reside		
		ection of care. Resident #2		resulting in improper positioning and a with injury from her Geri chair. Residen			
		dent on two or more staff pendent on one staff with	#2 continues to be transferred with			ı	
		unit, dressing, toileting,	two-person assistance and use of				
		d bathing. She was coded		mechanical lift per plan of care to pro			
		nsive assistance of two or			accidents with no further incidents.		
		nobility. Resident #2 was not					
		d was only able to stabilize			2. On 10/11/17, the Director of Clinical		
	with staff assistance	for surface to surface			Services and licensed nurse superviso	rs	
	transfers. The follow	ing activities were listed as			completed a QA (quality assurance)		
		ident #2 during the 7 day			monitoring of immobile residents requir	ing	
		d: moving from seated to			two-person assistance and use of		
		lking, turning around, and			mechanical lift with transfers by review	ing	
	_	e toilet. Resident #2 had			residents' plan of care and Kardex for		
		ides of the upper and lower			accuracy and by visual observations		
		utilized a wheelchair. She			during all 3 shifts (7a-3p, 3p-11p and	4-	
	and bladder. She ha	ays be incontinent of bowel			11p-7a) with transfers per plan of care prevent accidents. No further	ιο	
	and bladder. She ha	u no fails noted.			discrepancies were identified.		
	The Care Area Asses	ssment (CAA) related to falls			aisorcpaniolos wore lucituneu.		
	for the 7/21/17 annua	* *			3. Beginning 10/2/17 and completed	ĺ	
		2 required extensive to			10/11/17, the Director of Clinical Service	es	
		e with most Activities of Daily			and RN supervisor designee provided	-	
	T	vas assessed as requiring			competency based education to all nur	se	
		nical lift for transfers.			aides and licensed nurses, including P		
		ecent falls, but was noted at			and weekend staff, on following the		
	an increased risk due	e to the assistance she			residents' plan of care for immobile	ľ	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			09	/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				620	0 HEATHWOOD DRIVE		
FORREST	OAKES HEALTHCAR	RE CENTER		AL	BEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From pa	age 18	F.3	323			
	needed.	.90 10	'	,20	recidents requiring two person assistan	200	
	needed.				residents requiring two-person assistar with a mechanical lift during transfers t		
	The fall rick evalua	tion dated 7/31/17 indicated			prevent accidents. Education also	J	
		trisk for falls. She was			included the proper positioning		
		ented, chair bound, poor vision			requirements of immobile residents into	n a	
	status, and unable				Geri chair with the aide of two persons		
	Status, and anabis	to claire.			ensure resident safety. Newly hired nu		
	The plan of care fo	r Resident #2 related to ADLs,			aides and licensed nurses will be		
		indicated she had an ADL			educated upon hire. Continuing educat	ion	
		nce deficit, limited range of			will be provided on a semi annual basis		
		oility, and activity intolerance.			·		
	The ADL intervention	ons for Resident #2 included,			Nursing aides and licensed nurses to		
	in part, 1-2+ assista	ance with bed mobility, transfer			transfer immobile residents by providin	g	
	assistance, and a r	mechanical lift for transfers.			two-person assistance and use of		
					mechanical lift to aide in the proper		
		r Resident #2 related to safety indicated she had the potential			positioning and prevention of accidents) .	
	for injury, poor safe	ety awareness, poor			4. The Director of Clinical Services or L	_PN	
		story of seizures, and			supervisor to complete quality assuran	ce	
		. The safety interventions for			monitoring of three (3) immobile		
		ed, in part, a mechanical lift for			residents, randomly across all shifts ar		
	transfers.				weekends, by physical observation of		
					transfers to ensure two-person assista	nce	
		on, Background, Appearance,			with use of mechanical lift for proper		
		Communication Form dated			positioning and prevention of accidents		
	· ·	eted by Nurse #1 indicated an			Monitoring to be completed at a freque	-	
		ccurred at 11:05 AM. A skin			of 3 days per week for 4 weeks then, 1		
		d Resident #2 sustained a golf			time per week for 8 weeks, then month thereafter as determined by the Quality		
		na to the back of her head. A icated Resident #2 had chronic			Assurance Performance Improvement		
	·	ers, arms, and hands. A			(QAPI) Committee to maintain		
	'	ation assessed Resident #2			compliance.		
	_	The Nurse Practitioner (NP)			compliance.		
	_	5/17 at 11:14 AM. The NP			The results of the quality assurance		
		were to monitor and notify of			monitoring to be reported to the QAPI		
		gical changes for Resident #2.			Committee monthly by the Executive		
		, "[Nursing Assistant #1]			Director for twelve months and/or until		
		#1] that Resident #2 was in a			substantial compliance is obtained. Th	ie	
		chair fell back and [Resident			QAPI Committee to evaluate the		

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345442	B. WING	B. WING		09/	09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	written by Nurse #1 a Nursing Assistant (NA had a fall at 11:05 AN stated the geri chair from the chair. Resid hematoma to the bac checks were initiated and the family was not assessed for pain wit symptoms of pain. The symptoms of pain. The symptoms of pain. The "Fall Root Cause 8/15/17 and complete Resident #2 required transfers and a mech The staff summary st. #2 was observed on the staff summary st. #4 was observed on the staff summary st.	e 's note dated 8/15/17 and it 12:00 PM indicated A) #1 reported Resident #2 M. The note indicated NA #1 ell back and Resident #2 fell lent #2 sustained a k of her head. Neurological the physician was notified, offied. Resident #2 was h no abnormal signs or he geri chair was checked and it was noted to be entire the floor by Nurse #1 indicated two staff for assistance with anical lift was to be utilized. Attement indicated Resident the floor by Nurse #1. NA #2 was in her geri chair in the a #2 went into the resident 's side of the resident 's room) to bathroom she heard a d Resident #2 's room and had fallen from the geri /intervention for minimizing as staff re-education due to echanical lift. The Note of the Root Cause and not signed, indicated the the #2: ent: "Resident fell on floor" inwitnessed fall"	F	3323	effectiveness of the monitoring/observation tools for maintaining substantial compliance, an make changes to the corrective action necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultan Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. 5. The Executive Director is responsible for the implementation and execution of this plan.	as tive t,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345442	B. WING		09/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	,
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 323	- Why: "Position - Root Cause: "(The "Report of Res indicated Resident description of the ir #2] found on floor b indicated Resident was found on the fl Resident #2 sustair her head. New inte to be implemented investigation were of geri chair/ [Brand N nursing re-education residents, and com An inservice trainin "Mechanical Lift Co Checklist" was door	ge 20 ottom too far up in chair" ed in chair with use of lift" Geri chair positioning" ident Fall" form dated 8/15/17 #2 fell at 11:05 AM. The icident indicated, "[Resident ehind geri chair." The report #2 slid out of the chair and for in her room by NA #1. Inded a hematoma to the back of erventions that were indicated as a result of the fall one on one re-education on ame mechanical] lift, group In on proper placement of petency/skills checklists. In grecord with the subject of the grecord with the subject of the grecord with t	F 32	23	
	written for the 3:00 Resident #2 's vita concerns, she had status, and no sign: Neurological check identified. The phynew orders were of note indicated a far arrived at the facility sent to the Emerge The physician was Medical Services (Etransport Resident).	rse's note dated 8/15/17 PM to 11:00 PM shift indicated is were assessed with no no changes in cognitive is or symptoms of distress. Is continued with no concerns iscian was updated and no obtained for Resident #2. The nily member of Resident #2 y and requested for her to be ncy Room (ER) for evaluation. Inotified and Emergency EMS) were contacted to #2 to the ER. Resident #2 obeen evaluated at the ER and			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345442	B. WING	 	09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	,	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION	
