AUG 2 4 2012

PRINTED: 08/08/2012 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPL	
		345442	B. WI	€	•	07	/26/2012
NAME OF PR	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		720/2012
FORRES1	OAKES HEALTHCARE	CENTER		6:	20 HEATHWOOD DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X5) COMPLETION DATE
F 159 SS=C	Upon written authorized facility must hold, safed account for the person deposited with the fact paragraphs (c)(3)-(8). The facility must deposited in excess of \$50 account (or accounts) the facility's operating all interest earned on account. (In pooled account. (In pooled account.) The facility must maintifunds that do not excess of \$50 account.	nal funds of the resident ility, as specified in of this section. sit any resident's personal	F	159	This Plan of Correction does not an admission or agreement by the of the truth of the facts alledged conclusions set forth in this State Deficiencies. This Plan of Corresprepared solely because it is requestate and Federal law.	e provider or ement of ection is	
	The facility must estate that assures a full and accounting, according accounting principles, funds entrusted to the behalf.  The system must preciple resident funds with factor funds any person other that the individual financial through quarterly state the resident or his or his or his facility must notify must facility must notify medicaid benefits when	of each resident's personal facility on the resident's ude any commingling of lility funds or with the funds an another resident.  record must be available ments and on request to er legal representative.  each resident that receives in the amount in the			#1 Residents #69, #72, #6, and #57 fund reduced to within the SSI (Supplemental Income) resource limit. Residents #14, # have been provided quarterly statements respective Resident Fund Account by the Office Manager.  #2 A review of current resident accounts completed by the Business Office Managany residents with funds reaching \$200.0 resource limit with no corrective action in Quarterly statements were reviewed and the Business Office Manager to alert and residents as determined by review of the Data Set for those residents assessed as a oriented.	Security 12, and #37 for their Business has been er to identify 0 within SSI eeded. delivered by oriented Minimum	8/23/12
BORATORY DI	RECTOR'S OR PROVIDER/SU	PPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FL0J11

