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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 345186 | B. WNG_ | | c | |
| NAME OF DE | ROVIDER OR SUPPLIER | 340100 | | | 11/01/2012 | |
| | S MANOR | | | REET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | TION (X5) JLD BE COMPLETION DPRIATE DATE | | |
| F 000 | INITIAL COMMENTS | | F 000 | | | |
| SS=K | complaint investigation October 14 through 11 1, 2012. It was determ provided substandard immediate Jeopardy I survey was conducted conference was held to 11/1/2012. The SA determined the Jeopardy at F221 and notified of the Immediate Jeopardy at F221 and notified of the Immediate Jeopardy at 10/23/2012. The facilial allegation on 10/24/2012 An on-site visit was pervalidation of the credit Immediate Jeopardy at 10/24/2012. The Immediate Jeopardy | n Service Regulation ne Licensure and conducted a recertification, n and revisit survey on 8, 2012 and on November nined the facility had I quality of care at the evel. A partial extended d on 10/18/2012 and an exit with the facility on le facility has Immediate I F323. The facility was late Jeopardy at F323 on lity provided a credible old that was accepted by lefter formed on 11/01/12 for ole allegation for F 323. The lat F 323 was abated on lefter facility has Immediate lefter formed on 11/01/12 for ole allegation for F 323. The lat F 323 was abated on lefter facility has lefter formed on 11/01/12 for ole allegation for F 323. The lat F 323 was abated on lefter formed on 11/01/12 for ole allegation for F 323. The lat F 323 on 11/0/24/2012. In this date with Resident #209 lefter facility had lefter form any lefter form any lefter form any lefter form any lefter form and lefter formed for old lefter formed for lefter formed for old lefter formed for lefter formed for old lefter formed for lefter formed for old lefter formed for lefter formed for old lefter formed for old lefter for old lefter for old lefter formed for old lefter for old | F 221 | 1. Corrective action(s) accomfor those residents found the been affected by the allege deficient practice: Resident #18 was assessed Interdisciplinary Team whincludes the Director of Nonursing Home Administra Resident Assessment Director, Director of Reha Staff Development/ Risk Mand Dietary Manager, on I with pelvic belt discontinuself-releasing Velcro alart belt now in place. Resident on one to one observation his plan of care on 10/17/1 supervision will be provided hours per day and will conuntil resident is discharged experiences significant charcondition or Quality Assum Committee and Attending determines 1:1 continuous observation is no longer ne to maintain resident safety | by the hich ursing, ator, ector, ervices abilitation, Manager 10/17/12 ed and ming seat at placed as part of 2. The 1:1 ed 24 atinue d; enge in rance physician ecessary | |
| ABORATORY | RECTOR'S OR PROVIDER/S | UPPLIER 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

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Event ID: ZSMF11

Facility ID: 953488

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345186 | B. WING | | 1 | 1/2012 | |
| | ROVIDER OR SUPPLIER | | 4 | REET ADDRESS, CITY, STATE, ZIP CODE 113 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X6) COMPLETION DATE | |
| F 221 | by: Based on record rev interviews, the facility restrictive restraint, or reduction and eliminatevaluate the resident for 1 (Resident #18) physical restraint. The findings include: | T is not met as evidenced riew, observation and staff railed to use a least lid not develop a plan for ation and did not monitor and response to the restraint of 3 sampled residents on a began on 04/01/2012 and | F 221 | F 221 1:1 observation is defined continuous staff observat resident. Resident will be at all times. The staff me assigned will notify charg relief for breaks and will resident until staff memb present for relief. 1:1 obs will be documented on 1: sheet with behaviors reco observed. Behaviors obse are determined to be pote harmful will be reported charge nurse immediately. 2. Identify other residents we | | | |
| was identified on 10 Immediate Jeopardy at 7:30 PM. when the allegation of compliance at (a pattern of no actu | | 17/2012 at 6:20 PM. was removed on 10/18/2012 e facility provided a credible nce. The facility will remain a scope and severity level E al harm with potential for arm that is not immediate | | the potential to be affected same deficient practice an corrective action taken: A. All residents with rest have the potential to be by this alleged deficient practice. On 10/17/12 complete restraint red assessment was completed assessment was completed. | d what raints e affected at a uction eted on | | |
| 3 | on 07/13/11 and was multiple diagnoses in Bipolar Disorder, Her Traumatic Brain Injur The admission Minim 07/20/11 indicated the moderate cognitive in restraint, ambulation | um Data Set (MDS) dated | | all residents with restress the Interdisciplinary Tensure least restrictive use. Interdisciplinary observed resident with restraints, through stated interviews and observed effectiveness of restraints. Care plan was amended accordance with reduction, to include reduction, to include reduction, to include reduction of the alternation. | device in Team out ff ntions of nt use. d in notified | The second secon | |

PRINTED: 11/14/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345186 11/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD **FIVE OAKS MANOR** CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY Measures/systematic changes put in F 221 Continued From page 2 F 221 place to ensure that the deficient The significant change in status assessment practice does not reoccur: dated 12/22/11 indicated that Resident #18 had A. Corporate Clinical Consultant memory and decision making problems, had a who is a Registered Nurse intrunk restraint used in chair or out of bed. serviced the Interdisciplinary ambulation did not occur during the entire 7 day team on 10/17/12 on the use of period and was dependent on the staff for restraints to include facility transfers. policy on use of least restrictive The care area assessments (CAAs) summary for device, monitoring, response to physical restraints dated 12/22/11 indicated use of restraints and their "resident was provided with lap belt to wheelchair effectiveness. In-service in an effort to reduce injury related to falling. included policy content to Resident noted with frequent falls during include: Restrained individuals episodes of confusion/lethargy with elevated shall be reviewed regularly (at ammonia level. Resident slides/leans forward least quarterly) to determine and falls from the chair. Provided with Geri chair whether they are candidates for during episodes of lethargy to maintain safety. restraint reduction, less Provided 1:1 supervision as indicated." restrictive methods of restraints, or total restraint The physical restraint consent form dated elimination, care plans shall 12/23/11 was reviewed. The form indicated the also include the measures taken type of restraint used was pelvic restraint, the to systematically reduce or specific target behaviors were "unsafe transfers eliminate the need for restraint and positioning in chair "and the medical use and that Restraints shall be symptom was "encephalopathy". used in such a way as not to cause physical injury to the The care plan with 12/28/11 as date of onset was resident and to insure the least reviewed. The care plan problem was "resident possible discomfort to the is very impulsive with movements and has no resident. safety awareness placing him at risk for falls, unsteady, staggering gait and right knee buckles B. All nursing staff, to include at times. Needs verbal cues to stay focused. Requires need for pelvic restraint and broda Licensed Nurses and Certified Nursing Assistants, have been chair. Resident will sit self down on floor at times. will lie down to sleep on floor." The goal was in-serviced on facility policy on

