STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 07/02/2018

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

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F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		7/23/18

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

Electronically Signed | 07/23/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, and Department of Social Services Staff, the facility failed to treat Resident #1 in a respectful and dignified manner during incontinence care causing the resident to feel embarrassed. This was for 1 of 3 residents reviewed for dignity. The findings included: Resident #1 was admitted to the facility on 5/24/18 and most recently readmitted on 6/1/18 with diagnoses that included anxiety disorder, atrial fibrillation, heart failure, chronic obstructive pulmonary disease, peripheral vascular disease, muscle weakness, and difficulty in walking. The admission Minimum Data Set (MDS) assessment indicated Resident #1 ' s cognition was intact. She had no behaviors and no rejection of care. Resident #1 required the extensive assistance of 1 with toileting, dressing, and locomotion on the unit. She required the limited assistance of 1 with bed mobility and the supervision of 1 for transfers and personal hygiene. Resident #1 was not steady, but was able to stabilize without staff assistance. She had no impairment with range of motion and she utilized a wheelchair. Resident #1 was frequently incontinent of bladder and bowel. The Activities of Daily Living (ADL) Care Area Assessment (CAA) for Resident #1 ' s admission MDS indicated she was admitted to the facility post hospitalization related to heart failure. She	F 550	Preparation and/or execution of this plan, does not constitute agreement or admission by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F636483.20 (b) (1) (2) (i) (iii) F550 – 483.10 Resident Rights/Exercise of Rights(a)(1)(2)(b)(1)(2) On 6/13/2018, resident #1's family member completed a concern form indicating a Nursing Assistant asked resident #1 why she had not gone to the bathroom instead of using her brief. That statement, according to resident #1, made her feel bad. The facility completed a grievance report and conducted an investigation. The Executive Director instructed the interim Director of Nursing to remove the Nursing Assistant in question from resident #1's assignment for the remainder of resident #1's stay. The Executive Director and Social Services Director met with resident's family members and discussed the investigation and informed resident #1's family members of the facility plan to remove the Nursing Assistant in question from resident #1's assignment for the remainder of resident #1's stay. Additionally, the Executive Director and	

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F 550	Continued From page 2 was alert and was able to voice her wants and needs to staff. She required supervision to extensive assistance with her ADL completion. The Incontinence CAA for the admission MDS indicated Resident #1 was frequently incontinent of bladder and bowel and that staff provided all toileting needs. Resident #1 ' s plan of care included the problem area of an ADL self-care performance deficit, implemented on 6/14/18, related to limited mobility. The plan of care also included the problem area of safety, implemented on 6/14/18, related to Resident #1 ' s vision/hearing problems, gait/balance problems, incontinence, complaints of weakness, and decreased mobility. A concern form dated 6/13/18 completed by a family member of Resident #1 ' s indicated a Nursing Assistant (NA) asked Resident #1 why she had not gone to the bathroom instead of using her brief. The concern form stated, "This incident made [Resident #1] feel bad ...she can ' t control her bowels or bladder right now and this isn ' t her fault. She was demeaned and made to feel worse than she already feels about her condition". A social service progress review note dated 6/28/18 indicated Resident #1 was able to understand, respond, and make herself understood. Her cognition was noted as fully intact. A phone interview was conducted with Resident #1 on 7/2/18 at 10:26 AM. Resident #1 was alert and oriented. She reported that when she was admitted to the facility the staff had instructed her to use the call light if she needed to use the	F 550	Social Services Director met with resident #1 on 3 separate occasions, including date of discharge of resident #1, to follow up with resident #1 and ensure there were no further issues. Through root cause analysis and based on the findings for resident #1, it was determined the facility failed to interview all alert and oriented residents to determine if the Nursing Assistant in question had made similar comments to any other resident. Also, the facility did not follow through with resident #1 utilizing psychology and or social service disciplines to determine if resident #1 could benefit from these services. Following the root cause analysis, the Social Services Director interviewed 100% of the alert and oriented residents asking them each the following questions; 1. Do you feel safe in the facility? 2. Has anyone harmed you? 3. Have you witnessed abuse? 4. Has anyone been disrespectful to you? 5. Are you afraid of anyone? 6. Do you know how to report abuse? No further concerns following those questionnaires were discovered. On 7/19/208, the Corporate Risk Manager with Consulate Heathcare provided education to the Interdisciplinary Team on Consulate policies and procedures pertaining to Reportable Events. Education included completing thorough investigations and follow up. The Interdisciplinary Team Members are inclusive of, but not limited to, the Executive Director, Director of Nursing,	