Facility ID: 923154

If continuation sheet Page 1 of 15

0-22-12

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			B. WI				
	·-···	345442	B. Will			07/2	6/2012
NAME OF PE	ROVIDER OR SUPPLIER	•		1	REET ADDRESS, CITY, STATE, ZIP CODE		
FORREST	OAKES HEALTHCARE	CENTER		1	20 HEATHWOOD DRIVE		
·	l			-	ALBEMARLE, NC 28001	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
F 159		aches \$200 less than the	F	159	Continued from Pg 1 F-159		
	SSI resource limit for section 1611(a)(3)(B) amount in the accoun the resident's other no reaches the SSI resources.	one person, specified in of the Act; and that, if the t, in addition to the value of			#3 The Business Office Manager has be by the Nursing Home Administrator regrequirements in facility management of when the amount in the residents specified when the amount in the resident's accounts 200 less than the SSI resource limit not resident and/or responsible party must be quarterly statements are to be provided it	arding the personal funds ically that areaches ification to the done; and, a writing to	- Private manufacture in the second s
	by: Based on record review, the facility for sampled residents, (R #57) and/or their respirands reaching \$200.0 (Supplemental Security and failed to provide quand oriented residents	quarterly statements the resident and/or to 30 days after the enstatements will be desired to notify 4 of 4 sesidents #69, #72, #6, and staffent's 0 within the SSI y Income) resource limit uarterly statements to alert with Residents/Personal to statements to alert with Residents (Residents Social Services Directions of the resident to the resident/or the indicating that the resident to the resident accepts of the resident to t		the resident and/or the resident's represe 30 days after the end of the quarter. Qua statements will be delivered to all reside responsible party within 30 days after th quarter by the Business Office Manager. copy of the resident's trust fund account to the resident/or the designated respons indicating that the resident's fund balanc \$200 or the resource limit allowed by M that Medicaid eligibility could be jeopar	ntative within interly nts and e end of the A letter with a will be mailed ible party e is within edicaid, and dized if the s Office rovided to the	THE PARTY OF THE P	
Transfer of the second	funds were managed if revealed that Resident balance of \$1880.30 a review of Resident #69 that the resident received 4/4/12, 5/7/12, 6/6/12 a balance (after the mondebited) of \$2,000.60 dexceeded the resource indicated that Residen money for personal experience of the personal experience of	t #69 had an account as of 3/26/12. Further B's financial record revealed wed \$418.00 per month on and 7/6/12 with an ending othly cost of care was on 7/26/12, which a limit. The record t #69 had not spent any penses.			The Social Services Director has been re the Nursing Home Administrator to note resident's chart when conversations are I residents and/or responible party regardi reaching the resource limit and the plan A Quality Improvement tool will be conx 12 weeks, then monthly x 9 months to notification of residents and/or responsifunds reaching within \$200 of the resouralert and oriented residents receive quarstatements for their respective Resident by the Business Office Manager or Nurs Administrator.  #4 The Business Office Manager or Nurs Administrator will report the results of the Improvement tool to the Performance In committee monthly x 12 months to iden need for further education and/or monitor.	in the neld with ng funds to spend down. upleted weekly identify ole party if the limit and terly fund Accounting Home the Quality approvement tify trends and	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	STREET ADDRESS, CITY, STATE, ZIP CODE  620 HEATHWOOD DRIVE  ALBEMARLE, NC 28001  ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
		345442	B. WIN	NG		07/2	26/2012
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER	- N	620 HEATHWOOD DRIVE	CODE		
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	she notified the respo the balance being with limit but did not docum indicated that she notistart working with the the funds for the resid During an interview wi 7/26/12 at 12:30 PM s work with families to s \$200.00 of the spendipre burial need but did documentation of this 1b. During a review of funds were managed revealed that Residen balance of \$1874.94 review of Resident #75 that the resident received and the resident received (after the more debited) of \$1858.22 c within \$200.00 of the sindicated that Residen of \$137.00 from 3//26/ advance cash ", no of evident.  During an interview with Manager on 7/26/12 ar she notified the resport the balance being with limit but did not documindicated that she notified the rotions.	nsible party by telephone of hin \$200.00 of the spending ment this. She also ified the Social Worker to families on spending down ent.  Ith the Social Worker on the indicated that she did pend down funds within ng limit on things such as if not have any for resident #69.  If a list of resident's whose by the facility, the list the #87 had an account as of 3/26/12. Further 2's financial record revealed and 7/6/12 with an ending nathly cost of care was no 7/26/12, which remained the spending limit. The record the #72 had withdrawn a total 12 - 7/17/12 as "resident ther personal spending was the Business Office that 1:39 AM she stated that noisible party by telephone of in \$200.00 of the spending limit this. She also fied the Social Worker to families on spending down	F.	159			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SU COMPLE	
		345442	B. WIN	G		07/:	26/2012
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THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPER	7/26/12 at 12:30 PM swork with families to s\$200.00 of the spend pre burial need but di documentation of this  1c. During a review of funds were managed revealed that Resider balance of \$1,997.21 review of Resident #6 that the resident recei 4/4/12, 5/7/12, 6/6/12 balance (after the modebited) of \$2,117.53 the resource limit. The Resident #6 had not spersonal expenses.  During an interview w Manager on 7/26/12 a she notified the respothe balance being with limit but did not documindicated that she notistart working with the funds for the resid During an interview w 7/26/12 at 12:30 PM swork with families to s\$200.00 of the spendipre burial need but did documentation of this	with the Social Worker on she indicated that she did spend down funds within ing limit on things such as d not have any for resident #72.  If a list of resident's whose by the facility, the list as of 3/26/12. Further is financial record revealed fived \$633.00 per month on and 7/6/12 with an ending inthly cost of care was on 7/26/12, which exceeded are record indicated that is spent any money for the Business Office at 11:39 AM she stated that insible party by telephone of anin \$200.00 of the spending ment this. She also iffied the Social Worker to families on spending down ent.  If the Social Worker on the indicated that she did in the spending limit on things such as it not have any for resident #6.  If a list of resident's whose	Ę	159			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLET	TE SURVEY MPLETED	
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F 159	revealed that Resider balance of \$583.05 a review of Resident #5 that the resident receit 4/4/12, 5/7/12, 6/6/12 of \$2055.21 on 7/26/17 resource limit. No delisted for the period 3/ indicated that Resider money for personal exponency for personal expon	at #57 had an account as of 3/26/12. Further in its of and 7/6/12 with an ending 1/2, which exceeded the bits for care costs were 1/26/12 - 7/6/12. The record in its of a not spent any expenses.  Ith the Business Office at 11:39 AM she stated that ansible party by telephone of an in \$200.00 of the spending ment this. She also iffied the Social Worker to families on spending down tent.  Ith the Social Worker on the indicated that she did in indicated in the saident #57.  Soument titled "Resident ervice Authorization and Resident Funds and Resident Funds and Resident in facility.  Minimum Data Set (MDS) 3/12 for Resident #14	F	159				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345442	8. WI	IG		07/:	26/2012
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F 159	1:47 PM she stated the funds account with the amonthly statement. could get a statement she asked.  During interview with Manager on 7/26/12 a Resident #14 did have but she did not provid personal funds to Res Manager said only proto the Responsible Paragreement to Handle 1/30/12 revealed Resignal Fund Account with the Review of the Quarter (MDS) assessment da #12 revealed the resident #12 did have but she did not provide personal funds to Resident #12 did have but she did not provide personal funds to Resident #12 did have but she did not provide personal funds to Resident #12 did have but she did not provide personal funds to Resident #12 did have but she did not provide personal funds to Resident #12 did have but she did not provide personal funds to Resident #12 did have but she did not provide personal funds to Resident #12 did have but she did not provide personal funds to Resident #12 did have but she did not provide personal funds to Residents.	and she did have a personal be facility but was not issued. She indicated that she cor find out the balance if the Business Office at 11:39 AM she stated that be a personal fund account be a quarterly statement of sident #14. The Business ovided quarterly statements arty, even for alert and comment titled "Resident bervice Authorization and Resident Funds" dated dent #12 had a Resident befacility.  Ity Minimum Data Set atted 5/25/12 for Resident lent was cognitively intact. The Business Office a personal fund account be a quarterly statement of ident #12. The Business ovided quarterly statements avoided quarterly statements.	F	159			

