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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 10/30/23 through 11/2/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# VCCZ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 10/30/23 through 11/2/23. Event ID# VCCZ11. The following intakes were investigated NC00204808, NC00205027, NC00206730, NC00206760, NC00207439, NC00208468, NC00208798. 9 of the 31 complaint allegations resulted in deficiency.	F 000		
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	F 550		11/28/23

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

Electronically Signed | 11/17/2023

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 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 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to promote dignity by the resident having no control of her over the bed light resulting in being awakened and disturbed when her over the bed light was turned at the light switch by the room door to assist her roommate. This resulted in the resident feeling angry and frustrated. This was for 1 (Resident #29) of 3 residents reviewed for dignity. The findings included: Resident #29 was admitted on 2/17/23 with diagnoses of Osteoarthritis and Diabetes. Her quarterly Minimum Data Set dated 8/14/23 indicated she was cognitively intact.	F 550	Forrest Oakes Healthcare Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction as required by Federal and State regulations and statutes applicable to long term care providers. This plan does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or the scope or severity regarding any of the deficiencies cited are correctly applied.	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 An interview and observation was completed with Resident #29 in her room on 11/1/23 at 10:20 AM. She stated her over bed light would not turn off using the attached string. This surveyor pulled the string to turn off her light but the light remained on. She stated her light was controlled at the switch by the door so anytime staff entered the room to assist her roommate, her light would light up causing her to wake up at night. Resident #29 stated she had reported it to the staff but the Maintenance Director man was seldom around. An interview was completed on 11/1/23 at 11:10 AM with the Maintenance Director. He stated the process of repairs was for the staff to write down anything in need of repair in the notebook outside his office door. He stated nobody wrote down anything about Resident #29's over the bed light. An observation was completed with the Maintenance Director who noted Resident #29's over the bed light would not turn off when he pulled the string. He then turned the light off at the switch by the door stating her over the bed light was wired to the switch by the door. The Maintenance Director stated he wasn't aware of the wiring issue and that the staff had not written anything in his notebook nor had the staff or Resident #29 mentioned issues with her over the bed light. He stated anytime staff entered the room and turned on the light switch, it would turn on Resident #29's over the bed light and stated if he were awakened during the night by the over the bed light, he would be upset.	F 550	F550- Resident Rights/Exercise of Rights: 1. The over bed light in resident #29 room was fixed on 11-15-2023. 2. A quality review was completed by the Maintenance Director of all residents over bed lights to ensure light above bed is properly on 11-09-2023. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11-14-2023 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing educated nursing staff on residents' rights related ensuring lighting is kept at a minimal to attempt not to disturb resident not receiving care by 11-22-2023. Nursing staff will be educated by the Director of Nursing to document on the maintenance log when lighting is not properly working by 11-22-2023. The Executive Director will educate the Maintenance Director on identifying and fixing overbed lights not properly working on 11-09-2023. Nursing staff that has not completed the education will complete the education prior to working next scheduled shift. Newly hired nursing staff will be educated upon hire during orientation. 4. The Maintenance Director/Executive Director will conduct random Quality reviews of residents over bed lights 3 times a week for 8 weeks then weekly for	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3	F 550	4 weeks to ensure over bed lights are working properly. The Maintenance Director will report the results of the quality monitoring (audit) and report to the (QAPI) Quality Assurance Performance Committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to complete a self-administration of medication assessment, obtain a physician's order, and care plan self- administration of medication before leaving medication at the resident's bedside. This was for 1 of 7 residents (Resident #27) reviewed for unnecessary medication. Findings included: Resident #27 was admitted to the facility on 1/1/2022 with diagnoses including chronic obstructive pulmonary disease (COPD). A review of Resident #27's quarterly Minimum Data Set (MDS) assessment dated 8/27/2023 indicated the resident was cognitively intact with adequate vision. A review of Resident #27's current	F 554	F554- Resident Self-Admin Meds-Clinically Appropriate: 1. A self-administration evaluation was completed on resident #27 on 11/16/2023. Resident was informed that based on self-medication administration policy and evaluation for self-administration of medication that she will be able to self-administer Ipratropium Bromide Inhalation Solution as they are due. The nurse will keep the medication on the cart and whenever a dose is due per orders the nurse will deliver to the resident's room and leave at bedside for self-administration. Resident is her own RP. 2. A quality review was completed on 11/16/2023 by the Director of Nursing and the Unit Manager of current residents with	11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 4 comprehensive care plan last revised 9/11/2023 did not contain a focus for self-administration of medication. On 11/2/2023 a review of Resident #27's medical record revealed there were no assessments indicating Resident #27 was safe to self-administer medication and there was no physician's order for Resident #27 to self-administer medication. On 10/30/2023 at 11:00 AM an observation of Resident #27 revealed an ampule of albuterol (medication to treat wheezing and shortness of breath) on her bedside table next to her nebulizer machine. An interview was conducted with Resident #27 at that time. She stated the nurse left the ampule of albuterol for her to use if she needed it. She further stated the nurses typically left the medication bedside as she was able self-administer without any difficulty. An interview was conducted with Nurse #4, who was assigned to Resident #27, on 10/31/2023 at 2:32 PM. She stated the resident does sometimes self-administer her nebulizers. Nurse #4 further stated she had only been employed at the facility for a little over a week and was not familiar with all of the facility's policies. She was not aware the resident required an assessment and physician order to self-administer medication. On 11/2/2023 at 8:45 AM an observation of Resident #27 revealed an ampule of albuterol on her bedside table with her nebulizer machine. The resident stated the nurse left the medication bedside for her to use as needed. On 11/2/2023 at 10:04 AM an interview was	F 554	BIMS score of above 12 desire to self-administer, two other residents were identified, but unable to self-medicate per self-medication administration policy. A quality review of resident rooms was completed on 11/03/2023 and no further issues related to medications at the bedside were identified. An ADHOC Quality Assurance Performance Improvement Committee was held on 11/14/2023 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing will educate current nurses and medication aides on policy for self-administering medications to include not leaving medications at bedside by 11/22/2023. Nurses and medication aides that have not completed the education will complete the education prior to working their next scheduled shift. Newly hired nurses and medication aides will be educated upon hire during orientation. 