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F 550	Continued From page 3 bathroom as she required assistance with getting out of bed, into the bathroom, and onto the toilet. She was asked about the incident related to the concern form written on 6/13/18 by one of her family members. Resident #1 indicated she pressed her call light because she needed assistance to the bathroom for a bowel movement. She indicated it had taken about 15 minutes for the call light to be answered and during that time she had the bowel movement in her brief. Resident #1 stated that 2 NAs came into the room, she was unable to recall their names, and she told them she had already had the bowel movement in her brief. She reported that one of the NAs said something like, "don ' t you know when you have to use the bathroom". Resident #1 stated that this embarrassed her and "made her feel about a half an inch tall and it hurt her feelings". A phone interview was conducted with Department of Social Services (DSS) Staff on 7/2/18 at 9:39 AM. He indicated he was at the facility on 6/31/18 to investigate concerns reported by one of her family members. He stated he also interviewed Resident #1 at her home residence as she had been discharged from the facility on 6/28/18. The DSS staff stated there was one issue reported by the family member that Resident #1 also expressed as a concern. Resident #1 reported to DSS staff that one of the NAs, no name provided, had said something like, "you know better", when she had a bowel movement in her brief. He indicated Resident #1 told him this had made her feel bad. An interview was conducted with NA #3 on 7/2/18 at 11:15 AM. She stated she had worked at the facility for about a month and had been an NA	F 550	Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. The facility also conducted education on abuse, neglect, including verbal abuse for 100% of all staff as of 7/20/2018. This citation has the potential to affect all residents in the facility. An Ad Hoc Quality Assurance and Performance Improvement Meeting was conducted on 7/12/2018 to discuss the root cause analysis and plan of correction. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. To maintain compliance, starting 7/10/2018, the Social Services Director will monitor staff conversing with residents to ensure they are maintaining dignity and resident's rights. The Social Services Director will also monitor staff in utilizing appropriate language with residents throughout the facility. This will be completed on each shift, daily for 1 week, then weekly for 4 weeks, then monthly thereafter as determined by the Quality Assurance and Performance Improvement Committee to maintain compliance. The results of the Quality Assurance monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly by the	

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F 550	Continued From page 4 about 5 years. She was asked about the incident related to the concern form written on 6/13/18 by one of Resident #1 ' s family members. She confirmed she was assisting NA #4 with Resident #1 ' s incontinence care on 6/13/18. She indicated Resident #1 had a bowel movement in her brief. She stated she and NA #4 assisted Resident #1 into the bathroom, provided incontinence care, and changed her clothes. She denied saying anything disrespectful to Resident #1. She also denied hearing NA #4 saying anything disrespectful to Resident #1. A phone interview was conducted with NA #4 on 7/2/18 at 12:40 PM. She stated she had worked at the facility for about a month and had been an NA for over 5 years. She was asked about the incident related to the concern form written on 6/13/18 by one of Resident #1 ' s family members. She confirmed she was working with Resident #1 on 6/13/18 and she and NA #3 had assisted her with incontinence care as well as changing her pants as she had a bowel movement in her brief. NA #4 denied saying anything disrespectful to Resident #1. She also denied hearing NA #3 saying anything disrespectful to Resident #1. The Director of Nursing (DON) was unavailable for interview as she had been out of the facility since May 2018 on an overseas trip. An interview was conducted with Unit Manager (UM) #1 on 7/2/18 at 5:10 PM. She indicated she was responsible for oversight of the DON duties while she had been out of the facility. She stated she expected all residents to be treated in a dignified and respectful manner.	F 550	Executive Director for twelve months and /or until substantial compliance is obtained. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. The Executive Director is responsible for implementing and executing this plan. Date of compliance: July 23, 2018	