"resident will be free of injury thru 12/28/12, will

receive least restrictive most effective restraint

through 03/28/12, will receive no injury or

use of restraints and proper

placement on 10/18/12 by the

Director of Nursing and Staff

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| A. BUILDING B. WING TO SUPPLIER FIVE OAKS MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG A. BUILDING B. WING CONCORD, STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 (X4) ID PREFIX (EACH CORRECTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Development Coordinator and | STATEMENT OF DEFICAND PLAN OF CORRE | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI | JLTIPLE C | ONSTRUCTION | (X3) ĐẠTE SUI COMPLET | |
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| NAME OF PROVIDER OR SUPPLIER FIVE OAKS MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLE COMPLE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Development Coordinator and | AD FLAN OF CORRE | | DENTS TO ATTOM NO MIDER. | A. BUIL | DING | | į | |
| FIVE OAKS MANOR 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Development Coordinator and | ť | | 345186 | B. WIN | G | | Į. | ì |
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| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | | | | | | | 1 |
| may a 1 | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFI | | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | N SHOULD BE E APPROPRIATE | (X6) COMPLETION DATE |
| F 221 Continued From page 3 breakdown related to restraint thru 12/28/12." The approaches included "up to broad chair (tilting/reclining chair) as tolerated, pelvic restraint to broad chair, ensure pelvic restraint is properly placed/attached and functioning properly every shift and PRN (as needed), release during care rounds, supervised activities and PRN (as needed), frequent body audits for early identification of breakdown, weights to broda chair (added on 4/3/12), chair pad alarm to alert staff of unsafe movements (added on 9/11/12), low bed to wall and non skid socks when in bed (added on 10/1/12)." The "physical restraint elimination assessment" form was reviewed. The instruction on the form indicated that "restrained individual should be reviewed at least quarterly to determine whether or not they are candidate for restraint reduction, less restraints restraint on 12/23/11. The form did not indicate that Resident #18 was assessed for restraint reduction elimination in March, 2012. On 6/5/12, Resident #18 was assessed for restraint reduction or elimination program. The comments were "resident continued with impulsive behaviors, learning down to pick up items, scoots/stides in chair, etc (etcetera) requiring pelvic restraint for safety." On 9/5/12, Resident for or elimination program but there was no a ction plan written. The comments were "resident continued with impulsive behavior- learns. Continue with broad polvic restraint." On the form indicated that the resident was a candidate for restraint reduction. The form indicated what the resident was a candidate for restraint reduction or elimination program but there was no action plan written. The comments were "resident continued with impulsive behavior- learns." Continue with broad polvic restraint." On the form indicated that the resident was a candidate for restraint reduction or elimination program but there was no action plan written. The comments were "resident continued with impulsive behavior- learns." Continue with broad polvic restraint." On | break The a (tilting to bro place shift: round need ident chair staff low b (adde The form indic revie or no less restr on po indic restr 6/5/11 redu was elimi "resi leani chair safet asse indic restr there were | reakdown related to the approaches including feelining chair, obroda chair, ensurated and hift and PRN (as neounds, supervised a seeded), frequent be dentification of breakhair (added on 4/3/2 taff of unsafe mover ow bed to wall and readded on 10/1/12)." The "physical restrator was reviewed at least quarted that "restrator on they are candicated that "restrator on pelvic restraint elimination." on pelvic restraint on hidicate that Resider estraint reduction/election. The form was not a candidate elimination program. | restraint thru 12/28/12." uded "up to broda chair) as tolerated, pelvic restraint e pelvic restraint is properly functioning properly every eded), release during care activities and PRN (as ady audits for early kdown, weights to broda 12), chair pad alarm to alert ments (added on 9/11/12), non skid socks when in bed int elimination assessment" The instruction on the form eaned individual should be arterly to determine whether date for restraint reduction, ining measures or total "Resident #18 was started 12/23/11. The form did not nt #18 was assessed for imination in March, 2012. On 8 was assessed for restraint revealed that the resident for restraint reduction or The comments were with impulsive behaviors, tup items, scoots/slides in requiring pelvic restraint for Resident #18 was again nt reduction. The form sident was a candidate for relimination program but plan written. The comments th impulsive behavior- leans. | F | 221 | Development Coor RN Supervisor wh Review of requirent restraints to include placement every 30 and release and relevery 2 hours and and document comment of the resident Treatment Record physical restraints determined by the interdisciplinary to Director of Nursing accordance with the recommendations interdisciplinary to assure the use of least restrictive device. It restraint is applied safety of resident of based on change in condition, the interteam will convene restraint assessment change in condition use of least restrict within 24 hours of of the device. Tear available 7 days per participate in intertexiew when necessary of the restraint of the device of the de | dinator and no is an RN. ment to check le proper of minutes position when needed appletion every nt's. The use of will be eam. The g in ne of the eam will east of the eam will east or others or medical redisciplinary to review nt and or to assure tive device application m will be er week to redisciplinary sary. aff will or facility is and use of evice, et application, restraints | |

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| | • | 345186 | B. WIN | G | | 1 | 1/2012 |
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| F 221 | 10/17/12 at 9:25 AM, interviewed. She indi assessed Resident # 9/5/12 but he was not due to being impulsive. The latest quarterly M 08/24/12 indicated the severely impaired cogused in chair or out of occur during the entire dependent on the state of the severely impaired cogused in chair or out of occur during the entire dependent on the state of the severely impaired cogused in chair or out of occur during the entire dependent on the state of the severely impaired cogused in chair or out of occur during the entire dependent on the state of the severely impaired on the state of the lap was observed on the stomach. On 12/12/1 for the use of the lap was no assessment for the alarms. The nurse's notes and 12/23/11 at 10:00 AM had released the lap the floor on the hallwainformed and a new of broda chair was obtain assessment for a less lap belt to pelvic restrictive devices tries of the lap was obtain assessment for a less lap belt to pelvic restrictive devices tries. | MDS Nurse #1 was cated that she had 18 for restraint reduction on a candidate for reduction e. IDS assessment dated at Resident #18 had gnition, had a trunk restraint f bed, ambulation did not e 7 day period and was ff for transfers. Id the incident reports were 18 had several and the use of the restraint. Id the incident report dated andicated that Resident #18 floor in his room lying on his 1, there was doctor's order belt to wheelchair. There for a lesser restrictive device of the incident report dated and prior to using the lap belt indicated that Resident #18 floor in his room lying on his 1, there were no lesser and prior to using the lap belt indicated that Resident #18 floor in his report dated indicated that Resident #18 floor i | | 4. | Registered Nurse/Staff Development during orientation. D. Directed in-services on following topics will be completed for all staff 1. Behavior Manager 2. Restraints Local ombudsman will complete training on 1: and management will v service. Director of Nu and/or Staff Developme Coordinator will comp training with staff men unable to attend on or 12-5-12. Monitoring of corrective ac ensure the deficient practic reoccur: A. The interdisciplinary to (DON, NHA, Staff Dev Coordinator, Social Sel Director, Director of R Dietary manager and N will review all residents restraints weekly X 8 w then monthly X 3 then quarterly for continued least restrictive device, monitoring response to restraints and their effectiveness. Each patic has orders of restraint v reviewed by the team to effectiveness and safety device in use, evaluate s | the 1-30-12 video in- rsing ent lete abers before ction to e will not eam elopment rvices ehab, ADS) s with eeks use of use of ent who vill be assure of | |

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| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1` ′ | | E CONSTRUCTION | (X3) DATE SUF | |
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| WALL THAT OL | ONNEOTION | Pressit for more notification | A. BUIL | DING | | | c |
| ŧ' | | 345186 | B. WIN | G | | i | 1/2012 |
| | OVIDER OR SUPPLIER | | • | 41 | EET ADDRESS, CITY, STATE, ZIP CODE 3 WINEGOFF SCHOOL ROAD ONCORD, NC 28027 | | |
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| F 221 | The nurse's notes and 1/9/12 at 11:45 AM, I bathroom. He was of chair with his legs in was still tied to the content were down at knee area. He was to pelvic restraint. The education. There was continued need/effect did not assess the reand the risk to the reand t | d the incident report dated Resident #18 had a fall in the bserved in front of the broda the air. The pelvic restraint nair. His pants and the pelvic around his mid thigh to the angled in his pants and the only intervention was staff is no assessment for the citiveness of the restraint and estraint as an accident hazard sident. Indeed that Resident #18 room with the broda chair was lying on the floor with the firm. The interventions were weights were added to the there was no assessment for effectiveness of the restraint as an accident to the resident. Indeed 6/10/12 at 11:35 AM ent #18 placed himself in bed on top of him and the pelvic acched. There was no feer this incident. There was no effectiveness of the assess the restraint as an actident. | F. | 221 | and determine potential a reduction to a lesser restrest device. This review will in walking rounds to observe patient, staff interviews a review of documentation related to the use of restres Resident review will be documented on interdisciplinary team not within the resident's clinic record. B. Events involving accident injury or potential harm related to the use of restres will be reported to the Administrator immediate way of cell phone. The administrator will evaluate event to: Assure optimal safet well-being of resided determine if policy was adhered to, if policy not adhered to, the Administrator will ethe event to determine further necessary accompliance. | cictive include e the ind aints. Ites ical t, raints ely by ite the y and int and was was was valuate ne | |
| | indicated that Resid up with broda chair | ent #18 was observed to get attached and lying in bed with restraint attached. There | | | | | |