4. The Director of Nursing and the Unit Manager will conduct random Quality reviews of resident’s rooms to ensure medications were not left at bedside on 5 random residents 3 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring audit and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring audit updated as indicated.	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 5 conducted with the Director of Nursing (DON). She stated there needed to be a self-administration of medication assessment completed to determine if a resident was appropriate to self-administer medication and a physician's order for the self-administration of medication prior to the medication being left bedside.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 6 facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to provide showers as scheduled or as needed for 1 (Resident #29) 3 residents reviewed for choices. The findings included: Resident #29 was admitted on 2/17/23 with diagnoses of Osteoarthritis and Diabetes. A grievance dated 7/9/23 read she had not received a shower in a month. The investigation found documentation that she received a shower on 6/20/23, 6/26/23, 7/2/23 and 7/4/23. Resident #29 refused the shower bed and staff were to notify the nurse for any refused showers. Her quarterly Minimum Data Set dated 8/14/23 indicated she was cognitively intact and required staff assistance with showering. Resident #29 was care planned for staff assistance with her showers. There was no care plan indicating she refused showers. An interview and observation was completed with Resident #29 in her room on 11/1/23 at 10:20 AM. She stated she did not receive her showers as scheduled. Resident #29 stated she had tried the shower chair in the past but it doesn't feel safe so she was given her showers using the shower bed. Resident #29 stated she had her shower days and time changed because the staff told her they were too busy to give it to her on first shift. She stated she now was supposed to receive her showers in the evenings but she was still not getting them.	F 561	F561- Self Determination: 1. Resident #29 received a shower on 11/03/2023. Unit Manager interviewed Resident #29 regarding showers to ensure receiving showers per residents' choice. 2. A quality review was completed by the Unit Manager of current interview able residents to ensure residents are receiving showers per residents' choice on 11/17/2023. Care plan, Kardex and shower schedule updated to reflect resident's shower preference. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11/14/2023 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing and the Unit Manager will educate nursing staff on residents' choice related to receiving showers by 11/22/2023. Nursing staff that has not completed the education will complete the education prior to working next scheduled shift. Newly hired staff will be educated upon hire during orientation. 4. The Director of Nursing and Unit Manager will conduct random Quality reviews by resident interviews of 5 residents to ensure resident receiving showers per resident's choice 2 times a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 7 Review of Resident #29's written and electronic evidence of showers read she received a shower 9/1/23, 9/22/23, 10/3/23,10/13/23 and 10/25/23 rather than twice weekly. An interview was completed on 11/1/23 at 10:25 AM with Nursing Assistant (NA) #1. A tour was completed of the shower rooms with NA #1. Observed was a shower bed, bariatric shower chair and a mechanical lift pad with an opening at the bottom to allow for washing. NA #1 stated Resident #29 was not known to refuse her showers and she recently had showers moved to evenings because Resident #29 stated it helped her sleep better. An interview was completed on 11/1/23 at 2:47 PM with NA #4. She stated the facility was short staffed and occasionally, she was unable to complete her assignment and showers. She stated Resident #29 would refuse showers at times. An interview was completed on 11/2/23 at 9:35 AM with NA #3. He stated he worked at the facility for approximately 5 months and was familiar with Resident #29. He stated he was not aware of any shower refusals and he did not feel the facility was short staffed except to days when there is a call out. NA #3 stated on those days it was tougher to complete his assignment but he gets it done. An interview was completed on 11/2/23 at 11:00 AM with the Director of Nursing (DON). She stated Resident #29's should be provided her scheduled showers and showers as requested per her choice.	F 561	week for 8 weeks then weekly for 4 weeks. The Director of Nursing or Unit Manager will report the results of the quality monitoring audit and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident council	F 565	F565- Resident/Family Group and	11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 9 members and staff interviews, the facility failed to resolve repeated grievances regarding cold food for 2 of the last 4 months, not answering call bells timely for 3 of the last 4 months and late medications for 4 of the last 4 resident council meetings. The findings included: Review of the resident council meeting minutes for 7/26/23 read new business was call bells not being answered, cold food and late medications. Grievances were completed regarding late medications and cold food. There were no grievances regarding the call bells. Review of the resident council meeting minutes dated 8/22/23 read old and new business reviewed was late medications, aides answering call bells timely and cold food and remained unresolved. A grievance was completed regarding late medications but not for cold food or answering call bells timely. Review of the resident council meeting minutes dated 9/20/23 read old and new business of late medications and aides not answering call bells timely. A grievance was completed regarding late medications and call bells. Review of the resident council meeting minutes dated 10/24/23 read old and new business of late medications and aides not answering call bells timely. New business included cold food. Grievances were completed regarding late medications and the call bells but not for cold food. A resident council meeting was held on 11/1/23 at 1:30 PM with 12 residents that regularly attend the meetings. Five of the 12 stated they felt like	F 565	Response 1. The Executive Director, Social Services Director (SSD) and Activities Director (AD) reviewed last 3 months of resident council minutes and initiated a grievance for each concern. Cold food, call bells and late medications grievances were addressed and follow-up completed on 11-17-2023 and reported to Resident Council on next scheduled meeting on 11-27-2023. 2. The Executive Director, AD and SSD conducted a Resident Council to discuss prompt response to grievances and to ensure residents are free to participate in Group Meeting and receive a prompt response on their grievance on 11-17-2023. Cold food, call bells and late medications grievances were addressed. No new grievances received. An Ad hoc Quality Assurance Performance Improvement Committee was held on DATE to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director (ED) educated the Social Services Director (SSD) and Activities Director (AD) on timely response and filing of Grievances/Concerns received during Resident Council and, ensure follow-up and grievance is resolved and is reported to Resident Council at the next scheduled meeting on 11-14-2023. 