F 323	An NP progress no Resident #2 was se up to her ER visit fr noted to have faller and hit her head on checks were done lafter the ER visit all baseline for Reside Tomography (CT) s was conducted at the no acute abnormali hematoma to the baseline for the baseline	ge 21 lity with no new orders. te dated 8/16/17 indicated een at the facility for a follow om 8/15/17. Resident #2 was a backwards in her geri chair the floor. Neurological both prior to the ER visit and of which were noted to be ent #2. A Computed can of Resident #2 's head the ER and was reviewed with ties. Resident #2 's eack of her head was assessed empletely resolved within one	F 32	23		
	indicated Resident plan of care change fall were indicated a [Brand Name mechand the geri chair. Resident #2 's plar updated on 8/16/17 a fall on 8/15/17. T staff re-education olift and geri chair. An inservice trainin "[Brand Name] medas provided by the nurses) on 8/16/17 noted to include reachecklist.	e Minutes dated 8/16/17 #2 had a fall on 8/15/17. The es related to Resident #2 ' s as staff education related to hanical] lift policy/procedure of care related to safety was The Resident #2 was noted with the intervention added was on proper use of a mechanical grecord with the subject of chanical Lift" was documented UM to 18 staff (14 NAs and 4 at 7:00 AM. The training was adding materials and skills				
	A list of the nursing unlicensed) employ	staff (licensed and red at the facility on 8/15/17				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345442	B. WING _	B. WING		4/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	DDE		
(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 C ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	staff members (22 No at the facility on 8/15, at the facility on 8/15, An observation was of 9/11/17 at 12:05 PM. a geri chair in the din total assistance to Re Resident #2 was not geri chair during this A family interview wa on 9/11/17 at 3:45 PM reported Resident #2 chair about a month a had hit her head on the head. She report on 8/15/17 and was is slipped and fell out of had gone into the resident #2 chair about a month and hit her head on the head.	cated there were 37 nursing As and 15 nurses) employed (17.) conducted of Resident #2 on Resident #2 was seated in ing room. Staff provided esident #2 with eating. Ed with no movement in the observation. s conducted for Resident #2 M. The family member had fallen out of her geringo. She stated Resident #2 he floor and had a "knot" on ted she spoke with Nurse #1 informed Resident #2 had if the geri chair when NA #1 ident's bathroom. The	F3	323			
	Resident #2 to the hor for her to be sent to the afternoon of 8/15/17. Was not admitted to the facility several hor the ER. Resident #2 expressed concern a slipped out of the ger immobile and was deassistance. An observation was of 9/12/17 at 7:50 AM. In her room. She was answer questions due to the form th	bout how the resident i chair when she was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345442	B. WING		 	09/	14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCAR	E CENTER	•	620	REET ADDRESS, CITY, STATE, ZIP CODE D HEATHWOOD DRIVE BEMARLE, NC 28001		-	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 323	9/13/17 at 10:45 Al familiar with Resider regularly. She veri 8/15/17 when Resichair that resulted in her head. Nurse # s station when NA Resident #2 had fa surprised Resident resident was not m staff and a mechan had no recent falls. Resident #2 's roor (DON) and UM. Sithe room she obserground behind the Resident #2 's entitle mechanical lift beneath her. Nurse had transferred Relift to the geri chair then stepped into F she heard the resident #1 too far forward or to which had caused that Resident #2 when move her body aro. The interview with stated Resident #2 hematoma to the buthe NP was contact were initiated. She alert, had no cognit pain. She clarified pain issues and the	onducted with Nurse #1 on M. She indicated she was ent #2 and she worked with her fied she was working on dent #2 had a fall from her geri in a hematoma to the back of 1 stated she was at the nurse '#1 came up to her and said llen. She revealed she was #2 had fallen because the obile, she was dependent on 2 ical lift for transfers, and she Nurse #1 stated she went to m with the Director of Nursing he indicated when she got to rved Resident #2 lying on the geri chair. She reported re body was on the floor and sling was on the ground he #1 indicated NA #1 said she sident #2 from the mechanical without issue and she had Resident #2 's bathroom when lent fall. Nurse #1 stated she 2 had been positioned either too far back in the geri chair the chair to tip. She reiterated as immobile and was unable to bund in the chair independently. Nurse #1 continued. She had sustained a golf ball sized ack of her head. She indicated the dand neurological checks are reported Resident #2 was tive changes, and no abnormal that Resident #2 had chronic the were no signs or symptoms or distress. She stated the NP	F	323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345442	B. WING			00)/14/2017
NAME OF PROVIDER FORREST OAKES		CENTER	•	620 HE	TADDRESS, CITY, STATE, ZIP CODE ATHWOOD DRIVE MARLE, NC 28001		-
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
had not ER as Residu update condit remain day w was u day (8 She recame afternot Residu She si and re Nurse the SE Cause for Re An into 9/13/1 preser #2 had hemat she w she go entire mecha stated wrong mecha #2 fron confirm withou indica mecha	there were not ent #2 's statuted later that dated ion. Nurse #1 ned at her base the no acute chocated on Reside to the facility stoon or evening ent #2 to be seated Resident turned to the facility stoon or evening ent #2 to be seated Resident turned to the facility should be a fall from he on a facility of the room body lying on anical lift sling NA #1 said "I spot". She reanical lift independ the bed to he med NA #1 utility another staffed this was thanical lift transity.	t #2 required evaluation at the acute changes with as. The NP asked to be ay on Resident #2 's reported Resident #2 eline status throughout the ranges. She indicated the NP sident #2 's status later that onew orders were received. For each to the ER for evaluation. For each to the ER for exclusion for ea	F	323			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
F 323	resident to slide out The DON indicated staff followed the fact staff members where additionally indicate residents were positionally indicate residents were positionally indicate residents were positionally indicated residents were positionally at the facility for closindicated she was fact worked with her regular was not mobile, and that required two states was working with the time of the fall that the back of Resident was working with the back of Resident was readily available to help her operate was readily available her own lunch break the mechanical lift be was aware she was	ne geri chair to tip and the of the chair onto the floor. it was her expectation that cility 's procedure to have two a using a mechanical lift. She d she expected staff to ensure cioned correctly when and the stated she had worked se to two years. She smilliar with Resident #2 and cularly. She reported Resident she was dependent on staff mechanical lift was utilized aff members. She verified the Resident #2 on 8/15/17 at the resulted in a hematoma to the tyle of the she was dependent on staff method in the dining room. She was related to the 8/15/17 fall for exported she needed to the gerinch in the dining room. She ly looked for a staff member the mechanical lift, no one to the she had decided to use the not supposed to use the	F 3.	23			
	used the mechanica approximately three She stated she had on her own since the Resident #2.	erself. She revealed she had all lift on her own other times prior to 8/15/17. not used the mechanical lift a 8/15/17 incident with					

PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391

OLIVILIY	O I OIT MEDIO/ IITE A	MEDIO/ ND OLIVIOLO				CIVID ITE	7. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345442	B. WING			09/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FORREST	CAMED HEALTHOADE	CENTER		62	20 HEATHWOOD DRIVE		
FURREST	OAKES HEALTHCARE	CENTER		A	ALBEMARLE, NC 28001		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	,	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E		COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DAIL
F 323	Continued From pag	je 26	F	323			
	own and transferred	Resident #2 from her bed to					
	her geri chair withou	t issue. She indicated once					
	Resident #2 was pla	ced in the geri chair and the					
	mechanical lift sling	was unhooked, she had					
noticed there was n		ore weight on the top end of					
	,	ead of the chair) because					
		sitioned too far back/up in the					
	geri chair. NA #1 re						
	Resident #2 further of						
	more balanced posit						
	she believed Reside						
	and she went into the						
	I -	e resident 's room) to gather ted she was in the bathroom					
		out with Resident #2 out of					
	-	out one to two minutes when					
	she heard a "bang".						