Facility ID: 953488

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | | | 41 | EET ADDRESS, CITY, STATE, ZIP CODE 13 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | | 112012 |
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| F 221 | and there was no ass need/effectiveness of accident hazard to the The nurse's notes and 9/7/12 at 8:15 PM rev was found tipped ove pelvic restraint in place staff education and we chair. There was no it was provided and the added to the broda chassessment for the eff and the risk for accided On 10/17/12 at 9:25 A interviewed. She stat was to prevent falls/in | ut in place after the incident essment for the continued the restraint and the risk for e resident. d the incident reports dated realed that Resident #18 r in the broda chair with the ree. The interventions were eights added to the broda record that staff education re was no additional weights | F | 221 | C. Result of Audits related a use of restraints will be reported to the facility Q Assurance Committee by Nursing home Administr The Quality Assurance Committee consists of Di of Nursing, Medical Dire Nursing Home Administr Nurse Assessment Coord Pharmacy Consultant, So Services Director, and Di Manager monthly to revi need for continued intervor amendment of plan. | rector ctor, rator, inator, ocial etary ew the | |
| ٠ | member #1 was interved. PBA (personal body a lap belt were tried pricalso stated that 1:1 suend of 2011 but not in the pelvic restraint was get up and slid down. had helped to prevent that the pelvic restrain Resident #18. She fur had conducted a quartaking the restraint off | ther stated that the facility terly restraint reduction by and by observing the ed to get up, the use of | | | | NA. | |

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| NAME OF PR | OVIDER OR SUPPLIER | | 4 | EET ADDRESS, CITY, STATE, ZIP CODE 13 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | 1170 | 1740 (2 |
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| F 221 | were added a few more from tipping the brode stated therapy depart what type of restraints nursing decides what She also added that I belt and Geri chair har restraint. She also act was used for position On 10/17/12 at 4:20 I interviewed. She stated facility but she had out of Resident #18 not of immediately trained the stated of the correctly apply the | PM, therapist #2 was seed that the 10 lbs weights on the ago to prevent him a chair over. She also ment does not recommend is to use. She indicated that type of restraint to use. PBA, seat pad alarm, seat ad been tried prior to pelvic ded that the broda chair ing. PM, Nurse Manager #1 was seed that she was new to the oserved the pelvic restraint orrectly placed once. She he nursing assistant on how pelvic restraint. She stated mber the exact date and | F 221 | | | |
| | Jeopardy on 10/17/20 provided a credible a 10/18/2012 at 7:30 Procompliance indicated Credible Allegation of 1. Corrective action(residents found to ha alleged deficient practice Resident #18 was as Interdisciplinary Team | : f Compliance: s) accomplished for those ve been affected by the dtice: | | | | |

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| F 221 | Director of Rehabiliting Risk Manager and I with pelvic belt discovelor alarming sear placed on one to or plan of care on 10/1 be provided 24 hou until resident is disconsignificant change in Assurance Committed determines 1:1 con longer necessary to 1:1 observation of residuals observed at all time assigned will notify breaks and will not member is present be documented on recorded as observated as observated at the character of the character | sessment Director, cial Services Director, ciation, Staff Development/ Dietary Manager on 10/17/12 continued and self- releasing at belt now in place. Resident are observation as part of his 17/12. The 1:1 supervision will ars per day and will continue charged; experiences an condition or Quality are and attending physician attinuous observation is no a maintain resident safety. Selfined as continuous staff alent. Resident will be as. The staff member are charge nurse for relief for aleave resident until staff afor relief. 1:1 observations will at 1:1 flow sheet with behaviors ared. Behaviors observed that are potentially harmful will be arge nurse immediately. Astraints have the potential to alleged deficient practice. On the restraint reduction completed on all residents with atterdisciplinary Team to ensure | F 22' | | - | |

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| | ROVIDER OR SUPPLIER S MANOR | | 413 | TADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD NCORD, NC 28027 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PREÇEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 221 | observation of resideremoved for approximation removed for approximation resident with MD order obtains restriction. Care plate accordance with recordance and System The Corporate Clinic Registered Nurse in team on 10/17/12 of include facility policidevice, monitoring, and their effectiven content to include: reviewed regularly determine whether restraint reduction, restraints, or total resident and to include the systematically redurestraint use and the such a way as not resident and to instruct and proper placem. All assigned nursin Nurses and Certific in-serviced on faciliand proper placem. Director of Nursing Coordinator and Riversidents. | evice use; review included ents while restraints were imately 20 minutes each. 9 in designated device at this was amended, in accordance ned, to device of lesser an was amended in duction. Responsible party agreement with reduction, to enefits of the alternative plan. mic Changes ical Consultant who is a in-serviced the Interdisciplinary in the use of restraints to yo nuse of least restrictive response to use of restraints ess. In-service included policy Restrained individuals shall be (at least quarterly) to they are candidates for less restrictive methods of estraint elimination, care plans the measures taken to ce or eliminate the need for least Restraints shall be used in to cause physical injury to the ure the least possible | F 221 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD B. WING | | (X3) DATE SURVEY COMPLETED C | |
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| | | 345186 | D. WING | | 11 | /01/2012 |
| NAME OF PR | S MANOR | | \$ | STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 221 | Currently, 26 direct and are assigned for 3PM. in-service assigned to reside 11pm in-service or assigned to reside 11pm in-servicing is soft staff are re-in-serviced in-servicing is soft every 30 minutes every 2 hours and completion every Record. Part time nursing Assistants assigned to direct in-service. Training will be concerned by the interdisciple Nursing in accord of the interdisciple least restrictive displied to assure based on change interdisciplinary trestraint assessing assure use of least available 7 days | e until in-service attended. ct care staff have been trained to residents. 19 are scheduled e on Oct 18, 2012 then will be ents. 13 are scheduled for the in Oct 18, 2012 and then will be ents. There are 87 in total. ineduled before each shift until all viced. Review of requirement to o include proper placement and release and reposition d when needed and document shift on the resident's Treatment elicensed nursing staff, part time is and new hires will not be t care until completion of this conducted by the Staff ordinator or RN Supervisor. The estraint policy has been added to orgram for all new nursing cal restraints will be determined linary team. The Director of dance with the recommendations inary team will assure the use of evice. If emergency restraint is a safety of resident or others in medical condition, the earn will convene to review ment and change in condition to ast restrictive device within 24 ion of the device. Team will be per week to participate in review when necessary. | F 2 | 21 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) ĐATE SURVEY COMPLETED | |
|---|--|---|--------------------|---|---|----------|-------------------------------|--|
| | | 345186 | B. WING | | | 11 | C /01/2012 | |
| | ROVIDER OR SUPPLIER | | | 413 V | ADDRESS, CITY, STATE, ZIP CODE VINECOFF SCHOOL ROAD CORD, NC 28027 | | | |
| (X4) ID PREFIX TAG | (EACH DEFIC | Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 221 | on restraints and monitoring, corre- of restraints and it Nurse/Staff Deve Monitoring The interdisciplin Development Co- Director, Director manager and Mir coordinator will re weekly X 8 week quarterly for cont device, monitorin and their effective orders of restrain assure effectiven evaluate safety a reduction to a less review will include patient, staff interdocumentation re Resident review interdisciplinary to clinical record. Events involving related to the use the Administrator | receive training on facility policy use of least restrictive device, of application, response to use their effectiveness by Registered lopment ary team (DON, NHA, Staff ordinator, Social Services of Rehabilitation, Dietary nimum Data Set (MDS) eview all residents with restraints in the monthly X 3 months then inued use of least restrictive gresponse to use of restraints eness. Each patient who has the will be reviewed by the team to ess and safety of device in use, and determine potential for esser restrictive device. This is ewalking rounds to observe the reviews and review of elated to the use of restraints. Will be documented on earn notes within the resident's accident, injury or potential harm are of restraints will be reported to immediately by way of cell | F | | | | | |
| | to: Assure optimal s and determine if was not adhered | afety and well- being of resident policy was adhered to, if policy to, the Administrator will nt to determine further necessary | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | E CONSTRUCTION | COMPLETE | (X3) DATE SURVEY COMPLETED | |
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| | | 345186 | B. WNG | | C 11/01 | 1 | |
| NAME OF PRO | S MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 221 | Result of Audits rel will be reported to Committee by the The Quality Assura Director of Nursing Home Administrato Coordinator, Pharr Services Director, | continued compliance. clated to the use of restraints the facility Quality Assurance Nursing home Administrator. ance Committee consists of g, Medical Director, Nursing or, Nurse Assessment macy Consultant, Social and Dietary Manager monthly of for continued intervention or | F 221 | | | | |
| F 226 SS=D | 5:00 PM. as evided in-service training placement of restriction and when to release team was interview received on the usure proper application of the restraint how when to release results observed to have 1:1 observation by 483.13(c) DEVEL ABUSE/NEGLEC. The facility must depolicies and processing treatment, negotiates and processing processing treatment, negotiates are resulted to the policies and processing treatment, negotiates are resulted. | | F 226 | alleged deficient practice: A. No residents identifi B. Certifications for all have been verified th (Health Care Person maintained in person completed on 11-8-1 | ed. I nursing assistants arough HCPR and Registry) and nnel files. Audit | 11-9-12 | |
| | by: | ENT is not met as evidenced views of policy and employee | | 2. Identify other residents w potential to be affected by practice and what correct A. All residents who reshave the potential to alleged deficient pra | y the same deficient tive action taken: side in the facility be affected by this | | |