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F 160 SS=B	Fund Account with the Review of the Quarter (MDS) assessment do revealed the resident impaired.  During interview with Manager on 7/26/12 a Resident #37 did have but she did not provid personal funds to Res Manager said only proto the Responsible Paoriented residents.  483.10(c)(6) CONVEY FUNDS UPON DEAT!  Upon the death of a redeposited with the fact within 30 days the resaccounting of those fur probate jurisdiction ad estate.  This REQUIREMENT by:  Based on financial reinterview, the facility frunds money within 30 sampled residents where the proportion of the appropriate party frunds more party f	rly Minimum Data Set ated 4/6/12 for Resident #37 was moderately cognitively  the Business Office at 11:39 AM she stated that e a personal fund account e a quarterly statement of sident #37. The Business ovided quarterly statements arty, even for alert and  YANCE OF PERSONAL H  esident with a personal fund illity, the facility must convey ident's funds, and a final ands, to the individual or fiministering the resident's  is not met as evidenced  cords review and staff ailed to convey resident 0 days of death for 2 of 3 o had a Resident/Personal e facility (Resident #51 and evey resident funds money to for 2 of 3 sampled residents ersonal Fund Account with		159	F-160 #1 Residents #51 #89, #88 no longer resfacility. #2 Current residents are at risk for the depractice. #3 Business Office Manager has been rethe Nursing Home Administrator regarding requirements of conveyance of personal indeath to convey within 30 days the reside and a final accounting of those funds, to tindividual or probate jurisdiction administresident's estate.  A Quality Improvement tool will be composed within 30 days of death by the Business Office Manager. The Nursing Home Administration audit these results weekly x 12, the month months.  #4 The Business Office Manager or Nursi Administrator will report the results of the Improvement tool to the Performance Improvement tool to the Performance Improvement to dentify and need for further education and/or monital control of the performance of the Improvement tool to the Performance Im	eficient  -educated by ng the funds upon ent's funds, the stering the  oleted nupon death office tor will ly x 9  ing Home Quality rovement	8/23/12

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F 160	#51 expired on 5/18/1 Account was closed of the resident had expire amount of \$2,182.55 and Courts.  During an interview with Manager on 7/26/12 and Manager stated that sideadline for conveyar #51 she had initially been the funds as the lived in another State.  1b. Financial record in #89 expired on 12/5/1 was closed out on 1/1 resident had expired, of \$1,033.90 was mailed Administration.  During an interview with Manager stated that sideadline for conveyant was closed on 12/5/1 Account was closed on in the amount of \$1,00 home.  During interview with the state of the amount of \$1,00 home.	eview revealed Resident 12. The Resident Fund but on 7/10/12, 53 days after red, and a check in the was mailed to the Clerk of  ith the Business Office at 11:39 AM, the Business she was aware of the 30 day nce of funds but for Resident leen uncertain where to resident had previously  review revealed Resident 1. Resident Fund Account 0/12, 36 days after the and a check in the amount led to the Social Security  ith the Business Office at 11:39 AM, the Business he was aware of the 30 day nce of funds.  eview revealed Resident 1. The Resident Fund ut on 12/12/11, and a check 00 was mailed to a funeral	F	160			
		It 11:39 AM she stated the und so the Resident Fund					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPLI	
		345442	B. WING	)	07.	/26/2012
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 620 HEATHWOOD DRIVE ALBEMARLE, NC. 28001		
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F 160	Business Office Mana documentation author the funeral home in lie or Clerk of Court.  2b. Financial record r #89 expired on 12/5/1 was closed out on 1/1 amount of \$1,033.90 v Security Administration  During interview with the Manager on 7/26/12 a since she had receive #89 had an overpaym Security Income (SSI) 10/5/11 (prior to expirity has should convey the Security Administration Manager did not proving authorizing this direct Security Administration Party or Clerk of Court 483.25 PROVIDE CAF HIGHEST WELL BEIN Each resident must record the necessary or maintain the highes mental, and psychosological provinces in the security and psychosological provinces in the provinces in the provinces in the highes mental, and psychosological provinces in the following the provinces in the following the provinces in the provinces in the provinces in the following the fo	transferred there. The ager did not provide rizing this direct payment to au of the Responsible Party  review revealed Resident 1. Resident Fund Account 0/12 and a check in the was mailed to the Social n.  the Business Office at 11:39 AM she stated that d notification that Resident ent from Supplemental and owed \$1,760 as of any on 12/5/11) she believed a funds directly to the Social n. The Business Office de documentation payment to the Social n in lieu of the Responsible to the Re/SERVICES FOR IG  ceive and the facility must care and services to attain t practicable physical,	F 1	F-309	ain medication as dent #85 is sordered by the re-assessed for Pain Assessment of pain, type of all and/or non-tending physician to that exhibit	8/23/12
	This REQUIREMENT by:	is not met as evidenced		pain management with orders re carried out as indicated by the p assessments were completed by Supervisor and/or Unit Manager the Director of Clinical Services	ceived and hysician. The the Weekend	AVALANCE AND AVAILABLE AND AVA