		ut of the bathroom and saw					
	_	nd tipped backwards and					
	_	back and her head hit the					
	ground. She reporte	ed she had yelled for					
	assistance from Res	ident #2 's room and Nurse					
	#1, the DON, and the	e UM all came to the room to					
		NA #1 indicated following the					
		d a verbal statement to Nurse					
		t. She additionally stated the					
		neeting on mechanical lifts,					
	, .	tioning. She reported the					
		to never use the mechanical					
		embers. She indicated the					
		equired to complete any ow to properly use the					
		sition a resident in the geri					
		"I knew what to do I just didn					
	't do it."	Thirtow what to do I just didit					
	A follow up interview	was conducted with the					
	DON on 9/13/17 at 4	1:30 PM. She indicated					

inservices on the mechanical lift, geri chair

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345442	B. WING			09/	14/2017
FORREST	ROVIDER OR SUPPLIER OAKES HEALTHCARE		10	620	REET ADDRESS, CITY, STATE, ZIP CODE D HEATHWOOD DRIVE BEMARLE, NC 28001 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTION (EACH CORRECTION CONTROL BIT CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)		(X5) COMPLETION DATE
F 325 SS=D	#1 and other nursing 8/16/17. The inservice 8/15/17 and 8/16/17 is staff (22 NAs and 15 inservice were review nursing staff list that inursing staff list that inursing staff member employed at the facilit (8/15/17) was review verified all nursing stathe mechanical lift, gone in the facility working were the ones that we verified no audits or conducted related to gerichairs, transfers, 483.25(g)(1)(3) MAIN UNLESS UNAVOIDA (g) Assisted nutrition (Includes naso-gastriboth percutaneous endoscenteral fluids). Based comprehensive assessensure that a residen (1) Maintains accepta status, such as usual body weight range ar the resident's clinical this is not possible or indicate otherwise;	ning were conducted for NA staff on 8/15/17 and ce staff sign in sheets dated that indicated 18 nursing nurses) attended the wed with the DON. The indicated there were 37 is (22 NAs and 15 nurses) atty at the time of the incident ed with the DON. The DON aff were not re-education on eri chair, and positioning. In the staff members who were at the time of the inservices ere re-educated. She also ongoing monitoring was the use of mechanical lifts, or proper positioning. ITAIN NUTRITION STATUS and hydration. ITAIN NUTRITION STATUS and hydration. ITAIN REPORT of the inservices ere researched and hydration and hydration. ITAIN NUTRITION STATUS and hydration and hydration are sident's essment, the facility must it- Able parameters of nutritional body weight or desirable and electrolyte balance, unless condition demonstrates that		323			10/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345442	B. WING			09/14/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
				620 HEATHWOOD DRIVE			
FORREST	OAKES HEALTHCAF	RE CENTER		ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 325	Continued From page 28 orders a therapeutic diet.		F 32	25			
	This REQUIREME by: Based on observa and staff interviews recommendations diet to pureed and supplement as ord reviewed for nutriti experienced weight. Resident #73 was 4/25/17 and readmediagnoses included swallowing) and gate and an Admission Mini indicated resident: Supervision was redocumented as 61 documented as 14 gain was noted. A Care Area Assest dated 5/1/17 states some episodes of regular mechanical thin liquids. A care plan initiate 8/9/17 included a pintake and eating listated Resident #7 nutritional status as weight with no sign Interventions included facility protocol. Sri	tion, medical record review s, the facility failed to follow the of speech therapy to change failed to provide a nutritional ered for one of four residents on (Resident #73) who t loss. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative d dysphagia (difficulty astroesophageal reflux disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative d dysphagia (difficulty astroesophageal reflux disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative d dysphagia (difficulty astroesophageal reflux disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative d dysphagia (difficulty disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitted on 8/9/17. Cumulative disease. The findings included: admitted to the facility on sitte		1. On 10/2/17, a Quality Ass Performance Improvement (meeting was conducted by the Director to complete a root of and to develop corresponding action to ensure that diet or supplement recommendation provided for residents' who exeight loss. QAPI committed attendance included the Exe Director (QAPI Coordinator) Clinical Services, MDS nursing Manager, Dietary Manager, Worker, Activities Director, a Director Through Root Cause Analysis on the findings for Resident determined that the facility faproper communication between and dietary for diet and supprecommendations from speed and the registered dietitian recommendations to maintat status. On 9/14/17, the licen notified the physician of Resmissed dietary recommendation from speed and restart frozen tree orders were communicated implemented as indicated to nutrition. The Dietary Managethe nutrition/hydration care perfect.	che Executive cause analysis ng corrective ders and ins are experience experience experience of the cutive in Director of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1 '	ATE SURVEY DMPLETED	
		345442	B. WING _		 		09/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER	•	620 HE	T ADDRESS, CITY, STATE, ZIP CODE EATHWOOD DRIVE MARLE, NC 28001	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	limited assistance with documented as 130 per gain. A weekly weight histor Director of Nursing resoluted for Resident #3 5/30/17-137.5 pound 6/6/17-136 pounds; 6/22/17-137 pounds; 7/11/17-129 pounds; 7/26/17132.5 pound 8/18/17-134 pounds; 8/30/17121.2 pound 9/13/17-118.8 pound 1. a. A nursing note stated the Speech Thresident #73 aspirating (choking) aspirating (choking) aspirating (choking) aspirating (choking) aspirating pureed with nectar the A Speech Therapy in stated Resident #73 swallow assessment swallowing). She hapharyngeal dysphagi (holding food in her nextended oral transit posterior transfer, deformation, multiple sycoughing after swallow	ed 7/23/17 indicated gnitively intact. She required th eating. Weight was bounds with no weight loss ory report provided by the eyealed the following weights 73. 5/23/17-136 pounds; 8; 6/2/17-137 pounds; 6/26/17-139 pounds; 7/17/17135.5 pounds; 8/22/17129.5 pounds; 8/22/17127.6 pounds; 8/22/17121.2 pounds and s. dated 9/5/17 by Nurse #4 herapist was aware of on food and liquids. Nurse 73 's husband and informed and need for diet change to ick liquids. itial evaluation dated 9/6/17 was administered a bedside for dysphagia (difficulty d moderate to severe oral a with anterior pocketing nouth), extended bolus hold, time, reduced anterior	F3	See a correct research or research to Discontinuation of the correct research or research	ervices and Dietary Manager comquality assurance monitoring of sidents experiencing weight loss of 1/17-9/30/17 to ensure accurate of discommended to meet the nutritional commended to meet the plan of commended to meet the plan of or discrepancies were noted. On 10/2/17, the Regional Director inical Services reeducated the difference and procedures of implementation and procedures of implementation and discommendation included the control of the sident. Education included the control of the sident in	rom iet al care. r of nting ns to cal eetings ritional ursing on id les to cation the y hired on	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345442	B. WING _			09/	14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		62	TREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325	diet level was pureed On 9/13/17 at 8:00AN observed in the dining chair being fed by nur make any attempts to indicated Resident #7 mechanical soft diet. feeding Resident #73 appetite varied but sh than 25% of her meal On 9/14/17 at 8:48 Al conducted with the Si she had evaluated Re There was a problem could not provide sen Speech Therapist sai downgrade Resident continue thin liquids of evaluation. The nurs thickened liquids and was unsure of the nai she depended on the follow through with th she was finally able to yesterday and gave h The Speech Therapis small bites of the diet puree consistency be food. On 9/14/17 at 9:42 Al conducted with Nurse Resident #73 's Res recommendations on	at risk for maximum netration. Recommended food and thin liquids. M, Resident #73 was groom sitting in her broad rsing staff. She did not be feed herself. The diet slip ray received a regular The nursing assistant stated Resident #73 's see usually did not eat more is. M, an interview was peech Therapist. She stated resident #73 on 9/6/17. with her insurance so she vices until 9/13/17. The dishe asked nursing to make a sked her if she wanted she told the nurse no. She me of the nurse. She said nurse to write the order and the change in diet. She said on see Resident #73 took and was able to swallow the tter with less pocketing of	F	325	the physician to obtain orders as indica and to transcribe onto the Medication Administration Record (MAR)and complete a Dietary Communication for to ensure appropriate communication a implementation of nutritional needs to prevent weight loss and maintain nutriti The Director of Clinical Services to revidietary recommendations upon receipt from Registered Dietician following theis scheduled assessment and during the weekly Weight Risk Meeting to ensure compliance with recommended nutrition changes to prevent weight loss. 4. The Dietary Manager or LPN Supervisor to complete quality assurant monitoring of 5 random residents to ensure appropriate diet, and supplemented reachers/frozen treats have been implemented to meet the nutritional needs the resident per the plan of care. Monitoring will also include verification intake of supplements documented on Medication Administration Record (MAI Monitoring to be completed at a frequent of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then month thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee to evaluate the	m and on. ew r hal ce ht eds of R). hcy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345442	B. WING	·····		09/14/2017	
	ROVIDER OR SUPPLIER	: CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001		DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 325	said she spoke to the Assistant Director of Speech Therapist sadiet and they told hereferral so Speech The Resident #73 before pureed. She stated order. On 9/14/17 at 11:29 conducted with the Instated she expected recommendations for She stated nursing sheeded. At that time the physician and She further evaluation. 1. b. A Registered Instated weight trending downward weekly. Start a frozen nutrition weight trending downward weekly. Start a frozen nutrition weight trending downward weekly. A review of Nutrition Recommendations of Nursing for 8/4/2017 for Resident #73 to with lunch meal due. An RD note dated 9 weight triggered for over 3 months. Curpounds. Weight had over the last 3 months.	eed diet on 9/5/17. Nurse #4 e Director of Nursing and the i Nursing on 9/5/17 when the aid she could downgrade the ir to fill out a Speech Therapy Therapy could assess the diet was changed to she did not change the diet AM, an interview was Director of Nursing. She Speech Therapy egarding diets to be followed. Staff could downgrade a diet if e, the nurse would also notify deech Therapy for orders and Dietician (RD) note dated ghts continued to be The RD recommended to onal treat with lunch meal due ownward despite increase of lement) to three times daily all Therapy given to the Director of included a recommendation estart frozen nutritional treat	F 32	effectiveness of the monitoring/observation tools maintaining substantial comp make changes to the correct necessary. The Quality Assu Improvement Committee me consist of, but not limited to, Director, Director of Clinical Medical Director, Pharmacy Social Services Director, Act Director, Maintenance Direct Director, Minimum Data Asse Nurse, and facility certified mand LPN/RN designees. 5. The Executive Director is a for the implementation and e this plan.	oliance, and ive action as rance mbers the Executive Services, Consultant, ivities or, Dietary essment urse aides		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED		