| STATEMENT OF DE | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MÜLTI A. BUILDIN | | STRUCTION | (X3) DATE SUR COMPLETE | |
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| | | , | B, WING | | | | |
| | <u> </u> | 345186 | | | | 11/01 | /2012 |
| FIVE OAKS MA | DER OR SUPPLIER | | | 413 WINE | DRESS, CITY, STATE, ZIP CODE ECOFF SCHOOL ROAD RD, NC 28027 | | oriver likeroda |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| received cear 7 & The The Au Mapre reverse so apparent and point a | arify the license of 1 artifications of 2 of 2 & #8) prior to offering the findings include: The findings include | erview, the facility failed to of 2 nurses (Nurse #4) and nurse aides (Nurse Aides # ag employment. rohibition Policy, dated at "Human Resources, who assures that all enings are completed and " I and/or state regulations, all a must complete and a (n): Abuse registry check, investigation, licensure and reference check (per mple of new employee files ealed that Nurse #4, was copy of her license registry check, investigation, licensure and reference check (per mple of new employee files ealed that Nurse #4, was copy of her license resonnel file and 8/21/12 at 11:16 am, the tatus. I some of the new employee estaff who was normally ask, vacated her position, that she did not handle the y of the nurses. She shared taff has to verify a license; it | F 22 | 4. | Measures/systematic changes put the ensure that the deficient practice of recur: A. Nurse #4 and Nurse Aides #7 have licenses/certifications in standing with NC Board of NB. 100% audit of all licensed nurse CNA's to ensure that all have updated licenses/certification by Human Resource office by Human Resource/Business Opersonnel were in-serviced by Administrator on 11/1/2012 opolicy for verifications prior to the employment. D. Upon review of applications on the employment for the Business Office/Human Resource will print a copy of their current place copy in their personnel E. No nursing employee will be attend orientation until a cop license have been verified, proplaced in personnel file. F. Facility maintains copy of licenurse's within personnel file. completed by Human Resourby 11-8-12. HCPR (Health Completed by Human Resourby | and #8 good lursing. rses and e current completed y11/8/2012. ffice y the on facility of potential o offering verify and license and file. able to y of their inted and ense for Audit was ce office are fied on 10- ensure the velopment vill audit loyees ttion ly x 3 to | |

| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | (X3) DATE SUR COMPLETE | |
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| AND I BIN OI | OOTALESTION . | | A. BUII | .DING | | C | , |
| | | 345186 | B. WIN | G | | 11/01 | 1/2012 |
| NAME OF PR | OVIDER OR SUPPLIER S MANOR | | * | 413 | ET ADDRESS, CITY, STATE, ZIP COI 3 WINECOFF SCHOOL ROAD DNCORD, NC 28027 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 226 | were reviewed. It rev was hired on 8/16/12 certification was in he documented that on On 10/18/12 at 1:35 #1 was interviewed. she briefly performed pre-employment screwas normally responher position. She stavalidate certifications Nurse Aide Registry employment. She of have viewed the certif, before the employ 3. On 10/18/12 a sa | ealed that Nurse Aide #7 A copy of her nurse aide or personnel file and 8/20/12, it was verified. The personnel file and 8/20/12, it was verified. The personnel file and 8/20/12, it was verified. The personnel file and 9/20/12, it was verifie | | 226 | reported to the faci Assurance Commit Nursing Home Adn of Nursing, Medica Supervisors, SDC/1 | if applicable, will be lity Quality tee consisting of ministrator, Director I Director, Unit Risk Manager, MDS Consultant, Wound Services Director, ger monthly to r continued | |
| F 278 SS=D | was hired on 8/16/12 certification was in h documented that on On 10/18/12 at 1:35 #1 was interviewed. she briefly performe pre-employment scr was normally responder position. She st validate certification Nurse Aide Registry employment. She of have viewed the cerit, before the employ 483.20(g) - (j) ASSE ACCURACY/COOR | 2. A copy of her nurse aide er personnel file and 8/20/12, it was verified. pm, the Administrative Staff She stated that in August, d some of the nurse aides eenings, when the staff who asible for the task, vacated ated that when she must s, she always looked at the online, prior to any offer of fered that perhaps she might tification and omitted printing ment began. | | ⁻ 278 | residents found to hav alleged deficient prac A. Resident #18 hav quarterly MDS completed on 10 | d a modification to his | 12-5-12 12-5-12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE SURV COMPLETED | |
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| LIDI LINOI | 23.0.227701 | | A. BUILDING | | C | |
| | | 345186 | B. WING | | 11/01/ | 2012 |
| | ROVIDER OR SUPPLIER | | 41: | ET ADDRESS, CITY, STATE, ZIP CODE 3 WINECOFF SCHOOL ROAD DNCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 278 | resident's status. A registered nurse meach assessment will participation of health. A registered nurse massessment is competed in a sessment is competed in a subject to a civil more assessment assessment assessment assessment assessment. | nust conduct or coordinate th the appropriate in professionals. nust sign and certify that the leted. completes a portion of the gn and certify the accuracy of sessment. I Medicaid, an individual who ally certifies a material and resident assessment is ney penalty of not more than essment; or an individual who ally causes another individual and false statement in a t is subject to a civil money than \$5,000 for each | F 278 | Resident #17 had a m quarterly MDS from completed on 10/30/26 coding days of antide anticoagulation use by practice and what correction A. All residents who potential to be affected by practice and what correction A. All residents who residents who residents who resident practice and what correction alleged deficient practice. A. All residents who resident practice and what correction alleged deficient practice. B. All MDS's have been Interdisciplinary tear accuracy of assessments. 3. Measures/systematic changensure that the deficient precur: A. Corporate Resident A Specialist/Registered the MDS department proper coding of the B. Any new MDS nurse training during the oby Corporate Reside Specialist/Registered accurate coding of the Monitoring of corrective a deficient practice will not A. Director of Nursing/S | 8/13/2012 D12 to include pressant and y MDS/RN. To have the the same deficient we action taken: Ide in the facility be affected by this tice. reviewed by not oensure nots. Ide in place to ractice does not Assessment Nurse in-serviced on 10/30/2012 on MDS. will receive rientation period not Assessment Nurse to ensure e MDS. action to ensure the recur: Staff Development | |
| | This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to accurately assess residents on areas of ambulation (Resident # 18) and medications (Resident #17) for 2 of 22 sampled residents. The findings include: | | | Coordinator will and x 4 weeks then month have accurate coding B. Report of findings a disciplinary action, reported to the facil Assurance Committ Nursing Home Adm of Nursing, Medical Supervisors, SDC/F Nurse, Pharmacy Care Nurse, Social and Dietary Manag | hly x 3 to ensure all s. Ind subsequent for applicable, will be lity Quality ee consisting of inistrator, Director Director, Unit Risk Manager, MDS onsultant, Wound Services Director, | |