4.The Executive Director will review	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 10 their concerns 'fell on deaf ears" and voiced a lot of frustration with issues remaining unresolved. Residents voiced continued unresolved issues regarding cold food and call bells. They also voiced frustration regarding call bells, the ice machine in the dining room being broken since they mentioned it in their August resident council meeting. The only answer ever provided by the facility was that the part was on back order. Residents voiced the kitchen did not offer an alternate except for a peanut butter and jelly sandwich and did not serve what on the menu. An interview was completed on 11/1/23 at 2:53 PM with the Director of Nursing (DON). She stated she started her position late September and began working on call bell audits in October and was ongoing. She also stated the issue of late medications was partially resolved due to hiring and training more staff. An interview was completed on 11/2/23 at 10:45 AM with the Administrator. She stated the facility replaced the food serve carts in an effort to resolve the cold food issues and had been completing audits of the call bells. She stated she was unaware of the ongoing concerns regarding the ice machine in the dining room but she would follow up with the Maintenance Director. The Administrator stated resident council grievances should be resolved timely but there were concerns that required more time to fix. When that happens, the facility should follow up with the resident council to explain why an issues remained unresolved.	F 565	resident council minutes bimonthly for 2 months then monthly for 1 month to ensure resident's grievances including cold food, call bells and late medications are initiated and followed up timely. ED and DCS will attend Resident Group meetings (when invited) to ensure timely follow-up and response to grievances. Resident council meetings will be held every other week for 8 weeks then continue with monthly. Findings will be reviewed by QAPI committee monthly and Quality Monitoring updated as indicated.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 11	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 12 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to ensure residents over the bed lights were in working order. This was for 2 (Resident #30 and Resident #40) of 5 residents reviewed for pressure ulcers. The facility also failed to ensure the walls in resident rooms were in good repair. This was for 4 (room #'s 117, #118, #123 and #127) of 19 rooms reviewed for homelike environment. The findings included: a) During a wound care observation of Resident #30 on 10/31/23 at 11:00 AM, the Wound Nurse attempted to turn the over the bed light on, but it did not come on. The Wound Nurse stated it was difficult to see what she was doing because there were no ceiling lights in any of the resident rooms. Resident #30 stated the Maintenance Director came in and stated he would replace the bulb in his over the bed light. b) During an observation of wound care on 10/30/2023 at 10:19AM, the Wound Nurse could not get Resident #40's overhead light to function. The wound bed could not be visualized. After completing wound care, the Wound Nurse used her cell phone light to check the alternating air mattress settings. The Wound Nurse stated she would get the Maintenance Director to fix the over the bed light. c) Observations completed from 10/30/23 to 11/2/23, of rooms 117, 118, 123 and 127 revealed the wall behind residents' beds were in disrepair	F 584	F584- Safe/Clean/Comfortable/Homelike Environment: 1. Resident #30 and Resident #40 overbed light was fixed on 11-02/2023 by the maintenance director. The wall was repaired in rooms 117, 118, 123 and 127 on 11-17-2023 by the Maintenance Director. 2. A quality review was completed by the Maintenance Director and Executive Director to assess function of all overbed lights on 11-09-2023. 10 overbed lights was identified that needed to be fixed. A quality review was completed by the Maintenance Director and Executive Director to identify any walls needing repairs on 11-09-2023. 20 rooms identified as needing wall repair. An ADHOC Quality Assurance Performance Improvement Committee was held on 11-14-2023 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director educated the Maintenance Director on ensuring overbed lights are working properly and walls are in good repair on 11-09-2023. Department managers and nursing staff educated on documenting on maintenance log when overbed lights not working properly and any wall repair needed by the Executive Director/Director	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 13 with dents and exposed sheetrock. During an observation and interview on 11/1/23 at 11:10 AM, the Maintenance Director provided a notebook outside his office where staff wrote down issues and repairs for him to address. He attempted to turn on the light over Resident #30's bed, but it did not turn on. He stated there was nothing in his notebook about Resident #30's or Resident #40's bulb needing to be changed. The Maintenance Director stated someone likely just told him about a burnt-out light bulb yesterday, but he didn't recall which room it was. He toured rooms 117, 118, 123 and 127 and noted the condition of the resident's walls. The Maintenance Director stated he knew there were a lot of walls in need of repair, but he was doing his best and could only do so much. An interview was completed on 11/2/23 at 10:45 AM with the Administrator. She stated there was no specific plan for repairing the walls in the resident rooms and the Maintenance Director had trouble prioritizing his work.	F 584	of Nursing by 11-22-2023. 4. The Executive Director will conduct random Quality reviews by observation of 5 resident's overbed lights to ensure working and in good repair and 5 residents' rooms to ensure walls are in good repair 2 times a week for 8 weeks then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff, the facility failed to document correct route of medication administration for 1 of 5 resident's (Resident #40) reviewed for unnecessary	F 658	F658- Services Provided Meet Professional Standards: 1. Resident #40 physician orders were	11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 14 medication. The findings included: Resident #40 was admitted to the facility on 6/16/2021 with diagnoses that included cerebral vascular accident (stroke) and anoxic brain injury. The resident's annual Minimum Data Set (MDS) dated 9/15/2023 indicated the resident was severely cognitively impaired. She was totally dependent with activities of daily living, personal hygiene, toileting, and eating. The resident was provided enteral nutrition during the assessment period. Resident #40's care plan was last revised 10/5/2023 included a focus for therapeutic tube feeding to meet nutritional needs. The resident's medical record included physician's orders as follows: Administer Glucerna 1.5 via feeding tube at 270 milliliters (ml) every 8 hours for nutrition with a start date of 9/13/2023. Flush feeding with 200ml before and after each bolus feeding. The resident also had a physician's order for 220 milligrams (mg) of Zinc by mouth daily for wound. The order had a start date of 8/16/2023 and was entered by the Wound Nurse. On 10/31/2023 at 11:35AM an interview was conducted with Nurse #4 who was assigned to Resident #40. She stated she gave all the resident's medication via percutaneous endoscopic gastrostomy tube (PEG). Nurse #4 further stated Resident #40 did not tolerate	F 658	updated to reflect correct route of medication via G-tube on 10/31/2023 by the nurse. 