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F 691	Continued From page 5	F 691		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to provide urostomy (surgically created artificial opening for the elimination of urine) collection bag changes as ordered by the physician for 1 (Resident #3) of 1 residents reviewed for ostomy care. The findings included: Resident #3 was admitted 3/25/18 with cumulative diagnoses of Chronic Kidney Disease and Urostomy. His admission Minimum Data Set dated 3/31/18 indicated Resident #3 was cognitively intact and exhibited no behaviors. He was coded for a urostomy. Review of a written physician order dated 3/25/18 read for the staff to change Resident #3's urostomy bag every 5 days and prn (as needed). Review of Resident #3's care planned dated 4/5/18 indicated he was to receive urostomy care as ordered by the physician. Review of the March 2018 Treatment Administration Record (TAR) read an order to change Resident #3's urostomy bag every 5 days	F 691	F691 – 483.25(f) Colostomy, Urostomy, or Ileostomy care CFR(s) Through root cause analysis, it was found, the facility did not provide urostomy collection bag changes as ordered by the physician for resident #3. Additionally, through the root cause analysis and based on the findings for resident #3, it was determined the facility did not document resident #3's urostomy bag was changed from 3/30/2018 through 7/1/2018 as ordered by the physician. Also, it was discovered the facility did not have orders written specifically for care of the wafer as related to the urostomy bag, nor were there orders written to check for skin integrity around the site. On 7/10/2018, Physician orders were written for clarification for urostomy care for resident #3 to include; 1. Change urostomy wafer and bag every 5 days and as needed. 2. Ostomy site, skin checked every shift for signs/symptoms of infection. Notify physician of any	7/23/18

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F 691	Continued From page 6 dated 3/25/18. There were no documented staff initials that his urostomy bag was changed 3/30/18 as ordered. Review of the April 2018 TAR indicated Resident #3's urostomy bag was scheduled to be changed on 4/4/18. There were no documented staff initials that his urostomy bag was changed on 4/4/18. There were documented staff initials that the urostomy bag was changed on 4/8/18, 4/14/18 and 4/19/18 as scheduled. There were no documented staff initials that his urostomy bag was changed as scheduled on 4/24/18. There were staff initials indicated his urostomy bag was changed on 4/29/18. Review of the May 2018 TAR indicated Resident #3's urostomy bag was not changed again until 5/6/18, a period of 7 days. There was no documented staff initials that Resident #3's urostomy bag was changed as scheduled on 5/11/8, 5/16/18, 5/21/18, 5/26/18 or 5/31/18. Review of the June 2018 TAR indicated Resident #3's urostomy bag was not changed again until 6/5/18, a period of 30 days. There was evidence of documented staff initials that his urostomy bag was changed as scheduled on 6/10/18, 6/15/18 and 6/20/18. There was no documented staff initialed that Resident #3's urostomy bag was changed as scheduled on 6/25/18 and 6/30/18. Review of the July 2018 TAR indicated Resident #3's urostomy bag was not again changed until 7/1/18 a period of 10 days. In an interview and observation on 7/2/18 at 9:30 AM, Resident #3 was lying in bed. He lifted his shirt to reveal and small urostomy bag attached	F 691	urostomy site skin alterations. 3. Cleanse peristoma site with normal saline. Pat dry and place wafer and bag on change days which is every 5 days. Education was provided by the Director of Nursing to 100% of all nurses on the Clinical guidelines of Urostomy care and a Urostomy care competency checklist completed as of 7/11/2018. This citation has the potential to only affect resident's with Urostomy, Colostomy or Ileostomy care. An Ad Hoc Quality Assurance and Performance Improvement Meeting was conducted on 7/12/2018 to discuss the root cause analysis and plan of correction. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. To maintain compliance, starting 7/10/2018, the Director of Nursing will monitor physician orders for urostomy care and review for accuracy during daily clinical meeting. Additionally, the Director of Nursing will monitor urostomy care orders contain necessary components, site observation, cleaning and wafer and bag change. This monitoring will be completed daily for 7 days, then weekly for 4 weeks, then monthly thereafter as determined by the Quality Assurance and Performance Improvement Committee to maintain compliance.	