		345442	B. WING		09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCAR	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	,	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 325	8/9/17. Weight on approximately 125 weight was 139 por readmission on 8/9 pounds. Resident hospital prior to the lunch meal and Me centimeters) three on readmission on may have been relamedication) being of antibiotics being on #73 was being fed was mechanical so weekly until stabilized Med Pass 2.0 60 confrozen treat to the lunch for the lunch for the lunch to staff for 9/8/17 throconsumed by Resident 5/30/17-136 pounds 6/22/17-137 pound 7/11/17-129 pound 7/26/17132.5 pour 8/18/17-134 pound 8/18/17-134 pound	/17 and readmission on readmission on 7/7/17 was pounds. Prior to discharge, unds. Weight prior to /17 was approximately 129.5 #73 was discharged to the frozen treat starting with the d Pass 2.0 60 cc (cubic times a day was not restarted 8/9/17. Weight change also ated to synthroid (thyroid decreased on 8/14/17 and dered on 8/24/17. Resident by staff as of 8/28/17. Her diet ft. Monitor weight pattern ed. Recommend restart of c three times daily and add a unch meal daily. dated 9/7/17 revealed an 2.0 60 cc three times daily.	F 32	5		

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			09	/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER	·	620 HE	T ADDRESS, CITY, STATE, ZIP CODE EATHWOOD DRIVE MARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	chair being fed by numake any attempts to indicated Resident #7 mechanical soft diet. On 9/14/17 at 7:55 Al conducted with the Fostated she had not recommunication sheet frozen nutritional treashe would know what receive on her food to Director stated dietary provided the frozen to dietary trays. She add not received any frozen to dietary communication frozen treat to be placed on 9/14/17 at 10:00 A was conducted with to (FNP). He stated he continued weight loss thyroid medication would be a goal of his fostated a 30 pound we amount (from 147 on 118.6 pounds on 9/13 to follow the physician	M, Resident #73 was g room sitting in her broad rsing staff. She did not of feed herself. The diet slip 73 received a regular M, an interview was bood Service Director. She ceived a dietary of from nursing regarding a t. She said that was how to Resident #73 should rays. The Food Service by staff were the ones who reats that were placed on the offed that Resident #73 had den treats on her lunch tray. AM, a telephone interview the Family Nurse Practitioner had been aware of the solution. He said the change in her bould not cause weight loss. The Food Service of the said the change in her bould not cause weight loss. The said the change in her bould not cause weight. He sight loss was a significant admission on 4/25/17 to 8/17) and he expected staff	F	325			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345442	B. WING _			09/14/2017		
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	: CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
F 325	(RD). She stated she recommendations on Recommendations on Recommendations to Nursing staff would chart, fill out a dietar send the form to the assented and if there record, it would be for Dietician stated she through with the ord communication with On 9/14/17 at 11:29 conducted with the I stated her expectation followed. She stated RD were given to he nursing staff to follow recommendations a written if needed. Note that was on the MAR and the frozen treat from frozen treat to the rest the MAR. On 9/14/17 at 11:42 conducted with Nursing that the rest to the rest that the material sign it off on the and sign it off on the and sign it off on the second recommendations are the lunch trays by dietar nursing. She stated from and see if the and sign it off on the second recommendations are stated from and see if the and sign it off on the second recommendations.	the Registered Dietician he wrote her dietary in the Nutritional Therapy heet and gave a copy of her to the Director of Nursing. write the dietary order in the ry communication form and kitchen. She stated she he was an order in the medical followed. The Registered hexpected nursing to follow her and follow the process of he dietary. AM, an interview was he on was for doctor orders to be he or was for doctor orders to be he direcommendations from the her. A copy was given to the	F3	25				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345442	B. WING			09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 325 F 386	Continued From page treat. 483.30(b)(1)-(3) PHY	e 35 SICIAN VISITS - REVIEW	F 32			10/13/17	
SS=C	including medications visit required by para (2) Write, sign, and d visit; and (3) Sign and date all influenza and pneum be administered per policy after an assess This REQUIREMENT by: Based on record rev staff interviews, the fathe physician signed required, resulting in signature by non-phy resident records revie 88, 31, 25, 13, 73, 30. The findings included 1. Resident #88 was diagnoses that including blood pressure, right leg amputation, Review of #88's adm 9/5/17 through 9/30/1	ent's total program of care, and treatments, at each graph (c) of this section; atte progress notes at each corders with the exception of process of a corders, which may oblysician-approved facility sement for contraindications. It is not met as evidenced sew, physician interview and acility failed to ensure that and dated orders as the use of a rubber stamp sicians for 13 of 13 current lewed (Resident #'s 52, 39, 14, 11, 9, 2, and 19).		1. On 10/2/17, a Quality Ass Performance Improvement (imeeting was conducted by the Director to complete a root of and to develop corresponding action to ensure residents' plane signed and dated by the required per Regulation 430. regarding physician visits. Quality of the committee members in attentincluded the Executive Director Coordinator), Director of Clint MDS nurse, Unit Manager, Imanager, Social Worker, Act Director and Medical Director Through Root Cause Analys on the findings for Residents	QAPI) the Executive cause analysis ag corrective thysician order physician as .30(b)(1)-(3) the ladance ctor (QAPI phical Services, Dietary tivities or.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		` IDENTIFICATION NI IMBED:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345442	B. WING		0.9	9/14/2017	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	71-72017	
				620 HEATHWOOD DRIVE			
FORREST	OAKES HEALTHCARE	CENTER		ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	Records Director on stated the Physician records with her sign she did not have the noticed that a stamper in the past. She add use of the stamped sometime of the signature of the signature of the stamp any of the signature of the signature in place of the signature in place of the signature in signatur	aducted with the Medical 9/13/17 at 12:38 PM. She had stamped the medical ature. She further stated stamp and indicated she had ed signature had been used ed she had questioned the ignature but could not had spoken with about the stamp. PM an interview was hysician whose name was tated the record was mped signature and was not she did not stamp the her signature stamp. She had referenced was dated when an stated someone had referenced was dated the nose physician had used the nose physician had used the sout the stamp a while ago call a date. The regulation is said he had the physician to regarding the use of the occument stated the	F 38	31, 25, 13, 73, 30, 14, 11, 9, 2 a was determined that the facility the ensure the physician signed and physician orders resulting in rub signatures by non-physicians. Of the Physician signed and dated orders for Residents #52, 39, 81, 73, 30, 14, 11, 9, 2 and 19. Identified residents Physician Of Sheets were signed by physician 10/4/17. 2. On 10/4/17, the Director of Cl Services (DCS) and Unit Secret completed a quality assurance in and observation of 57 current rephysician orders from 7/1/17-9/3 ensure residents' physician orders igned and dated by the physician required. Multiple residents were by this practice, and signatures obtained from the MD/NP on 10 MDs, NPs, and PAs were notified Medical Director of the termination use of the rubber stamp signature 10/10/17. The Pharmacy Consultation of the trubber stamps are in 3. On 10/13/17, the Director of C Services (DCS) completed reed all licensed nurses, including we and PRN, and Unit Secretary on Regulation 483.30(b)(1)-(3) regardly sician visits and requirement physician orders to be signed and physician orders to physician o	failed to dated ber stamp in 10/2/17, identified 8, 31, 25, rder n on inical ary nonitoring isidents' 80/17 to er are an as e affected were /4/17. All d by the on of the re on ultant monitor to ot utilized. Clinical ucation to eekend arding arding arding arding arding arding is of		

PRINTED: 10/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			0:	9/14/2017	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	, ,		
				620	HEATHWOOD DRIVE			
FORREST	OAKES HEALTHCA	RE CENTER		AL	BEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 386	Continued From p	age 37	F3	386				
	against its misuse	." One document was signed			signatures. Newly hired licensed nurse	es		
	by the Physician a			will be educated upon hire.				
		Family Nurse Practitioner.			·			
	Neither document				The physician will sign and date orders	S		
				- 1	per Regulation 430.30(b)(1)-(3) regard			
	On 9/14/17 at 8:59	AM, an interview was			physician visits. The use of rubber star	mp		
	conducted with the	Administrator and the Director			signatures will not be permitted by the			
		regarding the use of the			facility and a record of physician			
	stamped signature being used by the physician to			- 1	signatures to be kept on file and			
I		said it had been one or two		- 1	maintained by the Executive Director f	or		
		were made aware of the use of			accuracy. Non-compliance will be			
	the stamp and had			reported immediately to the Executive				
		The regulation was reviewed at Medical Director. The			Director for reeducation and/or correct	ive		
		he had not seen the document			action as necessary.			
		of the physician stamp until			4. The Executive Director or Unit			
		of the physician stamp and			Secretary to monitor 5 residents'			
		and signed. The Administrator			physician orders for signature and date	e bv		
		ed it was their expectation that			the physician per requirements.	,		
		name was on the stamp should		- 1	Monitoring to be completed at a freque	ency		
	utilize the stamp o	nly and no other individual			of 3 days per week for 4 weeks then, 1	I		
	utilize his/her sign	ature stamp.			time per week for 8 weeks, then month	าly		
					thereafter as determined by the Quality	y		
		vas admitted on 6/12/17 with			Assurance Performance Improvement			
	_	luded diabetes, dementia,			(QAPI) Committee to maintain			
	anxiety, depressio	n, and muscle weakness.			compliance.			