2. A quality review was completed by the Unit Manager and the Director of Nursing of current resident's physician orders to ensure accurate route of medication noted on 11/17/2023. No further concerns noted. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11/14/2023 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing will educate current nurses including all shifts, part time and prn on ensuring orders are written accurately to reflect correct route of medication administration by 11/22/2023. Nurses that have not completed the education will complete the education prior to working their next scheduled shift. Newly hired nurses will be educated upon hire during orientation. 4. The Unit Manager and the Director of Nursing will conduct random Quality reviews of current physician orders to ensure correct route of medication noted on order on 10 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring audit and report to the Quality Assurance and Performance Improvement committee (QAPI). Findings will be reviewed by QAPI committee monthly and Quality monitoring audit updated as indicated.	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 15 anything by mouth. On 10/31/2023 at 11:45AM an interview was conducted with the Wound Nurse regarding the order for oral Zinc. She stated she entered the order. She further stated the order should have been via PEG tube and not oral. It was an error.	F 658		
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.	F 661		11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews, the facility failed to complete a comprehensive discharge summary for 1 of 1 resident reviewed for discharge. (Resident #63). The Findings included: Resident #63 was initially admitted to the facility on 08/18/22. Review of Resident #63's quarterly Minimum Data Set (MDS) assessment dated 04/18/23 revealed Resident #63 ' s cognition was moderately impaired. A review of the discharge MDS assessment dated 06/27/23 revealed it was a planned discharge. Review of Resident #63's electronic medical record revealed he was discharged from the facility on 06/27/23 to another skilled facility. Further review of the record revealed no discharge summary documentation for Resident #63's stay in the facility. During an interview with the Minimum Data Set (MDS) Nurse on 11/01/23 at 9:48 AM revealed she was working on 06/27/23 assisting the Assistant Director of Nursing (ADON) with the discharge of Resident #63. She stated she completed the discharge skin assessment but not the discharge plan/summary for Resident #63. She also stated the discharge summary was completed by different departments days prior to the actual discharge but there was not one located in the electronic record for Resident #63. An attempted phone interview was conducted	F 661	F661 Discharge Summary: 1. Resident #63 no longer resides at the facility. 2. A quality review of last 30 days of discharges were reviewed by Executive Director to ensure discharge plan and instructions complete to include recapitulation of stay from activities, social services, nursing, nutrition and therapy on 11-17-2023. An ADHOC Quality Assurance Performance Improvement Committee was held on 11-14-2023 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director provided re-education to Social Services Director, Activity Director, Director of Nursing, Unit Manager, Dietary Manager and Therapy Director on completion of discharge plan and instructions to include recapitulation of stay 11-14-2023. 4. The Executive Director will conduct random Quality reviews of resident’s discharge plan and instructions to ensure complete with recapitulation of stay from activities, social services, nursing, nutrition and therapy on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 17 with the former Assistant Director of Nursing (ADON) on 11/01/23 at 3:23 PM. She was unable to be reached. During an interview with the Administrator on 11/02/23 at 10:05 AM, she indicated it was expected that discharge summaries be initiated by the Social Worker and all departments are to complete their sections. The discharge summaries were to be provided to the resident or resident representative at the time of discharge. She was not aware the discharge summary was not completed for Resident #63. During an interview with the Director of Nursing on 11/02/23 at 10:30 AM, she reported per progress notes the discharge was a family requested discharge. She stated she was not working in the facility at the time of this discharge, but she expected each department to complete proper documentation (the discharge summary) prior to the discharge of a resident. She reported she was unsure why the discharge summary was not completed. During an interview with the Social Worker (SW) on 11/02/23 at 11:26 AM she reported at the time Resident #63 was discharged she was unaware she was supposed to initiate the discharge summary in the electronic medical record (EMR). She indicated she had been in the position for approximately 3 weeks prior to his discharge and indicated it was an oversight that the discharge summary had not been initiated. She stated the process for discharging a resident was she initiates the discharge summary in the EMR, emails all department heads of the upcoming discharge, printed copies of paperwork and creates a discharge packet for the Family Nurse	F 661	Quality monitoring (audit) updated as indicated.	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 18 Practitioner (FNP).	F 661		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and interviews with staff, the facility failed to set an alternating pressure mattress according to a resident's weight in 1 of 5 (Resident #40) residents reviewed for pressure injuries. The findings included: Resident #40 was admitted to the facility on 6/16/2021 with diagnoses that included cerebral vascular accident (stroke) and anoxic brain injury. The resident's annual Minimum Data Set (MDS) dated 9/15/2023 indicated the resident was severely cognitively impaired, rarely understood by others and rarely understood others. She was total dependent with activities of daily living, personal hygiene, and toileting. The MDS also	F 686	F686- Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. Resident #40 air mattress was set according to resident's weight on 10/30/2023 by the nurse. 2. The Director of Nursing and the Unit Manager completed a quality review of current residents with air mattresses to ensure that they are placed on the correct setting on 10/31/2023. No negative findings were identified. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11/14/2023 to formulate and approve a plan of correction for the deficient practice.	