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F 691	Continued From page 7 to his abdomen. Resident #3 stated his urostomy bag with adhesive wafer may have been changed twice since admission and he asked the nurse working yesterday to change it for him. He stated she changed it yesterday. In a telephone interview on 7/2/18 at 3:15 PM, Nurse #2 stated Resident #3 asked her to change his urostomy bag yesterday. She stated it was ordered to be changed every 5 days and noted it was not being changed as ordered. Nurse #2 stated she did not tell a supervisor that Resident #3's urostomy bag was not being changed as ordered. In an interview on 7/2/18 at 3:45 PM, Unit Manager (UM) #2 stated the Director of Nursing (DON) had been on leave since 5/11/18. She stated in her absence, UM #1 was assuming the responsibilities of the DON. UM #2 stated every month, the DON, herself and UM #1 reviewed all the Medication Administration Records (MAR) for any missing or omitted medications. She stated she personally did not review the TARs for missing or omitted treatments. UM #2 stated she was not aware until today that Resident #3 was not receiving his urostomy bag changes as ordered. In an interview on 7/2/18 at 3:50 PM, UM #1 stated she assisted with the monthly MAR review for omissions but did not review the TARs. She stated she was not aware that Resident #3 was not aware until today that Resident #3 was not receiving his urostomy bag changes as ordered. UM #1 stated it was her expectation that Resident #3's urostomy care be provided as ordered. In a telephone interview on 7/2/18 at 5:25 PM, the	F 691	The results of the Quality Assurance monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing for twelve months and /or until substantial compliance is obtained. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. The Director of Nursing is responsible for implementing and executing this plan. Date of compliance: July 23, 2018	

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F 691	Continued From page 8 Physician stated it was his expectation that Resident #3's receives his urostomy bag changes as ordered.	F 691		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention	F 732		7/23/18

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F 732	Continued From page 9 requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure the daily nursing staffing hours were accurate and complete for 4 of 4 months reviewed. The findings included: Review of the March 2018 Daily Nursing Staffing Form did not include the Registered Nurse (RN) Coverage for the following dates: 3/2/18 3/5/18 3/9/18 3/14/18 3/16/18 3/18/18 3/19/18 3/23/18 3/27/18 3/30/18 Review of the April 2018 Daily Nursing Staffing Form did not include the RN Coverage for the following dates: 4/2/18 4/6/18 4/11/18 4/13/18 4/16/18 4/20/18 4/25/18 4/27/18 4/30/18 Review of the May 2018 Daily Nursing Staffing	F 732	F732 – 483.35(g)(1)-(4) Posted Nurse Staffing Information On 39 occasions between 3/2/2018 – 6/25/2018, the facility did not appropriately document correct RN coverage on the Daily Nursing Staffing Forms. Through root cause analysis and based on the findings, it was discovered, the facilities Human Resource Coordinator had been filling out the forms but did not complete them correctly on all of the dates in question. The facility did however, have RN coverage on every single occasion for at least 8 hours within a 24 hour period each day, although did not document this correctly. The facility has in-serviced all nurses on how to fill out the form correctly as of 7/9/2018. Additionally, the staffing coordinator and unit managers were in-serviced on accurately completing the form as of 7/9/2018. Nursing, nurse unit managers or the staffing coordinator will make corrections throughout the day to the daily form as needed. This citation has the potential to affect all residents. An Ad Hoc Quality Assurance and Performance Improvement Meeting was conducted on 7/12/2018 to discuss the root cause analysis and plan of	

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F 732	Continued From page 10 Form did not include the RN Coverage for the following dates: 5/9/18 5/11/18 5/14/18 5/18/18 5/23/18 5/25/18 5/27/18 5/28/18 Review of the June 2018 Daily Nursing Staffing Form did not include the RN Coverage for the following dates: 6/1/18 6/6/18 6/8/18 6/15/18 6/20/18 6/22/18 6/23/18 6/24/18 6/25/18 In an interview on 7/2/18 at 3:37 PM, the Administrator stated there had been changes in who was responsible to ensure the daily nursing staffing hours posting was complete and accurate. He was unable to direct the surveyor to the staff member who posted the nursing staffing hours for the dates in question or who was responsible at present. The Administrator stated it was his expectation the Daily Nursing Staffing Form be complete and accurate.	F 732	correction. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data Assessment Nurse. To remain in compliance and under the direction of the Executive Director, beginning 7-3-18, monitoring the correctness of the Daily Nursing Staffing Forms commenced. This Daily Nursing Staffing Form monitoring will be reviewed daily for accuracy. This monitoring will be completed daily for 7 days, then weekly for 4 weeks, then monthly thereafter as determined by the Quality Assurance and Performance Improvement Committee to maintain compliance. The results of the Quality Assurance monitoring will be reported to the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing for twelve months and /or until substantial compliance is obtained. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the monitoring/observations for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Committee consist of, but not limited to, the Executive Director, the Medical Director, Director of Nursing, Social Services Director, Activities Director, Dietary Manager and Minimum Data	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 07/02/2018

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

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F 732	Continued From page 11	F 732	Assessment Nurse. The Executive Director is responsible for implementing and executing this plan. Date of compliance: July 23, 2018	