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M( A. BUIL		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345442	B. WIN	G		07/2	6/2012	
	ROVIDER OR SUPPLIER	CENTER		62	EET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE ILBEMARLE, NC 28001			
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F 309	put interventions in plan provide skin care trea residents (Resident #1 1a. Resident #85 was 7/5/12. Cumulative dia ulcer to the heel.  The admission Minima 7/12/12 indicated that moderate cognitive imextensive assistance amobility, had an unstained) and denied having Physician orders date "betadine swab right hidressing daily".  Nurse s notes dated 7 the physician was faxed pain for Resident #85. Review of Resident #85. Review of Resident #85 revealed no order for puring an interview or Resident #85 said that time but his doctor did prescription for a pain got some relief with rehe could do independent of 7/25/12 at 2:35 PM providing treatment to	n, resident and staff review, the facility failed to ace for pain and failed to tment as ordered for 1 of 2 ab). The findings included: admitted to the facility on agnoses included pressure  The pair and pair and pair and pair agnoses included pressure  The pair and pair and pair agnoses included pressure  The pair and pair and pair agnoses included pressure  The pair and pair agnoses included pressure  The pair agnoses included pressure ulcer (right agnoses included pressure agnoses included agno	F	309	#3 Current licensed nurses have been re educated by the Director of Clinical Ser Unit Manager, and/or Weekend Supervispain management policy and procedure, providing skin care treatments as ordere residents with new onset of pain will be documented on the 24 hour report until with an order and/or follow up by the pl This education will be reviewed during orientation process for newly hired licen nurses by the Unit Manager or Director Clinical Services.  A Quality Improvement tool will be confor three (3) residents receiving skin treby the Director of Clinical Services, Un Manager, and/or weekend supervisor by observation of treatments being perforn ordered, resident interview, and if verbaverbal indicator of pain present that intere in place. This tool will be completed daily x 14 days, then daily x days/week x 2 weeks, then 3/x per week weeks, then weekly x 2 weeks, then momonths.  #4 The Director of Clinical Services or Manager will report the results of the Q Improvement committee monthly x 12 identify trends and need for further educand/or monitoring.	vices, sor on d, and resolved hysician. The iscellation of the iscella		

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	Nurse #1 asked the reaction that proceeded with the treatment, Nurse #1 asked the reatment, Nurse #1 asked treatment, Nurse #1 asked treatment that the very day." Immediate treatment Nurse #1 asked treatment Nurse #1 asked time but will have pain. The resident said time but will have pain. The resident said time but will have pain. During a follow-up into PM, Resident #85 said right foot most of the total the pain kept him awa asked that Resider hard to judge. "He doe unless I actually touch pain in his right heel."  Nurse's notes dated 7/2 the physician was faxed medication.  During an interview on #1 stated that the faxed medication on 7/19/12 up by the nurse on 7/2 she did not pursue get medication for Resider act like he was having of pain when asked. N	esident if he had any pain. his right foot hurt. Nurse #1 eatment. During the gain asked if he was having d yes. Nurse #1 stated, "I #85 replied, "You apologize ely upon completion of the sked the resident about d he had no pain at this again.  erview on 7/25/12 at 3:10 d that he had pain in his ime. He said sometimes ke at night, or if he did fall urting when he awoke.  17/25/12 at 3:15 PM, Nurse at #85's level of pain was es not pull back or flinch the heel. He says he has  1/25/12 at 3:25 PM indicated ad again regarding pain  17/26/12 at 9:45 AM, Nurse d request for pain should have been followed 0/12. Nurse #1 stated that ting an order for pain at #85 because he did not pain and only complained urse #1 indicated that ted pain during a treatment,		8 8				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345442	B. WING		07/:	26/2012
	OVIDER OR SUPPLIER	E CENTER	S	TREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	***	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From pag	ge 11	F 30	99		
	Director of Nursing (expected pain assessand during treatmen pain, she would exprelieving measures to the Resident #85 was for Calmoseptine (a buttocks every shift a buttocks every shift a A Progress Note date Resident #85 was exclinician (WOC). The Lotrimin cream to but completely with Calmoseptine (a dated 7/17/12 include buttocks twice a day over Lotrimin cream On 7/25/12 at 2:35 P providing treatment to applied the Calmose on the buttocks, then the Calmoseptine. The Color. Nurse #1 indicated that the every other Tuesday	as admitted to the facility on diagnoses included ated dermatitis involving ated 7/5/12 included an order moisture barrier ointment) to and as needed.  Med 7/17/12 revealed that valuated by a Wound Ostomy a treatment plan included ttocks twice a day then covernoseptine. Physician orders and continue Calmoseptine				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	NOITOURTERNOO BLITLE  BONG	(X3) DATE SU COMPLE	
		345442	B. WING		07/2	26/2012
FORREST	ROVIDER OR SUPPLIER OAKES HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
	WOC verbally comm Calmoseptive was to Lotrimin. Nurse #1 and discrepancy between understanding of the Nurse #1 indicated th 483.30(e) POSTED I INFORMATION  The facility must post a daily basis: o Facility name. o The current date. o The total number and by the following cated unlicensed nursing st resident care per shift - Registered nurse - Licensed practice vocational nurses (ase - Certified nurses a o Resident census.  The facility must post specified above on a of each shift. Data m o Clear and readable o In a prominent place residents and visitors.  The facility must, upo make nurse staffing d for review at a cost no standard.  The facility must main	unicated to her that the be applied first, then the sknowledged the the written orders, and her verbal communication. Sat clarification was needed. NURSE STAFFING  If the following information on the following information of the posted as follows:  If the nurse staffing data daily basis at the beginning ust be posted as follows:  If the nurse staffing data daily basis at the beginning ust be posted as follows:  If or or or or written request, at a available to the public of the exceed the community that in the posted daily nurse	F 3:		tees and Unit chirements of g information to the Nursing Home rvisor and licensed sixting of the daily Service and/or the completed by or designee daily 5 x 2 weeks, then staffing posting is there or Director of stutts of the Quality nce Improvement identify trends and	8/23/12
	staffing data for a min required by State law,	imum of 18 months, or as whichever is greater.	The state of the s			O War Street