11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 19 indicated the resident had one stage 3 pressure injury and two stage 4 pressure injuries during the assessment period. Resident #40's care plan was last revised 10/5/2023 included a focus for risk of impaired skin integrity related to immobility and incontinence. Intervention for this focus included providing resident with alternating air mattress set to resident's weight. The intervention was dated 6/3/2022. On 10/30/2023 at 10:19AM during wound care observations, the resident's alternating air mattress was observed set on 350 pounds (lbs.). The Wound Nurse observed the alternating air mattress set on 350lbs. She stated the alternating air mattress should be set to the resident's weight, but she did not believe the resident was 350lbs. the Wound Nurse reviewed the resident's medical record and found her most recent weight was 136lbs on 10/6/2023. The Wound Nurse stated she was not sure who was responsible for maintaining the correct settings. On 11/02/2023 at 10:27 AM an interview was conducted with the Transporter. He stated he was responsible for setting up alternating air mattresses. He further stated he did set up Resident #40's alternating air mattress and set the control to align with her weight. The Transporter stated he currently had three alternating air mattresses in the facility and he tried to check them daily. He did not know how or why Resident #40's settings were changed. On 11/02/2023 at 10:29 AM an interview was conducted with Nurse #1 who was assigned to Resident #40. She stated she checked the	F 686	3. The Director of Nursing and the Unit Manager will educate nurses including all shifts, part time, and prn on applying correct air mattress setting for residents according to weight by 11/22/2023. Nurses that have not completed the education will complete the education prior to working their next scheduled shift. Newly hired nursing staff will be educated upon hire during orientation. 4. The Director of Nursing and the Unit Manager will conduct a quality monitoring audit of residents on air mattresses to ensure that they are placed on the correct setting 3 times per week for 8 weeks, then weekly for 4 weeks. The Director of Nursing will report on the results of the quality monitoring audit and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring audit updated as indicated.	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 20 mattress for functioning, but she did could not say she looked at the setting every day or every time she entered the room. An interview was conducted with the Director of Nursing (DON) on 1/2/2023 at 9:50AM. She stated she was fairly new to the facility and she was not familiar with the facility policy on alternating air mattresses. The facility's Administrator stated there was no policy or procedure for the use of alternating air mattress.	F 686		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 757		11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff and Physician interviews, the facility failed to obtain blood glucose checks as ordered for an insulin dependent resident. This was for 1 (Resident #25) of 7 residents reviewed for unnecessary medications. The findings included: Resident #25 was admitted on 7/26/22 with a diagnosis of Diabetes. The quarterly Minimum Data Set dated 9/29/23 indicated Resident #25 was cognitively intact and coded for 7 days of taking insulin. Resident #35 was care planned for Diabetes with the intervention of obtaining fast blood sugars as ordered by the Physician. Review of Resident #25's October 2023 Physician orders included an order dated 4/27/22 read blood sugar checks before meals (ac) and at bedtime (hs). Notify the provider of blood glucose <70 or >350. Insulin orders read she was prescribed Novolog 70/30 insulin 8 units in the morning and 6 units in the evening. Review of September and October 2023 medication administration records (MARs) did not include the order for her blood sugar checks ac and hs. Review of the electronic blood sugar results from 9/1/23 indicated Resident #25's blood sugar checks were done either daily or twice daily but no evidence of blood sugar checks 4 times daily at ac and hs.	F 757	F757 Drug Regimen is Free from Unnecessary Drugs 1. Blood sugar was obtained per physician's order on 11/01/2023 by the nurse. MD notified of omission of blood sugars on 10/31/2023. 2. A quality review was completed by the Unit Manager and Director of Nursing of current residents with physician orders for finger stick blood sugars to ensure blood sugars are obtained and documented on 11/16/2023. No further concerns noted. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11/14/2023 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing and the Unit Manager will educate current nurses including all shifts, part time and prn on ensuring blood sugars are obtained and documented as ordered by 11/22/2023. Nurses that have not completed the education will complete the education prior to working next scheduled shift. Newly hired nurses will be educated upon hire during orientation. 4. The Unit Manager or Director of Nursing will conduct random Quality reviews of current residents with physician orders for finger stick blood sugars to ensure blood sugar obtained and documented on 10 random residents 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 22 An interview was completed on 11/1/23 at 11:30 AM with the Physician. He stated the facility should facility obtain Resident #25's blood sugar checks as ordered. An interview was completed on 11/2/23 at 9:40 AM with Medication Aide)MA) #1. He stated he always checked Resident #35's blood sugars before the Unit Manager (UM) or the nurse administered her insulin ordered. MA #1 stated he was not aware there was an order to check Residnet#25's blood sugars ac and hs because it did not appear on his electronic MAR. An interview was completed on 11/2/23 at 10:15 Am with Nurse #1. She stated after reviewing the electronic medical record, they were to check Resident #25's blood sugars ac and hs. An interview was completed on 11/2/23 at 11:00 AM with the Director of Nursing (DON). She stated Resident #25's blood sugar checks should have been obtained as ordered.	F 757	times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring audit and report to the Quality Assurance and Performance Improvement committee (QAPI). Findings will be reviewed by QAPI committee monthly and Quality monitoring audit updated as indicated.	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening	F 809		11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 23 meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident, and staff interviews the facility failed to provide the residents with meals served at regularly scheduled times for 1 of 1 meal observation of the F-Hall. This practice had the potential to affect meals served to other residents. The findings included: A meal schedule was provided on 10/30/23. Meal delivery times were recorded as follows: · Breakfast - 7:30 AM - 8:15 AM · Lunch - 12:00 AM - 12:45 PM · Dinner - 5:30 PM - 6:15 PM On 10/30/23 at 09:05 AM, staff were observed removing the last 2 breakfast trays from the tray cart and taking them into rooms at the end of F-Hall. a. The admission Minimum Data Set (MDS) dated 10/24/23 had Resident #262 coded as cognitively intact and was independent with eating after set-up. During an interview with Resident #262 on 10/30/23 at 9:22 AM, Resident #262 stated the breakfast trays had just got served and that meal trays were often late and cold. He further stated	F 809	F809 - Frequency of Meals 1. The Dietary manager and the Dietary District Manager assisted with tray line to get breakfast served on 10-30-2023. Lunch and dinner were served on time. On 10-30-2023 2. The Dietary Manager and Dietary District Manager discussed to ensuring meals are served on time on 10-30-2023. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11-14-2023 to formulate and approve a plan of correction for the deficient practice. 3. The Dietary Manager will educated the dietary staff on meal delivery by 11/17/23. The Dietary Distract Manager educated the Dietary Manager on meal delivery on 10-30-2023. New hires will be educated prior to them starting on meal delivery. 4. A meal delivery log will be signed for each cart delivered at mealtimes to track compliance. The logs will be reviewed weekly and taken to QAPI for three months. Findings will be reviewed by	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 24	F 809	QAPI committee monthly and Quality Monitoring updated as indicated.	