	Review of #52's m	onthly physician's orders for			The results of the quality assurance			
		1/17 revealed a stamped			monitoring to be reported to the QAPI			
	signature in the ph	nysician's signature box and no			Committee monthly by the Executive			
	date.				Director for twelve months and/or until			
					substantial compliance is obtained. The	пе		
		conducted with the Medical			QAPI Committee to evaluate the			
		on 9/13/17 at 12:38 PM. She			effectiveness of the			
		an had stamped the medical			monitoring/observation tools for	_		
		gnature. She further stated			maintaining substantial compliance, ar			
		he stamp and indicated she had			make changes to the corrective action	as		
		nped signature had been used			necessary. The Quality Assurance			
	∣ in the past. She a	dded she had questioned the			Improvement Committee members			

Facility ID: 923154

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			09/	14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER	,	62	REET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 386	use of the stamped s remember who she h use of the signature so On 9/13/17 at 12:40 f conducted with the plon the stamp. She si stamped with her stadated. She revealed physician orders with said she would no lor she would make sure signed. The physicial brought up the use of signature to her beforthem not to use the so On 9/14/17 at 8:45 Al conducted with the Alphysician's group, who stamp, was asked about was unable to recomplete a documen rubber stamp. The diffollowing: "I desire to signature in place of am the only one in position and was signed by the Fallowing by the Physician and was signed by the Fallowing (DON) regions of 19/14/17 at 8:59 Al conducted with the Alof Nursing (DON) regions.	ignature but could not ad spoken with about the stamp. PM an interview was nysician whose name was rated the record was imped signature and was not she did not stamp the her signature stamp. She inger utilize the stamp and is the record was dated when in stated someone had if the rubber stamped it and she had informed it amp anymore. M, an interview was diministrator. He said the lose physician had used the out the stamp a while ago call a date. The regulation said he had the physician it regarding the use of the ocument stated the use a rubber stamp my handwritten signature. It is session of the stamp and I uses it. I will ensure that I the stamp, safeguard One document was signed another identical document imily Nurse Practitioner. It is dated. M, an interview was diministrator and the Director	F3	386	consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultan Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aidest and LPN/RN designees. 5. The Executive Director is responsible for the implementation and execution of this plan.	t, /	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345442	B. WING_			09/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 386	weeks since they we the stamp and had re Medical Director. The the time with the Med Administrator said he regarding the use of 9/13/17 and did not woriginally drafted and and the DON stated the doctor whose natutilize the stamp only utilize his/her signatus. 3. Resident #25 was diagnoses that include heart disease, high be high cholesterol, anx generalized weakness. Review of #25's more 8/1/17 through 8/31/signature in the physician records Director on stated the Physician records with her sign she did not have the noticed that a stamplin the past. She add	aid it had been one or two re made aware of the use of eviewed the process with the e regulation was reviewed at dical Director. The had not seen the document the physician stamp until know when it had been signed. The Administrator it was their expectation that me was on the stamp should and no other individual ire stamp. admitted on 9/9/15 with led: An abnormal heart rate, lood pressure, diabetes, iety, depression, and	F3	86		
	use of the signature On 9/13/17 at 12:40	PM an interview was hysician whose name was				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345442	B. WING _		-	09/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		STREET ADDRESS, CITY, STA 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 386	dated. She revealed physician orders with said she would no loss signed. The physicia brought this up to he informed them, referruse the stamp anymous the stamp anymous the stamp anymous the stamp anymous the stamp and he conducted with the Aphysician's group, what stamp, was asked at but was unable to recomplete a document rubber stamp. The defollowing: "I desire to signature in place of am the only one who retain possession of against its misuse." by the Physician and was signed by the Fancher document was of Nursing (DON) registamped signature be sign orders. They so weeks since they we the stamp and had reformed with the Medical Director. The time with the Medical Director and he deformed with the Medical Director. The time with the Medical Director and he deformed with the Medical Director and he deformed with the Medical Director. The time with the Medical Director and he deformed with the Medical Director and he deformed with the Medical Director. The time with the Medical Director and he deformed with the Medical Director and he deformed with the Medical Director. The time with the Medical Director and he deformed with the Medical Directo	imped signature and was not she did not stamp the her signature stamp. She inger utilize the stamp and is the record was dated when an stated someone had ring to her office staff, not to ore. M, an interview was individually did in the stamp a while ago call a date. The regulation is said he had the physician interest the stamp and it regarding the use of the locument stated the use a rubber stamp my handwritten signature. It is session of the stamp and it is stamp, safeguard One document was signed another identical document amily Nurse Practitioner. As dated. M, an interview was diministrator and the Director garding the use of the eing used by the physician to aid it had been one or two re made aware of the use of eviewed the process with the e regulation was reviewed at	F	386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345442	B. WING		09/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCAR	E CENTER	62	REET ADDRESS, CITY, STATE, ZIP CODE 10 HEATHWOOD DRIVE LBEMARLE, NC 28001	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 386	originally drafted an and the DON stated the doctor whose na utilize the stamp on utilize the stamp on utilize his/her signar. 4. Resident #39 wadiagnoses which inchigh blood pressure high cholesterol, an amputation, heart of fibromyalgia. Review of #39's mon 8/1/17 through 8/31 signature in the phydiate. An interview was concrete was a concrete with her signature of the Physician records with her signature of the stamped remember who she use of the signature. On 9/13/17 at 12:40 conducted with the on the stamp. She stamped with her standard. She revealed physician orders with said she would make sure.	know when it had been and signed. The Administrator of it was their expectation that same was on the stamp should by and no other individual sture stamp. As admitted on 5/2/17 with cluded: Anemia, heart failure, experipheral vascular disease, xiety, depression, right legisease, arthritis, and Another the Medical of the signature box and no conducted with the Medical of 9/13/17 at 12:38 PM. She of had stamped the medical nature. She further stated the stamp and indicated she had deed signature had been used ded she had questioned the signature but could not had spoken with about the	F 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			09/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 386	Continued From pag	e 42	F 3	86		
	brought this up to he informed them, refer use the stamp anyme	ring to her office staff, not to				
	physician's group, what stamp, was asked at but was unable to recomplete a document rubber stamp. The defollowing: "I desire to signature in place of am the only one in part the only one who retain possession of against its misuse."	dministrator. He said the nose physician had used the cout the stamp a while ago call a date. The regulation is said he had the physician it regarding the use of the locument stated the use a rubber stamp my handwritten signature. It possession of the stamp and I uses it. I will ensure that I the stamp, safeguard One document was signed another identical document amily Nurse Practitioner.				