| (X4) ID PREFIX TAG | OVIDER OR SUPPLIER S MANOR SUMMARY ST | IDENTIFICATION NUMBER: 345186 JATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL | 413 W | ADDRESS, CITY, STATE, ZIP CODE VINECOFF SCHOOL ROAD CORD, NC 28027 | C 11/01/2012 |
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| NAME OF PRO | OVIDER OR SUPPLIER S MANOR SUMMARY ST | TATEMENT OF DEFICIENCIES | STREET. 413 W CON | VINECOFF SCHOOL ROAD CORD, NC 28027 | 11/01/2012 |
| NAME OF PRO | OVIDER OR SUPPLIER S MANOR SUMMARY ST | FATEMENT OF DEFICIENCIES | 413 W CON | VINECOFF SCHOOL ROAD CORD, NC 28027 | |
| PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES | | | |
| F 278 | | LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETION |
| | 7/13/11 and was re- quarterly MDS asses indicated that ambul entire 7 day period. Review of the nursir 2012 revealed that I restorative ambulati The notes revealed ambulated with the week. On 10/16/12 at 2:38 interviewed. He sta ambulated at least: 1 person assist. On 10/16/12 at 3:34 observed walking u person assist. On 10/17/12 at 8:11 taking Resident #1 #18 was able to an She stated that res with unsteady gait. | admitted to the facility on admitted on 9/29/11. The sement dated 8/24/12 lation did not occur during the agreetorative notes in August, Resident #18 was on on program 6 times per week. that Resident #18 had use of rolling walker 6 times a set of the tat Resident #18 had use of folling walker #1 was ated that Resident #18 25 feet 6 times per week with 4 PM, Resident #18 was using a rolling walking with 1 of AM, NA #1 was observed 8 to the bathroom. Resident houlate with 1 person assist. | F 278 | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | | E CONSTRUCTION (X3) DATE SU COMPLE | | |
|--------------------------|---|--|----------------------|---------------|---|---|----------------------------|
| | | 345186 | B. WING | | | 11/01 |) 1/2012 |
| NAME OF PR | OVIDER OR SUPPLIER | | | 413 WINEC | ESS, CITY, STATE, ZIP CODE OFF SCHOOL ROAD D, NC 28027 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUN CROSS-REFERENCED TO THE APPRIDEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 278 | Review of Resident and revealed that she was (antidepressant) since (anticoagulant) since Coumadin was chan (anticoagulant). The MARs (Medicati July, 2012 and Augulant) MARs indicated that Trazodone and Coul | anticoagulant medications. #17's physician's orders as on Trazodone the 1/30/12 and on Coumadin ar 7/16/12. On 8/4/12, | F 2 | 78 | | | |
| F 279 SS=B | interviewed. She ag Resident #17 was no use of the antidepre medications. 483.20(d), 483.20(k) COMPREHENSIVE A facility must use the to develop, review a comprehensive plant. The facility must develop plan for each reside objectives and timest medical, nursing, and needs that are idental assessment. | CARE PLANS ne results of the assessment nd revise the resident's | F | 279 1. | Corrective action(s) accomplist residents found to have been a alleged deficient practice: A. Resident #17 had her Caupdated on 10/30/2012 to use of anticoagulant med Interdisciplinary team. Resident #209 had her Cupdated on 10/30/21012 to use of Psychotropic medi Interdisciplinary team. Resident #64 has an IDT completed on 10/17/2012 Worker to indicate that a term plan is to remain in | re Plan o include the lication by the are Plan to include the ication by the are Plan to include the ication by the | 25-12 125-12 |

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPE A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | | B. WNG | | С |
| NAME OF PF | OVIDER OR SUPPLIER | 345186 | | EET ADDRESS, CITY, STATE, ZIP CODE | 11/01/2012 |
| FIVE OAK | S MANOR | , | l | 13 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE COMPLETION |
| F 279 | highest practicable ppsychosocial well-be §483.25; and any set be required under §4 due to the resident's §483.10, including the under §483.10(b)(4). This REQUIREMENT by: Based on medical reinterviews, the facility plan for two (2) of tel the appropriate use of #17, Resident #209) plan for discharge pl (3) sampled resident community discharge included: 1. Resident #17 was 4/18/11 and was resignificant change in 5/25/12 indicated the anticoagulant medic decision was to produce that Reside anticoagulant medic. The care plan for Resident for the care plan for Resident for the was no care puse of the anticoagulant medic. The MARs (Medicat July, 2012 and August 1 well and August 2012 and August | hysical, mental, and ing as required under revices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment. It is not met as evidenced ecord review and staff y failed to develop a care in (10) residents reviewed for of medications (Resident and failed to develop a care anning for one (1) of three is who were reviewed for the (Resident #64). Findings admitted to the facility on admitted on 1/27/12. The instatus assessment dated at the resident was on ation and the care plan is eed to care plan. The issment dated 8/13/12 ent #17 was not on | F 279 | 2. Identify other residents who ha potential to be affected by the s practice and what corrective as A. All residents who reside in have the potential to be affected practice. B. All Care Plans have been the Interdisciplinary team to ensure all residents hav comprehensive care plans. 3. Measures/systematic changes pensure that the deficient practice. A. Corporate Resident Assess Specialist/Registered Nurregistered nurses responsing development and accurace plans. Interdisciplinary Tinclude in the in-service of on the development of concare plans. B. Any new MDS (RN) Interteam member will receive during the orientation percorporate Resident Assess Specialist/Registered Nurdevelopment and accurace plans. Any new Interdiscimember will receive train orientation on develop of comprehensive care plans be completed by Corpora Assessment Specialist (RM). 4. Monitoring of corrective action deficient practice will not recurate of the consurer all have accurate of care plans. | ame deficient tion taken: I the facility fected by this reviewed by by 11/7/2012 e I tion place to be does not sment for the grown was also in 10/30/2012 for |