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLI LDING	E CONSTRUCTION	(X3) DATE S	
		345442	B. WI	IG		07	/26/2012
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		620	ET ADDRESS, CITY, STATE, ZIP CODE D HEATHWOOD DRIVE BEMARLE, NC 28001	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 356	Continued From page	÷ 13	F	356			
	by: Based on observation interview, the facility interview, the facility interview, the facility interview, the facility interview. The findings include:  On 7/23/12 at 2:47 pm the facility, the daily son the bulletin board a station. On the board, 7/21/12 that lacked re  On 7/24/12 at 4:55 pm alongside the current however, it still lacked. The Assistant Director on 7/24/12 at 5:45 pm completed the daily st being trained during of forms, for nursing staff she completed the we and left them for the we She stated that she pucensus off of the form have that information veridays.  She stated that her we trained how to complete update the form when adjusted or resident certains.	n, the 7/23/12 staffing hung staffing, dated 7/24/12, the resident census.  Tof Nursing was interviewed as the explained that she affing and was putting staff, rientation on all of the f. Further, she stated that ekend staffing on Fridays eekend supervisor to post. Imposely left the resident because she does not when she left the papers on the the staffing or how to staffing needed to be ensus changed. She ed to train her weekend					

<u> </u>	CO TOTAL COLOTTICE CO.	MEDICAID SERVICES				OWRIN	IO. 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBÉR:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	URVEY
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		345442	B. Wil	√G		07/	26/2012
	ROVIDER OR SUPPLIER OAKES HEALTHCARE	CENTER		6	REET ADDRESS, CITY, STATE, ZIP CODE 520 HEATHWOOD DRIVE ALBEMARLE, NC 28001		
<u> </u>			,	<u>'</u>	TEDENIARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLE CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 356	Continued From page regulations.	. 14	F	356			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2012 FORM APPROVED OMB NO. 0938-0391

	r of deficiencies of correction	IDENTIFICATION NUMBER:	(X2) M A. BU	LDIN	SECTION I	COMPLE	
		345442	B. Wil	1G		08/2	4/2012
	ROVIDER OR SUPPLIER TOAKES HEALTHO	ARE CENTER		6	EET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XB) COMPLETION DATE
K 000	Surveyor: 27871 This Life Safety Co conducted as per T at 42 CFR 483.70(a Care section of the publications. This is construction, one sautomatic sprinkler NCSBC-special local transport of the deficiencies de are as follows:	de(LSC) survey was the Code of Federal Register a); using the Existing Health LSC and its referenced willding is Type III-protected tory, with a complete system. Facility is using king.		000	This Plan of Correction does constitute an admission or agreement by the provider of truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. The Plan of Correction is prepare solely because it is required State and Federal law.  K 012  1) The penetrations in the general constitution of the properties of the provider of the prov	of the his ed by	
K 012. SS≃E	Building construction of the following. 18 19.3.5.1  This STANDARD is Surveyor: 27871 Based on observat approximately 8:00 items were nonconfincted of building polyalizating as furnace room 2. smoke wall in att	n off C-hall. lic off F-hall.		012	furnace room on C-Hall and wall in attic on F-Hall shall be sealed with approved fire-st material.  2) The Administrator and Maintenance Director shall in the facility for other unsealed penetrations and repair ther approved fire-stop material.  3) The Maintenance Director maintain a log of any installations work that includes penetratione hour rated fire barriers the facility. The log shall ind the date and locations of the penetrations and the materiate seal the penetrations.  4) The Maintenance Director attend monthly facility safet committee meetings and revenue to search as a search of the penetration log to assure the penetration log to a source the penetration log to a sourc	smoke e op  nspect d n with estion on of within lcate e al used r shall y //ew	9-28-12
K 029 \$8=E		FETY CODE STANDARD		029	compliance.		(Xe) DATE
<b>人のかいりんかののり</b>	へいいにんてんりは へり りけんいり	CRISTIPPI IER REPRESENTATIVE'S SIG	ΛΙΔΤΙΙΩΕ		TITLE		CAOLDATE