he has only been at the facility for 6 days. He indicated he looked at his clock when the trays are delivered. He also indicated it was important to him to eat his meals at consistant times due to him being a diabetic.

b. The quarterly Minimum Data Set (MDS) dated 08/25/23 had Resident #43 coded as cognitively intact and was independent with eating after set-up.

During an interview with Resident #43 on 11/02/23 at 9:30 AM, he stated breakfast normally comes out daily between 9:00 AM and 10:00 AM, late and cold all the time. He also stated lunch is normally no later than 1:00 PM and dinner between 5:30-6:30 PM. Resident #43 pointed at the clock and indicated he looked at it when the meals are brought to the room.

During an interview with NA #2 on 10/31/23 at 1:08 PM, she stated meals come out late all the time. The latest time she had seen breakfast served was 10:00 AM, lunch at 2 PM, and dinner at 7 PM. She also stated the kitchen had recently hired more staff and that hopefully the meal trays would start coming out daily on time.

During an interview with NA #5 on 10/31/23 at 1:13 PM, she stated meals come out late all the time. She further stated breakfast was normally served between 9:00 AM and 10:00 AM. She indicated that the breakfast meal was the only one that she observed coming out late. She further indicated the kitchen had hired new dietary aides so the time of the breakfast trays being brought to the halls should improve.