Facility ID: 953488

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1, , | | | | X3) DATE SURVEY COMPLETED | |
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| | | | A. BUILD | | | | | С |
| | | 345186 | B. WING | | | | | 11/01/2012 |
| NAME OF PR | OVIDER OR SUPPLIER S MANOR | | | 413 WI | NECO | SS, CITY, STATE, ZIP CODE FF SCHOOL ROAD NC 28027 | | , |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | | PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION COSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| F 279 | Trazodone and Prada ordered. On 10/18/12 at 10:45 interviewed. She statuse of the anticoagul developed in May, 20 August, 2012 when to Pradaxa. She further of because Prada medication. She further of because Prada medication. She further use of the anticoath of the use of the | axa in August, 2012 and axa in August, 2012 as 5 AM, MDS Nurse #1 was ated that the care plan for the ant medication was 2012 but was discontinued in the Coumadin was changed her stated that it was an axa was also an anticoagulant her stated that she would ar Resident #17 to address agulant medication. Is admitted on 8-21-12 with a sive disorder. In wof the physician orders led that Resident #209 was a hypnotic medication) 5 medication for the dication and proceed at bedtime and Zoloft medication for the physician orders are discontinuously for the month of the care Plan (CP) dated Psychotropic medication no approaches and occumented. | F 2 | 79 | В. | Report of findings and disciplinary action, if a reported to the facility Assurance Committee on Nursing Home Administ of Nursing, Medical Discussive, Pharmacy Consolar Nurse, Pharmacy Consolar Nurse, Social Servand Dictary Manager of review the need for contintervention or amendmental managements. | pplicable, will b Quality consisting of strator, Director rector, Unit Manager, MDS ultant, Wound vices Director, nonthly to tinued | |
| | conducted with Nurs | pm, an interview was e #4 who was also the MDS orted that she was new to | | | | | | |

| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | | (3) DATE SURVEY COMPLETED | |
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| WALL LEWIN OL | CONTECTION | | A. BUII | | | C | | |
| | • | 345186 | B, WIN | · | | 11/01 | /2012 | |
| NAME OF PR | OVIDER OR SUPPLIER | | | 413 | ET ADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD NCORD, NC 28027 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| F 279 | process worked. She unaware that the CP medication use along interventions. On 10-25-12 at 10:0 was conducted with indicated her expect assessments to be a specific. Resident #64 wa 5/21/12. Cumulative Diabetes Mellitus, cl chronic kidney diseases ment dated 5/4 was mildly impatitled "Participation in Setting" indicated the assessment Resident assessment Resident assessment Resident and return home. On 5/22/2012, a Screvealed Resident and return home. | still learning how the MDS indicated that she had been had to address psychotropic gwith approaches and Oam, a telephone interview Administrative staff #1. She ations were for the Care Plan accurate and be resident address included: hronic respiratory failure and ase with dialysis. Inum Data Set (MDS) 5/28/12 indicated Resident aired in cognition. Section Q in Assessment and Goal Resident #64 participated in sident #64's overall goal was harged to the community. dent #64 dated 6/6/12 and yed. There was no care plan tential discharge to ocial Services Evaluation form #64 planned to be short term 15 PM., an interdisciplinary sated long term plans per | F | 279 | | | | |

| | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONST | RUCTION | (X3) DATE SURVI COMPLETED | |
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| AND PLAN OF | CORRECTION | IDENTIFICATION NOMBER. | A. BUILDING | | | С | |
| | | 345186 | B. WING | | | 11/01/ | 2012 |
| NAME OF PR | OVIDER OR SUPPLIER | | 413 | WINEC | ESS, CITY, STATE, ZIP CODE OFF SCHOOL ROAD D, NC 28027 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 279 | progress note indicated Resident #64 to return to not 10/16 12 at 3:10 the Interdisciplinary discuss a resident some for continued the potential discharge plan resident and family, for Resident #64 and discharge planning of the Interdisciplinary of the Interdisciplinary discuss a resident some for continued the potential discharge plan resident and family, for Resident #64 and discharge planning of the Interdisciplinary of the Interdisciplina | is PM., an interdisciplinary and long term plans were for an to the community. M., an interdisciplinary discharge plans were approval. PM., MDS Nurse #1 stated fleam (IDT) met weekly to a progress in therapy, the merapy/ nursing services and rom the facility. She stated rivices and the Social Worker and meetings with the she reviewed the care pland indicated she did not find a care plan. PM., Administrative staff #2 indicated on admission that an and grandchildren and the community. #2 said Resident #64's power as concerned about her e stated she met with the POA on 8/17/2012. During the period of the period of the list charge plans and the list charge pla | F 279 | 1. | Corrective action(s) accomplist residents found to have been at alleged deficient practice: | fected by the | 25-12 |
| SS=D | | ER ent's comprehensive | | | A. Resident #33 had her indocatheter secured with a le 10/18/2012 by nurse. | welling g strap on | \J. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | | |
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| AND PLAN OF | CORRECTION | DENTI TOMOR NOMBER | A, BUILD | | | С | |
| , | | 345186 | B, WING | | | 11/01/2 | 2012 |
| NAME OF PR | OVIDER OR SUPPLIER | | | 413 WINEC | ESS, CITY, STATE, ZIP CODE OFF SCHOOL ROAD D, NC 28027 | | 100 |
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| F 315 | assessment, the faci resident who enters indwelling catheter is resident's clinical corcatheterization was rytho is incontinent of treatment and service infections and to resifunction as possible. This REQUIREMENT by: Based on record resident indwelling catheter of 3 sampled residencatheter. The finding 1. Resident #33 was 8/3/12 and was reamultiple diagnoses in admission MDS (Mindated 9/6/12 indicated 9/6/12 indicated severe cognitive impressure ulcer and indwelling catheter individual individual individual individual included "Foley catheter | lity must ensure that a the facility without an a not catheterized unless the indition demonstrates that necessary; and a resident bladder receives appropriate es to prevent urinary tract tore as much normal bladder T is not met as evidenced view, observation and staff failed to secure the or 2 (Residents # 135 & #33) ints with an indwelling | F 3 | 2. | Resident #135 had her indicatheter secured with a leg 10/18/2012 by nurse. Identify other residents who have potential to be affected by the sapractice and what corrective act. A. All residents with indwelling have the potential to be affalleged deficient practice. B. All residents with indwelling were assessed on 10/18/2016 that leg strap was in place supervisors. Measures/systematic changes pensure that the deficient practice recur: A. Director of Nursing/Staff Coordinator will inservice staff on facility policy on icatheter by 11/1/2012. B. All new nursing staff will during orientation by the Development Coordinator policy for indwelling catheter include atheter remains secured strap to reduce friction as at the insertion site. Monitoring of corrective action deficient practice will not recur. A. Director of Nursing/Staff Coordinator/Unit Coordinator/Unit Coordinator/Unit Coordinator/Unit Coordinators weekly x 4 week monthly x 3 to ensure indicatheters are secured per | ye the ame deficient tion taken: ng catheters feeted by this ng catheter 12 to ensure by unit ut in place to be does not Development e all nursing ndwelling be in-serviced Staff or on facility eter. ding led that the with a leg and movement in to ensure the r: Development a to ensure the r: Development nators will livelling as then levelling | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | Ι' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ED C |
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| F 315 | as needed, assess Foley catheter flus with MD order as r be lowered than the patency." On 10/16/12 at 10 observed during the treatment nurse as the room to provid Resident #33 was catheter in place. It was catheter was not so the side, it was catheter was not so the catheter was not so the catheter was on 10/16/12 at 4: indwelling catheter the catheter was on 10/16/12 at 4: interviewed. She indwelling cathete secure the catheter that she did not keep strap on but so immediately. 2. Resident #135 2/14/12 and was multiple diagnose The quarterly MD indicated that Re was intact and he the care plan da | for signs/symptoms of UTI, hes with NS (normal saline) needed, drainage bag should e abdominal level to maintain and the abdominal level t | F . | disciplinary action, reported to the facil Assurance Commite Nursing Home Adn of Nursing, Medical | if applicable, will be lity Quality tee consisting of linistrator, Director I Director, Unit Risk Manager, MDS Consultant, Wound Services Director, ter monthly to continued | |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | PLE CONSTRUCTION | (X3) DATE SUR' | |
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| NAME OF PR | OVIDER OR SUPPLIER S MANOR | | 4 | REET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | _ |
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| F 315 | FR (French) Foley ca urinary retention with centimeter) post void trauma, UTI and disciplacement through 12 included "secure Fobladder at all times, k when out of bed and catheter tubing remainmentor for signs/sym. On 10/18/12 at 8:40 observed in bed. She in place and the tubir leg/thigh. Interview was taff member had reago and did not put it the name of the staff know why the staff morning with the catheter with the catheter tubing the staff member had reago and did not put it the name of the staff know why the staff memorning with the catheter tubing the staff memorial tubing tubin | theter in place secondary to more than 200 cc (cubic residual, she is at risk for omfort." The goal was "will ons related to Foley catheter 2/19/12." The approaches ley catheter to leg, below seep in Foley catheter bag in hallway, ensure Foley in patent and not kinked and aptoms of UTI." AM, Resident #135 was had an indwelling catheter ng was not secured to her with the resident revealed that emoved the leg strap days back on. She did not know member and she did not | F 315 | 5 | | |
| F 323 | interviewed. She sta Resident #135 had in was observed inform Resident #135 needs catheter tubing. 483.25(h) FREE OF | | F 32: | 3 1. Corrective action(s) accom | unlished for | 13 |
| SS=K | The facility must ens | | | those residents found to he affected by the alleged def practice: | ave been | 12-5-12 |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING Ç B. WING 345186 11/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD **FIVE OAKS MANOR** CONCORD, NC 28027 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Resident #18 accident history was F 323 Continued From page 25 F 323 assessed by the Interdisciplinary Team which includes the Director of Nursing, as is possible; and each resident receives Nursing Home Administrator, Resident adequate supervision and assistance devices to Assessment Director, Coordinator, the prevent accidents. Social Services Director, Director of Rehabilitation, Staff Development/ Risk Manager and Dietary Manager on 10/17/12 with pelvic belt discontinued and self-releasing Velcro alarming seat This REQUIREMENT is not met as evidenced belt now in place. Resident placed on by: 1 one to one observation as part of his Based on record review, observation and staff plan of care on 10/17/12. Review of interviews, the facility failed to evaluate the need incident logs reveals no further falls as for the restraint to prevent falls and did not of 10/24/2012. The 1:1 supervision will identify and assess the use of the restraint as an be provided 24 hours per day and will accident hazard/risk to 1 (Resident #18) of 3 continue until resident is discharged; sampled residents with accidents. experiences significant change in condition or Quality Assurance Committee and Attending physician The findings include: determines 1:1 continuous observation is no longer necessary to maintain Immediate Jeopardy began on 04/01/2012 and resident safety. was identified on 10/23/2012 at 4:13 PM. Immediate Jeopardy was removed on 10/24/2012 1:1 observation is defined as continuous when the facility provided a credible allegation of staff observation of resident. Resident compliance. The facility will remain out of will be observed at all times. The staff compliance at a scope and severity level E (a member assigned will notify charge pattern of no actual harm with potential for more nurse for relief for breaks and will not than minimal harm that is not immediate leave resident until staff member is ieopardy)*. present for relief. 1:1 observations will be documented on 1:1 flow sheet with behaviors recorded as observed. Resident #18 was originally admitted to the facility Behaviors observed that are determined to be potentially harmful will be on 07/13/11 and was re-admitted on 09/29/11 with multiple diagnoses including Hypertension, reported to the charge nurse immediately. Bipolar Disorder, Hepatic Encephalopathy, and Traumatic Brain Injury. Identify other residents who have the potential to be affected by the same The admission Minimum Data Set (MDS) dated deficient practice and what corrective 07/20/11 indicated that Resident #18 had action taken: moderate cognitive impairment, had no physical