	of Nursing (DON) reg stamped signature be sign orders. They so weeks since they we the stamp and had re Medical Director. The the time with the Med Administrator said he regarding the use of 9/13/17 and did not ke originally drafted and and the DON stated the doctor whose nat	dministrator and the Director garding the use of the eing used by the physician to aid it had been one or two re made aware of the use of eviewed the process with the e regulation was reviewed at dical Director. The had not seen the document the physician stamp until know when it had been a signed. The Administrator it was their expectation that me was on the stamp should and no other individual				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345442	B. WING _			09	/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		620 H	ET ADDRESS, CITY, STATE, ZIP CODE HEATHWOOD DRIVE EMARLE, NC 28001	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 386	Continued From pag	e 43	F:	386				
	diagnoses that include peripheral vascular of cholesterol, arthritis, depression, history of delay. Review of #31's more 8/1/17 through 8/31/signature in the physician records Director on stated the Physician records with her signishe did not have the noticed that a stamp in the past. She adduse of the stamped stremember who she have of the signature. On 9/13/17 at 12:40 conducted with the ponthe stamp. She stamped with her standard. She revealed physician orders with said she would no look of the stamp and the ponthe stamp. She stamped with her standard. She revealed physician orders with said she would no look of the stamp and the ponthe stamp.	of falls, and developmental of falls, and a stamped sician's signature box and no of falls, and the stamped the medical of falls, and the stamped the medical of falls, and the stamp and indicated she had of falls of falls, and the signature but could not fall of falls, and the stamp. PM an interview was of falls of falls, and was not fall of falls, and the record was comped signature and was not falls of falls. She inger utilize the stamp and						
	signed. The physicial brought this up to he informed them, refer use the stamp anym On 9/14/17 at 8:45 A	e the record was dated when an stated someone had before and she had ring to her office staff, not to ore. MM, an interview was administrator. He said the						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345442	B. WING			09/	14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	į		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 386	stamp, was asked all but was unable to re was reviewed and he complete a documer rubber stamp. The of following: "I desire to signature in place of am the only one in pam the only one who retain possession of against its misuse." by the Physician and was signed by the Fi Neither document with the Action of Nursing (DON) restamped signature be sign orders. They sweeks since they we the stamp and had remained the Medical Director. The time with the Me Administrator said he regarding the use of 9/13/17 and did not looriginally drafted and and the DON stated the doctor whose na utilize the stamp only utilize his/her signation. Resident #13 was 5/4/2012. A review of physician revealed a rubber stamp of the stamp only utilize his/her signation.	hose physician had used the cout the stamp a while ago call a date. The regulation is said he had the physician integrating the use of the document stated the ouse a rubber stamp in my handwritten signature. It is ossession of the stamp and I is ouses it. I will ensure that I is the stamp, safeguard. One document was signed if another identical document amily Nurse Practitioner. The cast dated. MM, an interview was administrator and the Director garding the use of the eing used by the physician to aid it had been one or two are made aware of the use of eviewed the process with the precedit in the physician stamp until know when it had been disigned. The Administrator it was their expectation that me was on the stamp should y and no other individual	F	386			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _		0:	9/14/2017	
	ROVIDER OR SUPPLIER	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001		,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 386	On 9/13/17 at 12:38 conducted with Med Physician had stampher signature. She stamp and indicated stamped signature had questioned the but could not rememwith about the use of On 9/13/17 at 12:40 conducted with the fidid not stamp the phignature. The Physicand was not dated. Utilize the stamp and record was dated with the Aconducted with the Aco	PM, an interview was ical Records. She stated the bed the medical records with stated she did not have the she had noticed that a had been used in the past and use of the stamped signature of the stamp. PM, an interview was physician. She revealed she hysician orders with her sician acknowledged the lawith her stamped signature. She said she would no longer dishe would make sure the men signed. AM, an interview was administrator. He said the was asked about the stamp a hable to recall a date. The wed and he said he had the adocument regarding the use ature. The document was diministrator. The document "I desire to use a rubber only one who uses it. I will possession of the stamp, is misuse." One document thysician and another identical	F3	86			
	document was signe	hysician and another identical ed by the Family Nurse r document was dated.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345442	B. WING _		09/14/20	017
	ROVIDER OR SUPPLIER OAKES HEALTHCAR	RE CENTER	-	STREET ADDRESS, CITY, STATE, ZIP CO 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COM IE APPROPRIATE	(X5) IPLETION DATE
F 386	conducted with the Nursing regarding signature being use orders. They state monthly orders for (09/13/17) and had reviewed them (darbeen one or two waware of the use of the process with the regulation was reviquestioned as to the signed by the Phys Practitioner regard used as a signature had not seen the d (09/13/17). The Ad Nursing stated it was doctor whose name	AM, an interview was Administrator and Director of the use of the stamped ed by the physician to sign ed the physician had signed the September yesterday I dated them when she te unknown). They said it had eeks since they were made if the stamp and had reviewed e Medical Director. The ewed at that time. When the initiation of the document sician and the Family Nurse ing the use of the stamp being e, the Administrator said he ocument until yesterday dministrator and the Director of as their expectation that the e was on the stamp utilize the other individual utilize their	F3	386		
	11/11/2016. A review of physicia revealed a rubber sused as a physicia monthly orders. On 9/13/17 at 12:3 conducted with Me Physician had stan her signature. She stamp and indicate stamped signature	as readmitted to the facility an orders for August 2017 stamp signature had been in signature for review of the 8 PM, an interview was dical Records. She stated the inped the medical records with e stated she did not have the ed she had noticed that a had been used in the past and e use of the stamped signature				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		STREET ADDRESS, CITY, S 620 HEATHWOOD DRIVE ALBEMARLE, NC 280	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 386	Continued From pag		F3	86			
	but could not remem with about the use of On 9/13/17 at 12:40 conducted with the P did not stamp the physignature. The Phys record was stamped and was not dated. Sutilize the stamp and record was dated who On 9/14/17 at 8:45 A conducted with the A Physician 's group while ago but was ur regulation was review physician complete a of the stamped signar reviewed with the Ad stated the following: stamp signature in place.	ber who she had spoken is the stamp. PM, an interview was physician. She revealed she eysician orders with her ician acknowledged the with her stamped signature. She said she would no longer she would make sure the en signed.					
	stamp and I am the censure that I retain per safeguard against its was signed by the Ple document was signed Practitioner. Neither On 9/14/17 at 8:59 Aconducted with the Annursing regarding the signature being used orders. They stated monthly orders for Sc (09/13/17) and had defined the signature of the signatu	only one who uses it. I will ossession of the stamp, misuse." One document hysician and another identical d by the Family Nurse document was dated. M, an interview was dministrator and Director of e use of the stamped I by the physician to sign the physician had signed the eptember yesterday lated them when she					
		unknown). They said it had kks since they were made					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345442	B. WING		09/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	, 30.7.11.20.7
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 386	the process with the regulation was review questioned as to the signed by the Physic Practitioner regardin used as a signature, had not seen the doc (09/13/17). The Adn Nursing stated it was doctor whose name stamp only and no o signature stamp. 8. Resident #73 was 4/25/17. A review of physician revealed a rubber staused as a physician monthly orders. On 9/13/17 at 12:38 conducted with Medi Physician had stamp her signature. She stamp and indicated stamped signature had questioned the ubut could not remem with about the use or On 9/13/17 at 12:40 conducted with the Fidid not stamp the ph signature. The Physician was stamped was stamped stamped was stamped stamped was stamped with the Fidid not stamp the ph signature. The Physician was stamped	he stamp and had reviewed Medical Director. The wed at that time. When initiation of the document ian and the Family Nurse go the use of the stamp being the Administrator said he cument until yesterday ininistrator and the Director of their expectation that the was on the stamp utilize the ther individual utilize their eadmitted to the facility and orders for August 2017 amp signature had been signature for review of the PM, an interview was cal Records. She stated the ed the medical records with tated she did not have the she had noticed that a and been used in the past and use of the stamped signature ber who she had spoken	F 38	6	

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			E SURVEY IPLETED
	345442	B. WING _		09	9/14/2017
ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
utilize the stamp and record was dated who record was dated who on 9/14/17 at 8:45 A conducted with the A Physician 's group while ago but was ur regulation was review physician complete a of the stamped signal reviewed with the Ad stated the following: stamp signature in place stamp and I am the censure that I retain place stamp and I am the censure t	she would make sure the en signed. M, an interview was dministrator. He said the vas asked about the stamp a table to recall a date. The wed and he said he had the document regarding the use atture. The document was ministrator. The document "I desire to use a rubber face of my handwritten only one in possession of the only one who uses it. I will ossession of the stamp, a misuse." One document mysician and another identical diby the Family Nurse document was dated. M, an interview was dministrator and Director of the use of the stamped and by the physician to sign the physician had signed the exptember yesterday lated them when she unknown). They said it had the stamp and had reviewed Medical Director. The wed at that time. When initiation of the document ian and the Family Nurse of the use of the stamp being	F3	86		
	CONTINUED FROM PLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From pag utilize the stamp and record was dated wh On 9/14/17 at 8:45 A conducted with the A Physician 's group with while ago but was ur regulation was reviewed with the Ad stated the following: stamp signature in place stamp and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place and I am the consure that I retain place	TOAKES HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	A BUILDIN 345442 ROVIDER OR SUPPLIER OAKES HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 utilize the stamp and she would make sure the record was dated when signed. On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the Physician 's group was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the stamped signature. The document stated the following: "I desire to use a rubber stamp signature in place of my handwritten signature. I am the only one who uses it. I will ensure that I retain possession of the stamp, safeguard against its misuse." One document was signed by the Physician and another identical document was signed by the Family Nurse Practitioner. Neither document was dated. On 9/14/17 at 8:59 AM, an interview was conducted with the Administrator and Director of Nursing regarding the use of the stamped signature being used by the physician had signed the monthly orders for September yesterday (09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at that time. When questioned as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as a signature, the Administrator said he had not seen the document until yesterday	ROWDER OR SUPPLIER OAKES HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 49 utilize the stamp and she would make sure the record was dated when signed. On 9/14/17 at 8.45 AM, an interview was conducted with the Administrator. He said the physician 's group was asked about the stamp a while ago but was unable to recall a date. The regulation was reviewed and he said he had the physician complete a document regarding the use of the stampe and I am the only one who uses it. I will ensure that I retain possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp and I am the only one who uses it. I will ensure that I retain possession of the stamp and I am the office of the stamp and I comment was signed by the Physician and another identical document was signed by the Physician to signature. Neither document was dated. On 9/14/17 at 8.59 AM, an interview was conducted with the Administrator and Director of Nursing regarding the use of the stamped signature being used by the physician had signed the monthly orders for September yesterday (09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the process with the Medical Director. The regulation was reviewed at that time. When questioned as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as a signature, the Administrator said he had not seen the document util yesterday	A BUILDING 34542 B WING OKES HEALTHCARE CENTER SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 49 utilize the stamp and she would make sure the record was dated when signed. On 9/14/17 at 8:45 AM, an interview was conducted with the Administrator. He said the Physician complete a document regarding the use of the stamp almainst in place of my handwritten signature. I am the only one in possession of the stamp signature in place of my handwritten was signed by the Physician and another identical document was signed by the Physician and signed the world with the Administrator and Director of Nursing regarding the use of the stamp by stated the physician to signed by the Physician and signed the monthly orders for September yesterday (09/13/17) and had dated them when she reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp and had reviewed the model of the stamp being used as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as to the initiation of the document signed by the Physician and the family Nurse Practitioner regarding the use of the stamp being used as to the initiation of the document signed by the Physician and the Family Nurse Practitioner regarding the use of the stamp being used as a signature, the Administrator said he had not seen the document until yesterday (1997-1871) and had dated them when she regulation was reviewed them (date unknown). They said it had been one or two weeks since they were made aware of the use of the stamp being used as a signature, the Administrator said he had not seen the document until yesterday

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345442	B. WING	· · · · · · · · · · · · · · · · · · ·	09/14/2017	
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	ECENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET	TION
F 386	Continued From pag	ge 50	F 38	36		
	doctor whose name	s their expectation that the was on the stamp utilize the other individual utilize their				
	9. Resident #30 wa 5/2/2011.	s readmitted to the facility				
	revealed a rubber st	n orders for August 2017 camp signature had been signature for review of the				
	conducted with Med Physician had stam her signature. She stamp and indicated stamped signature had questioned the	PM, an interview was ical Records. She stated the ped the medical records with stated she did not have the she had noticed that a nad been used in the past and use of the stamped signature of the stamp.				