During an interview with the Dietary Manager

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 25 (DM) on 11/01/23 at 2:35 PM, he stated a new relief cook called out on 10/30/23 approximately 45 mins prior to his shift which caused breakfast to be served late. He then stated the meals have come out late at times due to staff not showing up or calling out. If it's a no call, no show he sometimes finds out right before he gets to the facility or when after he arrives. He indicated the kitchen was short staffed but he had recently hired new dietary aides that were still learning how the kitchen functions. He further indicated he still needed a relief cook. During an interview with the Dietary District Manager on 11/02/23 at 9:45 AM, she stated she was aware breakfast was late at times due to staffing issues. She then stated they had recently hired new dietary aides but the kitchen was short a relief cook at this time. During an interview with the Administrator on 11/02/23 at 10:05 AM, she stated the kitchen staff are contracted out and were not Forrest Oakes employee's. She indicated they had been working with the Dietary Manager and trying to get staff hired, but they had not had much luck for a relief cook. She was aware the kitchen was short staffed, and that staff had called out late or didn't call out at all, which interfered with the meal being served at scheduled times. She then stated she expected meals to be served on time and expected enough kitchen staff to carry out the functions of food and nutrition services.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 26 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to discard opened food items ready for use by the labeled discard date and failed to label, and date opened foods in 1 of 1 reach-in refrigerator and failed to label, and date opened foods in 1 of 1 reach-in freezer. This practice had the potential to affect food served to residents. The findings included: 1. During the initial tour of the main kitchen with the Dietary Manager (DM) on 10/30/23 at 10:30 AM, revealed the following items were observed in the reach-in refrigerator and reach-in freezer available for use. -A 4 quart plastic container with a label on top of the container that read grape jelly opened on 10/13/23. -Bag of opened cool whip wrapped in plastic wrap with an open date of 10/22/23.	F 812	F812 - Food Storage 1. The dietary manager discarded the grape jelly, cool whip, ham, white rice, nectar cranberry juice, fruit cocktail, honey water and blueberry muffins on 10-30-2023. 2. The Dietary Manager and Dietary District Manager discussed to importance of discarding expired foods and beverages per company policy on 10-30-2023. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11-14-2023 to formulate and approve a plan of correction for the deficient practice. 3. The Dietary Manager educated the dietary staff on proper food storage on	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 27 -1 opened ham wrapped in plastic wrap with an open date of 10/19/23. -A 4 quart plastic container of cooked white rice with a label on top of the container that read opened on 10/22/23. -1 quart carton of nectar thickened cranberry cocktail flavored liquid on top of the container that read opened on 10/10/23. -A 4 quart plastic container with 1 quart of fruit cocktail with no open date labeled. -1 opened quart carton of honey thickened lemon flavored water with no open date labeled on container. -2 opened boxes of blueberry muffins with no open dates labeled on boxes or plastic wrap. Total of 25 muffins. On 10/30/23 at 10:40 AM the Dietary Manager (DM) discarded the above items. He indicated that it was everyone ' s responsibility for labeling food and beverages after opening. He stated he did daily checks and that it was an oversite that he missed the above items. He further stated, opened foods were to be thrown away 7 days after opening. An interview was conducted on 11/02/23 at 9:45 AM with the Dietary District Manager. She stated she expected all coolers and freezers to be checked for expired food and beverages. She also stated she expected all food and beverages to be properly labeled when opened. An interview was conducted on 11/02/23 at 10:05 AM with the Administrator. She stated she expected all coolers and freezers to be checked for expired food and beverages. She also stated she expected all food and beverages to be properly labeled when opened.	F 812	10/30/23. The Dietary Distract Manager educated the Dietary Manager on proper food storage on 10-30-2023. New hires will be educated prior to them starting on proper food storage. 4. The dietary manager will complete a monitoring tool to ensure all food is stored properly 5 times a week for four weeks, 3 times a week for three weeks, and 2 times a week for two weeks. A copy of the monitoring tool will be taken to QAPI for three months. Findings will be reviewed by QAPI committee monthly and Quality Monitoring updated as indicated.	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 29 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records in the areas of medication and PICC (a peripherally inserted central catheter inserted into the vein of the arm) line dressing change (Resident #62) for 1 of 7 residents whose medications were reviewed. The findings included: Resident #62 was admitted to the facility on	F 842	F842 Resident Records – Identifiable Information 1. Resident #62 no longer resides at the facility. 2. The Director of Nursing/Nurse Manager completed a quality review of current residents receiving IV medication and PICC line dressing changes to ensure medications are being signed on	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 30 9/22/23 with diagnoses that included a spinal abscess requiring intravenous (IV) antibiotics. a) Review of Resident #62's physician orders included an order dated 9/22/23 for Cefazolin (an antibiotic) 2 grams given by IV every eight hours until 10/23/23. The admission Minimum Data Set (MDS) assessment dated 9/29/23 indicated Resident #62 was alert and oriented, and received IV medications. The September 2023 Medication Administration Record (MAR) was reviewed and revealed there was no documentation that the Cefazolin was administered as ordered or refused by Resident #62 on the following days: -9/24/23 at 10:00 PM - 9/25/23 at 6:00 AM - 9/25/23 at 10:00 PM - 9/26/23 at 6:00 AM - 9/27/23 at 2:00 PM - 9/27/23 at 10:00 PM - 9/28/23 at 2:00 PM - 9/30/23 at 6:00 AM An interview occurred with Nurse #1 who was assigned to care for Resident #62 on 9/28/23. After reviewing the September MAR, she stated she couldn't think of a reason she wouldn't have provided the IV medication and felt it was an oversight that she didn't document on the MAR that it was given. On 11/1/23 at 11:37 AM, an interview was conducted with the Unit Manager who was assigned to care for Resident #62 on 9/24/23. She recalled initiating the IV medication for	F 842	medication administration record and PICC line dressings are changed per order and signed on medication administration record on 11/02/2023. No further concerns were identified. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11/14/2023 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing will educate nurses on ensuring IV medications and PICC line dressing changes are completed and signed per physician's orders on the medication administration record by 11/22/2023. Nurses that have not completed the education will complete the education prior to working their next scheduled shift. Newly hired nursing staff will be educated upon hire during orientation. 4. The Director of Nursing and the Unit Manager will conduct a random quality monitoring audit of 5 residents receiving Intravenous (IV) medication and PICC line dressing changes 3 times per week for 8 weeks, then weekly for 4 weeks to ensure medications administered and signed on medication administration record and PICC line dressing changes are signed and completed per physician's orders. The Director of Nursing will report on the results of the quality monitoring audit and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring audit updated as indicated.	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 31	F 842		

Resident #62 and felt it was an oversight to not have documented on the MAR that the medication was provided.

A phone interview occurred with Nurse #2 on 11/1/23 at 2:45 PM. She was the nurse overseeing the care of Resident #62 on 9/25/23, 9/26/23, 9/27/23 and 9/30/23. She recalled providing the IV medication as ordered but most likely forgot to sign the MAR that it was provided.

The Director of Nursing was interviewed on 11/2/23 at 10:47 AM and stated she expected the nurses to document when medications were provided.

b) Review of Resident #62's physician orders included an order dated 9/25/23 to change the PICC line dressing every Thursday.

The September 2023 MAR was reviewed and revealed there was no documentation that the dressing to Resident #62's PICC line was changed or refused on 9/28/23.

An interview occurred with Nurse #1 who was assigned to care for Resident #62 on 9/28/23. She explained that the dressing change to the PICC line would have been completed by the wound care nurse.

On 11/1/23 at 1:48 PM, an interview was completed with the wound care nurse. She recalled changing the dressing to Resident #62's PICC line site and stated she must have forgotten to document it as completed on 9/28/23.