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| PREFIX TAG | | Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | T I | COMPLÉTION DATE |
| F 323 | entire 7 day period ar with transfer. The significant change dated 12/22/11 indicated memory and decision trunk restraint used in ambulation did not of period and was depetransfers. The care area assess falls dated 12/22/11 vindicated "will continued staff supportion for injury related fallir 1:1 supervision as inepelvic restraint, low balert staff of unsafe nof status changes an indicated." The care plan with 12 reviewed. The care plan with 12 reviewed. The care plan with safety awareness plaunsteady, staggering at times. Needs verk Requires need for pechair. Resident will swill lie down to sleep resident will be free or receive least restrictive through 03/28/12, will breakdown related to The approaches including the side of the side of the approaches including the side of the side of the approaches including the side of the | did not occur during the not needed limited assistance e in status assessment ated that Resident #18 had a making problems, had a nother court of bed, cour during the entire 7 day andent on the staff for exempted with care plan with the ordinary of the remaining the entire of the summary are with care plan with the ordinary of the summary are with care plan with ordinary of the summary are with care plan with ordinary of the summary are with care plan with ordinary of the summary o | F | 323 | A. All residents who sustain falls/accidents have the pote be affected by this alleged of practice. B. On 10/24/12 a complete au the Interdisciplinary Team residents with falls/acciden last 30 days has been compensure all residents have appropriate interventions it to prevent reoccurrence an Plans have been amended tourrent interventions. Audicompleted by review of Fall/Accident report, revied charts and updates to Carell IDT note completed in each resident chart to support for audits. 3. Measures/systematic changes per place to ensure that the deficient practice does not reoccur: A. The Corporate Clinical Number is a Registered Nurse insecting the Interdisciplinary Team 10/24/2012 on accident present and monitoring as it related providing an environment from hazards that the facility policy on Preventing accidents by providing an environment that is free fundards over which the facontrol by the Director of Staff Development Coordinand RN Supervisor by 11/4 | dit by of all ots in the deted to in place od Care to reflect its were wo of e Plan. ch findings out in ourse who erviced in on evention es to t free dity has viced on ing rom cility has Nursing / inator | |