	conducted with the l did not stamp the ph signature. The Phys record was stamped and was not dated.	PM, an interview was Physician. She revealed she hysician orders with her sician acknowledged the d with her stamped signature She said she would no longer d she would make sure the hen signed.				
	conducted with the A Physician 's group' while ago but was u regulation was revie	AM, an interview was Administrator. He said the was asked about the stamp a nable to recall a date. The wed and he said he had the a document regarding the use				

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		I ' '	(X3) DATE SURVEY COMPLETED		
		345442	B. WING		09	0/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	E CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPOPULATION DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 386	reviewed with the Adstated the following: stamp signature in particular signature. I am the stamp and I am the ensure that I retain pasfeguard against it was signed by the Edocument was signed Practitioner. Neither On 9/14/17 at 8:59 particular conducted with the process with the process with the regulation was reviewed them (date been one or two we aware of the use of the process with the regulation was reviewed as a signature had not seen the do (09/13/17). The Adr Nursing stated it was doctor whose name stamp only and no disignature stamp.	ature. The document was diministrator. The document "I desire to use a rubber place of my handwritten only one in possession of the only one who uses it. I will possession of the stamp, as misuse." One document physician and another identical end by the Family Nurse of document was dated. AM, an interview was addinistrator and Director of the use of the stamped do by the physician to sign do the physician had signed the deptember yesterday dated them when she are unknown). They said it had the stamp and had reviewed at Medical Director. The the wed at that time. When a initiation of the document can and the Family Nurse and the Family Nurse and the stamp being the use of the stamp being the Administrator said he cument until yesterday ministrator and the Director of as their expectation that the was on the stamp utilize the other individual utilize their	F 38	6		
	I .	s initially admitted to the nd most recently readmitted				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345442	B. WING		09/14/2017
	ROVIDER OR SUPPLIER	: CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	00/14/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 386	Continued From pag	ge 52	F 38	36	
	August 2017 revealed had been used as a review of the monthle	t #9 's physician orders for ed a rubber stamp signature physician signature for y orders. PM, an interview was			
	conducted with Med Physician had stamp her signature. She s stamp and indicated stamped signature h had questioned the	ical Records. She stated the ped the medical records with stated she did not have the she had noticed that a had been used in the past and use of the stamped signature other who she had spoken			
	conducted with the I did not stamp the ph signature. The Phys record was stamped and was not dated.	PM, an interview was Physician. She revealed she sysician orders with her sician acknowledged the with her stamped signature She said she would no longer d she would make sure the nen signed.			
	conducted with the A Physician's group while ago but was u regulation was revie physician complete of the stamped signareviewed with the Adstated the following: stamp signature in psignature. I am the stamp and I am the ensure that I retain p	AM, an interview was Administrator. He said the was asked about the stamp a nable to recall a date. The wed and he said he had the a document regarding the use ature. The document was diministrator. The document "I desire to use a rubber ollace of my handwritten only one in possession of the only one who uses it. I will possession of the stamp, as misuse." One document			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			9/14/2017	
	ROVIDER OR SUPPLIER	RE CENTER	-	STREET ADDRESS, CITY, STATE, ZIP CO 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 386	document was sig Practitioner. Neith On 9/14/17 at 8:59 conducted with the Nursing regarding signature being us orders. They staff monthly orders for (09/13/17) and hareviewed them (dabeen one or two waware of the use of the process with the process with the gulation was requestioned as to the signed by the Phy Practitioner regard used as a signature had not seen the conformal of the process with the conformal of the process with the process with the process with the process with the gulation was reviewed as a signature stanguist and not seen the conformal of the process with t	Physician and another identical ned by the Family Nurse ner document was dated. AM, an interview was a Administrator and Director of the use of the stamped sed by the physician to sign ed the physician had signed the a September yesterday dated them when she ate unknown). They said it had recks since they were made of the stamp and had reviewed the Medical Director. The riewed at that time. When the initiation of the document sician and the Family Nurse ding the use of the stamp being re, the Administrator said he document until yesterday dministrator and the Director of was their expectation that the the was on the stamp utilized the other individual utilize their was admitted to the facility on the stamp signature a physician signature for	F3	386			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345442	B. WING		09/14/2017	
	ROVIDER OR SUPPLIER	E CENTER	6	TREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE ILBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 386	stamp and indicated stamped signature I had questioned the but could not remer with about the use of the did not stamp the pl signature. The Phyrecord was stamped and was not dated. Utilize the stamp an record was dated willize the stamp an record was dated willize the stamp an record was reviewed with the Physician 's group while ago but was uregulation was reviewed with the A stated the following stamp signature in provide the stamped sign reviewed with the A stated the following stamp and I am the ensure that I retain safeguard against it was signed by the F document was signed Practitioner. Neither On 9/14/17 at 8:59 conducted with the Nursing regarding the	d she had noticed that a had been used in the past and use of the stamped signature of the stamp. DPM, an interview was Physician. She revealed she hysician orders with her sician acknowledged the d with her stamped signature She said she would no longer d she would make sure the	F 386			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTI		` ′	E SURVEY PLETED
		345442	B. WING_			09	/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER	·	STREET ADDRES 620 HEATHWO ALBEMARLE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTIO ACH CORRECTIVE ACTION SHOULE SS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 386	been one or two wee aware of the use of the the process with the regulation was review questioned as to the signed by the Physic Practitioner regarding used as a signature, had not seen the doo (09/13/17). The Adm Nursing stated it was doctor whose name		F	886			
	2/22/10. A review of Resident August 2017 reveale had been used as a review of the monthly. On 9/13/17 at 12:38 conducted with Medi Physician had stamp her signature. She stamp and indicated stamped signature had questioned the ubut could not remem with about the use of On 9/13/17 at 12:40 conducted with the P	PM, an interview was cal Records. She stated the ed the medical records with tated she did not have the she had noticed that a ad been used in the past and use of the stamped signature ber who she had spoken					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION		E SURVEY PLETED
		345442	B. WING _			09	/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		620	EET ADDRESS, CITY, STATE, ZIP CODE HEATHWOOD DRIVE BEMARLE, NC 28001	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 386	Continued From pag	e 56 ician acknowledged the	F	386			
	record was stamped and was not dated.	with her stamped signature She said she would no longer she would make sure the					
	Physician 's group we while ago but was un regulation was review physician complete a of the stamped signal reviewed with the Ad stated the following: stamp signature in place stamp and I am the consure that I retain place safeguard against its was signed by the Place document was signed was under the procure of the pro	M, an interview was dministrator. He said the vas asked about the stamp a table to recall a date. The wed and he said he had the document regarding the use sture. The document was ministrator. The document "I desire to use a rubber ace of my handwritten only one in possession of the only one who uses it. I will ossession of the stamp, misuse." One document mysician and another identical d by the Family Nurse document was dated.					