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

9-4-12

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	PLE CONSTRUCTION  O1 - MAIN BUILDING 01	(X3) DATE S COMPLE	(X3) DATE SURVEY COMPLETED	
		345442	B, WING		08/2	4/2012	
	ROVIDER OR SUPPLIER TOAKES HEALTHO	ARE CENTER	6:	EET ADDRESS, CITY, STATE, ZIP COD 20 HEATHWOOD DRIVE LBEMARLE, NC 28001	<b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLUTION COMPLUTION DATH	
K 029	Continued From particles of the approved autoroption is used, the other spaces by surfield-applied protect 48 inches from the permitted. 19.3.2  This STANDARD Surveyor: 27871 Based on observate approximately 8:00 items were nonconinclude: dry storage door are not self of 42 CFR 483.70(a) NFPA 101 LIFE SA if there is an autominstalled in accordance with N inspection, Testing Water-Based Fire	construction (with ¼ hour an approved automatic fire m in accordance with 8,4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or tive plates that do not exceed bottom of the door are 2.1	K 029	K 029  1) Automatic door closers installed on the dry stora door in the kitchen and trecords room door on C-2) The Administrator and Maintenance Director shat the facility for any other areas that have doors wi closing devices. Automaticlosers shall be installed needed.  3) The Maintenance Director's in the facility each assure the automatic docare in place and operatio inspection shall be part of Maintenance Director's maintenance Director's maintenance schedule.  4) The Maintenance Director attend monthly facility secondittee meetings and	s shall be ge room he medical lall.  Il Inspect hazardous thout self-ic door as ctor shall a room month to or closers hal. This f the conthly ector shall ifety review assure connected shall be facility's tamper inspect all	9-28-12	

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	Ple construction 3 o1 • Main Building o1	(X3) DATE SI COMPLE	
		345442	B. WING		08/2	4/2012
1	ROVIDER OR SUPPLIER TOAKES HEALTHO		63	EET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY PULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-RÉFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
K 062 SS≓E	This STANDARD Surveyor: 27871 Based on observe approximately 8:0 items were nonco include: valves co electrical supervis 42 CR 483.70(a) NFPA 101 LIFE'S Required automat continuously main condition and are periodically. 19 25, 9.7.5  This STANDARD Surveyor: 27871 Based on observe approximately 8:0 items were nonco include: facility co documentation the year obstruction in performed on sprii 42 CFR 483.70(a) NFPA 101 LIFE S	Is not met as evidenced by:  ations and staff interview at 0 am onward, the following mpliant, specific findings nnected to accelerator are not ed.  AFETY CODE STANDARD  Ic sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA  Is not met as evidenced by: ations and staff interview at 0 am onward, the following mpliant, specific findings uld not provide proper at the 3 year full flow test and 5 avestigation has been nkler system.	K 062	K 056 (cont.)  3) The Maintenance Direct maintain a permanent file containing records of all a system repairs, tests and equipment installations. A switches shall be inspected tested by SimplexGrinnel required by State Life Sair regulations.  4) The Maintenance Direct attend monthly facility sair committee meetings and any sprinkler system word done to assure compliance.  K 062  1) Documentation of the full flow test and five year obstruction investigation facility's sprinkler system obtained from SimplexGribe submitted with this Place Correction.  2) The Maintenance Direct maintain a permanent file containing records of all reprinkler system repairs, equipment installations.  3) The Maintenance Direct attend monthly facility sair committee meetings and any sprinkler system world one to assure compliance.	e or binder sprinkler All tamper ed and las fety Code tor shall fety review k that was e.  Three year of the shall be nnell and in of tor shall be tor shall fety and tor shall fety review k that was tor shall fety review k that was	9-28-12

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE \$	
		345442	B, WIN	G	LA CONTRACTOR OF THE CONTRACTO	08/2	4/2012
	ROVIDER OR SUPPLIER TOAKES HEALTHO	ARE CENTER		62	ET ADDRESS, CITY, STATE, ZIP CODE 0 HEATHWOOD DRIVE BEMARLE, NC 28001	1 <del>3.                                    </del>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF GORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X8) COMPLETION DATE
K 144	Continued From pa under load for 30 n accordance with Ni This STANDARD Surveyor: 27871 Based on observat approximately 8:00 Items were noncon	inge 3 Initial per month in FPA 99. 3.4.4.1.  Is not met as evidenced by: Ions and staff interview at am onward, the following inpliant, specific findings survey staff could not get	K 1		K 144  1) Kraftpower Company sha contacted to service the face emergency power generate not start on test mode and accordingly.  2) The Kraftpower service technician shall educate the Maintenance Director on the procedure to start the gene test mode.  3) The Maintenance Directo include running the emerge power generator on test mother monthly preventative maintenance schedule.  4) The Maintenance Directo attend monthly facility safet committee meetings and rethe monthly preventative maintenance schedule to as	all be cility's r to. or did repair e rator on r shall ncy ode on r shall ty view	9-28-12
					compliance.		