The Director of Nursing was interviewed on

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 32 11/2/23 at 10:47 AM and stated it was her expectation for resident records to be complete and accurate.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867		11/28/23

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 33	F 867		

systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 34 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 867		

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 35 Based on record reviews, observations, Hospice, Physician, resident and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following an annual recertification and complaint survey completed 5/20/21. This was for two deficiencies that were cited in the areas of Activities of Daily Living Care Provided for Dependent Residents, and Resident Records-Identifiable Information. In addition, six additional deficiencies were cited during the annual recertification and complaint survey on 11/10/22 in the areas of Resident Rights/Exercise of Rights, Resident/Family Group and Response, Safe/Clean/Comfortable/Homelike Environment, Services Provided Meet Professional Standards, Activities of Daily Living Care Provided for Dependent Residents, Food Procurement, Store/Prepare/Serve Sanitary. The duplicate citations during three federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. The findings included: The citations are cross referenced to: 1) F842- Based on record review and staff interviews, the facility failed to maintain accurate medical records in the areas of medication and PICC (a peripherally inserted central catheter inserted into the vein of the arm) line dressing change (Resident #62) for 1 of 7 residents whose medications were reviewed. During the facility's annual recertification and complaint survey dated 5/20/21, the facility failed	F 867	F867 - QAPI/QAA Improvement Activities 1. The Executive Director held a Quality Assurance Performance Improvement meeting on 11-14-2023 with the Interdisciplinary Team including the Director of Clinical Services, Social Services, Dietary Manager, Admissions Director, MDS Coordinator, Activities Director, Medical Records Director and Business Office Manager focusing on the areas of F842 Accurate medical records related to IV medication and PICC line dressing change, F550 related to dignity failed for resident to be able to control lighting waking resident up at night, F565 resident council failed to resolve grievances related to call bells, cold food and late medications, F584 environment related to working overbed lights and wall repair, F658 related to correct route of medication, and F812 related to discard and label food items. The facility Quality Assurance reviewed the new plan of correction for maintaining compliance in these areas. 2. During the Quality Assurance Performance Improvement on 11-14-2023 the Regional Director of Clinical Services along with the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained. 3. The Quality Assurance Performance Improvement Committee will continue to meet on at least a monthly basis	

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 36 to discontinue a physician ' s order for hospice services when a resident was discharged from hospice care for 1 of 1 sampled resident. In an interview with the Administrator and Director of Nursing on 11/2/23 at 10:47 AM, they felt the nursing staff needed to be held more accountable for documentation to ensure it was complete and accurate. 2) F550- Based on observations, resident and staff interviews, the facility failed to promote dignity by the resident having no control of her over the bed light resulting in being awakened and disturbed when her over the bed light was turned at the light switch by the room door to assist her roommate. This resulted in the resident feeling angry and frustrated. This was for 1 (Resident #29) of 3 residents reviewed for dignity. During the facility's annual recertification and complaint survey dated 11/10/22, the facility failed to maintain resident dignity when meals were not provided to all residents at the same table for residents seated at the same time. This deficient practice occurred during 2 of 3 lunch meals observed. The reasonable person concept was applied to example #3 as residents have an expectation of being treated with dignity in their home environment. In an interview with the Administrator and Director of Nursing on 11/2/23 at 10:47 AM, they indicated they felt it was an oversight for the maintenance director to not have fixed the over the bed light. 3) F565- Based on record review, resident council	F 867	identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Executive Director Market Leader and or the Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for 3 months for validation. Opportunities will be corrected as identified by the Executive Director. 4. The results of these reviews will be submitted to the QAPI Committee by the Executive Director for review by IDT members each month for 12 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 37 members and staff interviews, the facility failed to resolve repeated grievances regarding cold food for 2 of the last 4 months, not answering call bells timely for 3 of the last 4 months and late medications for 4 of the last 4 resident council meetings. During the facility's annual recertification and complaint survey dated 11/10/22, the facility failed to record and resolve grievances which were reported in the Resident Council meetings for 8 out of 10 months reviewed. In an interview with the Administrator and Director of Nursing on 11/2/23 at 10:47 AM, they felt the grievances had been resolved at each occurrence. 4) F584- Based on observations, resident and staff interviews, the facility failed to ensure residents over the bed lights were in working order. This was for 2 (Resident #30 and Resident #40) of 5 residents reviewed for pressure ulcers. The facility also failed to ensure the walls in resident rooms were in good repair. This was for 4 (room #'s 117, #118, #123 and #127) of 19 rooms reviewed for homelike environment. During the facility's annual recertification and complaint survey dated 11/10/22, the facility failed to ensure bathrooms were clean and in good repair for 2 of 8 bathrooms observed for environmental concerns. During an interview with the Administrator on 11/2/23 at 10:47 AM, she stated the Maintenance Director had been working on other prioritized projects.	F 867		

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 38	F 867		

5) F658- Based on record review and interviews with staff, the facility failed to document correct route of medication administration for 1 of 5 residents (Resident #40) reviewed for unnecessary medication.

During the facility's annual recertification and complaint survey dated 11/10/22, the facility failed to transcribe the correct medication administration route for 1 of 2 residents reviewed for gastric feeding tube.

During an interview with the Administrator and Director of Nursing on 11/2/23 at 10:47 AM, they indicated they felt it was human error to not have the correct route of medication administration.

6) F812- Based on observations, and staff interviews the facility failed to discard opened food items ready for use by the labeled discard date and failed to label, and date opened foods in 1 of 1 reach-in refrigerator and failed to label, and date opened foods in 1 of 1 reach-in freezer. This practice had the potential to affect food served to residents.

During the facility's annual recertification and complaint survey dated 11/10/22, the facility failed to maintain the refrigerator temperature of 41 degrees (°) Fahrenheit (F) or below, failed to store opened and cooked foods within safe temperature ranges, failed to discard expired foods stored ready for use and failed to label and date opened foods which had the potential to affect food served to residents.

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 11/02/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 39 In an interview with the Administrator and Director of Nursing on 11/2/23 at 10:47 AM, they indicated there had been a lot of transition in the kitchen with new staff to include the dietary manager.	F 867		