	On 9/14/17 at 8:59 A conducted with the A Nursing regarding the signature being used orders. They stated monthly orders for Sc (09/13/17) and had dreviewed them (date been one or two wee aware of the use of the process with the regulation was review questioned as to the signed by the Physic	M, an interview was dministrator and Director of e use of the stamped by the physician to sign the physician had signed the eptember yesterday					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ISTRUCTION	(X3) DATE SURVEY COMPLETED			
		345442	B. WING _			09/	/14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER	•	620 HE	TADDRESS, CITY, STATE, ZIP CODE EATHWOOD DRIVE MARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 386	used as a signature, had not seen the doc (09/13/17). The Adm Nursing stated it was doctor whose name is stamp only and no or signature stamp. 13. Resident #2 was facility on 9/27/10 and on 7/31/17. A review of Resident orders for 7/31/17 re signature had been used for review of the order for review of the order stamp and indicated stamped signature. She is stamp and indicated stamped signature in had questioned the ubut could not remem with about the use of On 9/13/17 at 12:40 conducted with the Fidid not stamp the phing signature. The Physical record was stamped and was not dated. Suttilize the stamp and record was dated with the Aconducted with the Acon	the Administrator said he cument until yesterday inistrator and the Director of a their expectation that the was on the stamp utilized the ther individual utilize their initially admitted to the d most recently readmitted #2 's readmission physician vealed a rubber stamp used as a physician signature ers. PM, an interview was cal Records. She stated the ed the medical records with tated she did not have the she had noticed that a ad been used in the past and use of the stamped signature ber who she had spoken the stamp. PM, an interview was chysician. She revealed she yesician orders with her ician acknowledged the with her stamped signature She said she would no longer she would make sure the en signed.	F3	386			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345442	B. WING			09/	14/2017
	OAKES HEALTHCARE	CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 386	regulation was review physician complete a of the stamped signal reviewed with the Adr stated the following: "stamp signature in plasignature. I am the ostamp and I am the oensure that I retain posafeguard against its was signed by the Physician practitioner. Neither On 9/14/17 at 8:59 Al conducted with the Adrignature being used orders. They stated monthly orders for Second them (date been one or two weel aware of the use of the the process with the Adresse of the use of the process of the use of the use of the process of	able to recall a date. The red and he said he had the document regarding the use sure. The document was ministrator. The document I desire to use a rubber ace of my handwritten may one in possession of the may one who uses it. I will assession of the stamp, misuse." One document ysician and another identical I by the Family Nurse document was dated. M, an interview was diministrator and Director of a use of the stamped by the physician had signed the eptember yesterday ated them when she unknown). They said it had as since they were made as stamp and had reviewed Medical Director. The red at that time. When nitiation of the document an and the Family Nurse the use of the stamp being the Administrator said he	F	386			
F 412		OUTINE/EMERGENCY	F	412			10/13/17

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345442	B. WING _			09/	14/2017
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		62	TREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE ILBEMARLE, NC 28001	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 412 SS=D	resource, in accordant part, the following derivative needs of each resider. (i) Routine dental servinder the State plan): (ii) Emergency dental (b)(2) Must, if necess the resident- (i) In making appoint: (ii) By arranging for tridental services location (b)(5) Must assist residental services as an under the State plan. This REQUIREMENT by:	r obtain from an outside ace with §483.70(g) of this notal services to meet the not: vices (to the extent covered and services; ary or if requested, assist ments; and ansportation to and from the	F	1112	1. On 10/2/17, a Quality Assurance		
	facility failed to follow recommendation for i 1 of 2 residents (Resi services. The finding	the dental provider 's mmediate follow up care for dent #9) reviewed for dental			Performance Improvement (QAPI) meeting was conducted by the Executi Director to complete a root cause analy and to develop corresponding correctiv action to ensure residents' receive dense services as recommended to meet the	/sis re	
	8/22/08 and most rec	ently readmitted on 2/7/15 es that included dementia,			dental health needs of the resident. QA committee members in attendance	νPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345442	B. WING	B. WING		09/14/2017	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				6	20 HEATHWOOD DRIVE		
FORREST	OAKES HEALTHCARE	CENTER		Α	ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 412	Continued From page 60		F.	412			
	depression, anxiety, and delusional disorder.				included the Executive Director (QAPI		
					Coordinator), Director of Clinical Service	202	
	The annual Minimum	n Data Set (MDS)			MDS nurse, Unit Manager, Dietary	,00,	
	I .	0/17/16 indicated Resident			Manager, Social Worker, Activities		
		severely impaired. She had			Director and Medical Director.		
	no behaviors and no rejection of care. Resident						
	#9 required the extensive assistance of one staff				Through Root Cause Analysis and bas	ed	
	for eating and personal hygiene. She was on a				on the findings for Resident #9, it was		
	mechanically altered diet and had no significant				determined that the facility was unable	to	
	weight loss. Resident #9 's Oral/Dental Status				obtain a dental provider that could		
	was assessed as obvious or likely cavity			complete the dental services onsite a			
	broken natural teeth.				due to the two-person assistance		
	The Care Area Asses	nament (CAA) related to			requirements for transfer of an immobi		
	I .	ssment (CAA) related to 16 annual MDS indicated			resident via mechanical lift, an alternat approach would need to be arranged.		
					date 10/2/17, the Unit Manager and So		
	Resident #9 had her own natural teeth which were in poor condition with several broken teeth.				Worker scheduled dental services for	,ciui	
	She denied needing to see a dentist and denied			Resident #9 on 10/5/17 and coordina			
	any current mouth pain or difficulty with eating.			transportation with a contracted trans			
	Staff continued to assist Resident #9 with her oral				provider. The facility to send two nurs		
	care. It was indicated this area was not going to				assistants and a mechanical lift to		
	be included in the plan of care for Resident #9				residents' dental appointment to aide i	า	
	due to her denying the need to see a dentist.				the safe transfer of resident into denta	I	
					providers' service chair for dental care	as	
		dated 1/19/17 indicated			indicated.		
		en for a periodic oral exam.					
	The consultation indicated Resident #9 needed				All dental recommendations will be		
		to Resident #9 's left root			reviewed by the Interdisciplinary team		
	tips hurting. The formuncomfortablenee				(IDT), including the Director of Clinical Services, LPN Supervisor, and Social		
	unconiorablenee	d extractions .			Worker, to ensure dental services are		
	The quarterly MDS a	ssessment dated 8/4/17			provided as indicated. Upon completio	n of	
	1	9 's cognition was severely			Section L (Dental), the MDS Coordinate		
	impaired. She had no behaviors and no rejection				will review dental recommendations to		
	1 -	required the extensive			ensure dental services are provided as		
	assistance of one staff for eating and personal				indicated.		
	hygiene. She was o						
	and had no significar	nt weight loss.			2. On 10/4/17, the Director of Clinical		
					Services(DCS), MDS Coordinator, ar	ıd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 09/14/2017	
		345442 B. WING					
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		1 03/14/2017	
FORREST		CENTER		620 HEATHWOOD DRIVE			
FORREST	OAKES HEALTHCARE	CENTER		ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	DATE	
F 412	Continued From page 61		F 4				
		ical record revealed no nsultations, or appointments #9 's dental care.		Social Worker completed assurance monitoring and 57 current residents' dent dental care recommendat orders from 7/1/17-9/30/1	d observation of al status and of iions and/or		
	Worker (SW) on 9/14 indicated she was re	nducted with the Social 4/17 at 9:10 AM. She esponsible for scheduling		dental services are provid No further discrepancies v	were identified.		
	routine dental visits for the residents. She stated if a dentist recommended a follow up appointment after a routine visit the nursing staff was responsible for coordinating the follow up appointment. The dental consultation dated 1/19/17 for Resident #9 that indicated she needed immediate care was reviewed with the SW. The medical record that contained no			3. On 10/13/17, the Director of Clinical Services completed reeducation to licensed nurses and the Social Worker on following physicians' orders and the coordination of dental services for residents to meet their dental care needs. Education included the expectation of the licensed nurse to communicate emergent			
	related to Resident # 1/19/17 dental appoint the SW. She stated	nsultations, or appointments 49 's dental care following the intment was reviewed with she was going to review the e if anything was missing chart.		dental care needs to the S via a copy of physician or coordination and scheduli services as ordered by the Newly hired licensed nurs Workers to be educated u	der for ing of dental e physician. ses and Social		
	A follow up interview was conducted with the SW on 9/14/17 at 9:28 AM. She stated she was unable to locate any additional documentation related to Resident #9 's dental care. She revealed the dental recommendation from 1/19/17 for immediate care for Resident #9 had not been followed. The SW stated she contacted a dental provider and scheduled an appointment for Resident #9 on 9/21/17 at 9:00 AM.			The licensed nurse to conemergent dental care need Worker for coordination at dental services as ordered physician to meet the resicare needs. The Social Worker coordinate routine onsite dental services to resident of bi-annually.	eds to the Social and scheduling of d by the idents' dental /orker to contracted ts at a minimum		
	Nursing (DON) on 9/indicated the SW wa	nducted with the Director of //14/17 at 10:35 AM. She as responsible for scheduling for the residents. She stated		4. The Minimum Data Set LPN Supervisor to comple assurance monitoring of 5 residents by review of der recommendation and/or o compliance and by physic	ete quality 5 random ntal orders for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345442	B. WING			09/14/2017	
NAME OF PROVIDER OR SUPPLIER FORREST OAKES HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)		I	PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO TH		ULD BE COMPLETION	
F 412	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	· · · · · · · · · · · · · · · · · · ·		BE COMPLÉTION DATE Der ary. ency 1 thly ty t t II The and a as utive nt, ry es ble	