		I AND HUMAN SERVICES & MEDICAID SERVICES				APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION WE (X3) DATE SE G 01 - MAIN BUILDING 01 SEP 0 1 20 FEMPLE	RVEY TED
		345442	B. WIN	1G	CONCTRUCTION SE <b>08</b> (2)	(/2012
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	
FORRES	T OAKES HEALTHO	ARE CENTER			20 HEATHWOOD DRIVE LBEMARLE, NC 28001	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY (	SHEET .	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012 SS=E	at 42 CFR 483.70(a Care section of the publications. This is construction, one s automatic sprinkler NCSBC-special loc The deficiencies de are as follows: NFPA 101 LIFE SA Building construction of the following. 1919.3.5.1  This STANDARD is Surveyor: 27871 Based on observation approximately 8:00 items were noncominclude: facility had hour rated of building personal of the following personal control of the following of building personal control of the following of building personal control of the following personal control of the following of building personal control of the following of building personal control of the following personal contro	stermined during the survey AFETY CODE STANDARD on type and height meets one 0.1.6.2, 19.1.6.3, 19.1.6.4,  s not met as evidenced by: lions and staff interview at am onward, the following apliant, specific findings unsealed penetration in one and. To maintain construction enetrations must be seal.  rations: n off C-hall.		)) 12 0)	This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law.  K 012  1) The penetrations in the gas furnace room on C-Hall and smoke wall in attic on F-Hall shall be sealed with approved fire-stop material.  2) The Administrator and Maintenance Director shall inspect the facility for other unsealed penetrations and repair them with approved fire-stop material.  3) The Maintenance Director shall maintain a log of any installation work that includes penetration of one hour rated fire barriers within the facility. The log shall indicate the date and locations of the penetrations and the material used to seal the penetrations.  4) The Maintenance Director shall attend monthly facility safety committee meetings and review the penetration log to assure	9-28-12
SS=E						
	DIRECTOR'S OR PROVIDE	DER/SUPPLIER REPRESENTATIVE'S SIG		_		(X6) DATE
( Ry	carri, Luga	- communication	~~			, . —

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

If continuation sheet Page 1 of 4

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION  IG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345442		B. WING			4/2012
FORRES (X4) ID		ATEMENT OF DEFICIENCIES	ID	6 <u>A</u>	REET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE ALBEMARLE, NC 28001 PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE
K 029  K 056 SS=E	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved auton option is used, the other spaces by sm doors. Doors are sfield-applied protec 48 inches from the permitted. 19.3.2  This STANDARD I Surveyor: 27871 Based on observati approximately 8:00 items were noncominclude: dry storage door are not self clot 42 CFR 483.70(a) NFPA 101 LIFE SA If there is an autom installed in accorda for the Installation of provide complete or building. The syste accordance with NF Inspection, Testing, Water-Based Fire F supervised. There supply for the syste systems are equipp	construction (with % hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or tive plates that do not exceed bottom of the door are 1.1 s not met as evidenced by:  I ons and staff interview at am onward, the following apliant, specific findings or room door and Med. records	•	029	K 029  1) Automatic door closers s installed on the dry storage door in the kitchen and the records room door on C-Hai 2) The Administrator and Maintenance Director shall it the facility for any other had areas that have doors without closing devices. Automatic closers shall be installed as needed.  3) The Maintenance Director inspect all hazardous area in doors in the facility each measure the automatic door of are in place and operational inspection shall be part of the Maintenance Director's mon preventative maintenance schedule.  4) The Maintenance Director attend monthly facility safet committee meetings and revenue.	room medical ll.  nspect zardous out self- door  r shall oom onth to closers . This ne thiy  r shall cy view sure  nnected hall be collity's nper pect all nstall	9-28-12

K 056 Continued From page 2 building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: valves connected to accelerator are not electrical supervised.  K 062 SS=E  Required automatic sprinkler systems are continuously maintained in reliable operating  K 056  K 056 (cont.) 3) The Maintenance Director shall maintain a permanent file or binder containing records of all sprinkler system repairs, tests and equipment installations. All tamper switches shall be inspected and tested by SimplexGrinnell as required by State Life Safety Code regulations.  4) The Maintenance Director shall attend monthly facility safety committee meetings and review any sprinkler system work that was done to assure compliance.  K 062	STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	ILDIN		(X3) DATE S COMPLE	ETED
FORREST OAKES HEALTHCARE CENTER    220 HEATHWOOD DRIVE ALBEMARLE, NC 28001     PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE)     TAGE   REGULATORY OR LSC IDENTIFYING INFORMATION)     FREERIX TAGE   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION ABOULD BE CROSS-REFERENCE) TO THE APPROPRIATE CONT.     CROSS-REFERENCE TO THE A			345442	D. VVII			08/2	4/2012
K 056 Continued From page 2 building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompilant, specific findings notition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include; facility could not provide proper documentation that the 3 year full flow test and 5 year obstruction investigation investigation has been performed on sprinkler system.  42 CFR 483.70(a)  K 768  K 056 (cont.) 3) The Maintenance Director shall attend monthly facility safety committee meetings and review any sprinkler system repairs, tests and equipment installations.  4 Documentation of the three year obstruction investigation of the facility's sprinkler system shall be obtained from SimplexGrinnell and be submitted with this Plan of Correction.  2) The Maintenance Director shall maintain a permanent file or binder containing records of all required sprinkler system repairs, tests and equipment installations.  3) The Maintenance Director shall maintain a permanent file or binder containing records of all required sprinkler system repairs, tests and equipment installations.			ARE CENTER		6	20 HEATHWOOD DRIVE		
building fire alarm system. 19.3.5    This STANDARD is not met as evidenced by: Surveyor: 27871	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF	ΊX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	ULD BE	(X6) COMPLETION DATE
Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: facility could not provide proper documentation intat the 3 year full flow test and 5 year obstruction investigation has been performed on sprinkler system.  K 144 NFPA 101 LIFE SAFETY CODE STANDARD  K 144 SS=D		building fire alarm s  This STANDARD i Surveyor: 27871 Based on observati approximately 8:00 items were noncom include: valves con electrical supervise 42 CR 483.70(a)	system. 19.3.5 s not met as evidenced by: ons and staff interview at am onward, the following apliant, specific findings nected to accelerator are not d.			3) The Maintenance Director maintain a permanent file of containing records of all sprogress system repairs, tests and equipment installations. All switches shall be inspected tested by SimplexGrinnell arequired by State Life Safet regulations.  4) The Maintenance Director attend monthly facility safe committee meetings and reany sprinkler system works.	tamper and sy Code or shall ty eview that was	
K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 done to assure compliance.		continuously mainta condition and are in periodically. 19.7 25, 9.7.5  This STANDARD is Surveyor: 27871 Based on observati approximately 8:00 items were noncominclude: facility could documentation that year obstruction inv	ained in reliable operating aspected and tested .6, 4.6.12, NFPA 13, NFPA s not met as evidenced by:  ons and staff interview at am onward, the following pliant, specific findings d not provide proper the 3 year full flow test and 5 estigation has been			K 062  1) Documentation of the th full flow test and five year obstruction investigation of facility's sprinkler system sl obtained from SimplexGrint be submitted with this Plan Correction.  2) The Maintenance Directo maintain a permanent file of containing records of all recontaining records of all recontain	ree year the hall be hell and of r shall r binder juired sts and r shall by view	9-28-12
CANAGERIA DE MARIO DE LA TRANSPORTA DE LA CONTRACTOR DE L		NFPA 101 LIFE SA		K ′	144		nat Was	

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
	345442	B. WIN	lG	3-70-C	08/2	4/2012
	ARE CENTER		620 l	HEATHWOOD DRIVE		
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL		×	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI	IOULD BE	COMPLETION DATE
under load for 30 m	inutes per month in	K1	44			
Surveyor: 27871 Based on observati approximately 8:00 items were noncominclude: at time of s	ons and staff interview at am onward, the following apliant, specific findings urvey staff could not get		th put a country the country that a country the country that a cou	I) Kraftpower Company sontacted to service the formergency power general letermine why the general letermine who the coordingly.  I) The Kraftpower service lechnician shall educate the laintenance Director on the coordinate to start the generation of the maintenance Director letermine monthly preventative maintenance schedule.  I) The Maintenance Director letermine monthly facility saformittee meetings and remonthly preventative maintenance schedule to a laintenance schedule to a l	acility's cor to ator did d repair ne he he erator on cor shall ency node on or shall ety eview	9-28-12
	TOF DEFICIENCIES OF CORRECTION  PROVIDER OR SUPPLIER OF COAKES HEALTHCA  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR LE  Continued From pa under load for 30 m accordance with Ni  This STANDARD is Surveyor: 27871 Based on observati approximately 8:00 items were noncominclude: at time of signerator to crank in	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345442  PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Surveyor: 27871  Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: at time of survey staff could not get generator to crank under test.	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345442  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: at time of survey staff could not get generator to crank under test.	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CATION NUMBER:  345442  ROVIDER OR SUPPLIER  TO AKES HEALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Surveyor: 27871  Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: at time of survey staff could not get generator to crank under test.	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER SUPPLIER 345442  PROVIDER OR SUPPLIER STOAKES HEALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Surveyor: 27871  Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: at time of survey staff could not get generator to crank under test.  42 CFR 483.70(a)  (X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001  STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001  ALBEMARLE, NC 28001  K 144  1) PROVIDER STAN OF CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP OEFICIENCY)  K 144  1) Kraftpower Company si contacted to service the feemergency power generate determine why the general determine why the generator start on test mode an accordingly.  2) The Kraftpower service technician shall educate the Maintenance Direction of the month of the m	TO FDEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:  345442  STREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE ALBEMARLE, NC 28001  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  K 144  I K 145  I K 144  I K 146  I K 147  I K 147  I K 148  I K 144  I K 146  I K 147  I K 147  I K 148  I K 149  I K 149  I K 144  I K 146  I K 147  I K 147  I K 147  I K 148  I K 148  I K 148  I K 148  I K 149  I K 149  I K 149  I K 144  I K 148  I K 149  I K 149