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| F 323 | placed/attached and shift and PRN (as nee rounds, supervised at needed), frequent book identification of break chair (added on 4/3/1 staff of unsafe moven low bed to wall and not (added on 10/1/12). " The latest quarterly MO8/24/12 indicated the severely impaired cogused in chair or out of occur during the entire dependent on the state of the floor lying on his state front of the wheelchait taken were labs (labor (ammonia level), staff monitoring. On 12/12 order for "lap belt to release on care round 11:15 AM, administratin-service records. To on 12/8/11 with the to when resident is lether upright and wheelchal able to sit upright and were lap belt restraint were lap belt restraint. | pelvic restraint is properly functioning properly every eded), release during care ctivities and PRN (as dy audits for early down, weights to broda 2), chair pad alarm to alert ments (added on 9/11/12), on skid socks when in bed at Resident #18 had anition, had a trunk restraint foed, ambulation did not e 7 day period and was ff for transfers. In the incident reports were the incident reports were the had several ments are of the restraint. The incident #18 was observed on stomach next to his bed in r. The immediate action | F 3. | AND | C. All residents that have falls/accidents will be revithe daily Interdisciplinary morning meeting during residents hours to ensure produce to prevent reoccurrents. Care Plans have been amounterest current intervention. All new hires will receive a confacility policy on preverent accidents by providing an environment that is free finazards which facility has by Registered Nurse/Staff Development during orien. Directed in-service on the falls will be completed for on or before 12-5-12 utilize Mobility and Safe Movem Elderly. Director of Nursing Staff Development Coordination will be completing in-service was purchased from NCH. 4. Monitoring of corrective action ensure the deficient practice we reoccur: A. The interdisciplinary team NHA, Staff Development Coordinator, Social Service Director, Director of Reham Dietary manager and MD review all residents through incident reports, 24 hours chart reviews who sustain falls/accidents daily in the meeting during regular by hours to ensure all have pointerventions in place and Plans have been amended | regular regular regular repoper ut in ence and ended to ens. training rom control etation. topic of all staff eing DVD, ent of the ng and/or inator ice. DVD ICFA. In to ill not example of the ing and or ing an | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | TIPLE CONSTRU | CTION | (X3) DATE SURVEY COMPLETED | | |
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| F 323 | device prior to using a lesser restrictive devibelt aside from the alam The notes and the repart AM indicated the staff nurse's station. Resisting position with the doctor was informated for pelvic respoor safety awarenes 12/23/11 revealed "Industry due to poor safety awarenes 12/23/11 revealed "Industry due | ment for a lesser restrictive a lap belt and there was no ce tried prior to using the lap | F 32 | | Events involving accident or potential harm will be to the Administrator imm by way of cell phone. The administrator will evaluate event to: Assure optimal safet well-being of reside Determine if policy adhered to, if policy adhered to, the Adm will evaluate the even determine further not actions to assure concompliance Tracking and audits will completed by the Staff Development/RN or Dire Nursing on falls/accidents and Administrator and falls/accidents are reported to the facility Q Assurance Committee by Nursing home Administrator, Nurse Assurance Consultant, Social Service Director, and Dietary Mamonthly to review the necontinued intervention or amendment of plan. | reported nediately e te the y and not and was was not inistrator not to eccessary tinued be ctor of s into the log daily. The notite e ator. The nittee arsing, g Home sessment es anager ed for | |
| | 10/17/12 at 11:15 AM | l, the administrative staff | | VALIVOTANIA | | | |

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| F 323 | could not find any for 1/9/12 incident the need/effective falls/accidents. The notes dated that Resident #18 off pelvic restrain very unsteady gabroda chair multi sitting on the floorequired 2 plus shown. The pelvic will continue to material that the need/effective falls/accidents. The notes/report revealed that Resident. The notes/report resident. The notes/report revealed that Resident. The stated that the restraint incident. The imposervation. Or administrative sident at that time instemonitored by the | page 29 Interviewed. She stated that she Itraining/staff education record It. There was no assessment for Inness of the restraint to prevent Inness of the restraint to the Inness of the restraint to the Inness of the was observed walking with It and was getting out of the Inness. He was observed It and was getting out of the Inness of the was observed Inness of the was put back on and Innition him. On 10/17/12 at Inness with the administrative staff Inconducted. She stated that she Incident report for 2/25/12 Innot know what intervention was Instituted was no assessment for Inness of the restraint to prevent Inners was no assessment to be an accident hazard to the Indiana an accident hazard to the Indiana an accident the was 1:1 Indiana an accident was 1:1 Indiana an accident was Interviewed. Indiana an accident was I | F 323 | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUIL | (X2) MULTIPLE CONSTRUCTION A BUILDING B. WING | | | URVEY ETED C |
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| F 323 | for the need/effect prevent falls/accide assessment to id accident hazard to accident hazard to the revealed that Resin his room. The resident had untillaid down on the resident back in 1. The immediate a monitoring and reappropriately. Or interview with the conducted. She was applied applied stated that the reconstruction of the prevention of the prev | tiveness of the restraint to dents. There was no lentify the restraint as an | F | 323 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPI | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF PR | OVIDER OR SUPPLIER | | 4 | EET ADDRESS, CITY, STATE, ZIP CODE 13 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | | |
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| F 323 | accident hazard to t | | F 323 | | | |
| | revealed that Residifloor in his room with him. The physical rof the incident. Whise lying on the floor top of him. The important of the incident of the incident of the important of the inserviced on 4/3/3 added to the brodal and frequent to the inserviced on the | ent #18 was observed on the high the broda chair tipped over estraint was in use at the time en assessed, he was noted to rand the broda chair was on nediate actions taken were weights were added to the | | | | |
| | recommended by 2:15 PM, therapist stated that she wa recommended the the base of the brown she also stated the weights on the brown remember how may used on each side there was no assembled/effectivenes | the therapist. On 10/18/12 at #1 was interviewed. She s the therapist who 10 lbs weights on each side of oda chair to reduce the tipping. at she was the one who put the oda chair but unable to any lbs. of weights she had of the broda chair. Again, | | | | |

| CENTERS FOR MEDICARE & MEDICAID SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | | | ! | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| E OF PROVIDER O | R SUPPLIER | | | STREE | TADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD | | 1 |
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| 5 003 Contin | nued From pag | | F | 323 | | | |
| that I brod. AM, inter incid did not take Nur had cha pel Shr wa sitt res Shr en take not tak | Resident # 18 a chair on top administrative viewed. She stent report for not remember in after the incise #2 was interested in the resident for the control of the control | placed himself in bed with the of him. On 10/17/12 at 11:15 staff member #1 was tated that she could not find an the 6/10/12 incident and she what immediate action was ident. On 10/17/12 at 9:43 AM, eviewed. She stated that she at #18 in bed with the broda an and was still attached to the e was lying on his stomach. How he did it but this behavior him. He was also observed annode attached to the pelvic broda chair was against the wall, the resident was on pelvic the he tried to stand up and he was she also indicated that she had attracted to the pelvic restraint. She at restraint was checked every but not checked for correct ain, there was no assessment for veness of the restraint to prevent. There was no assessment to traint as an accident hazard to the detail of the chair attached, lying in bed with the chair attached, lying in bed with aff and cursing. Haldol (anti | | | | | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SU COMPLET | |
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| NAME OF PR | OVIDER OR SUPPLIER | | 413 | T ADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD NCORD, NC 28027 | | |
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| F 323 | with the administraticonducted. She state incident report for the did not remember we taken. She reported conducted on 8/8/12 had socks/shoes where during care rounds, members were insertaints. On 10/17 was interviewed. She had been found in but the pelvic restraint a occasions. It happened also reported to her that the resident was because he tried to unsteady. She furth wiggle to get out of reported that she chon but not for proper was no assessment the restraint to prevent the restraint to prevent the restraint to prevent the restraint to prevent taken with the restraint to prevent taken. | /17/12 at 11:15 AM, interview we staff member #1 was ted that she could not find the e 8/12/12 incident and she hat immediate action was that an in-service was and 8/9/12 to ensure that he en out of bed and toileting. She also stated that the staff erviced on how to apply the r/12 at 8:55 AM, Nurse #3 he stated that Resident #18 hed with the broda chair and attached on several hed on her shift and it was by the other shift. She added is using the pelvic restraint get up and he was very her stated that he tried to the pelvic restraint. Nurse #3 hecked the restraint if it was a r placement. Again, there for the need/effectiveness of the entify the restraint as an | F 323 | | | |
| | indicated that Reside the broda chair at the and the nursing aid when they came out found the resident to The pelvic restraint immediate action to weights added to weights. | eport dated 9/7/12 at 8:15 PM lent #18 was found sitting in the nurse's station. The nurse the heard a loud noise and the of the resident's room they tipped over in the broda chair. was still in place. The ken were staff education and theelchair. On 10/17/12 at with the administrative staff | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | ORRECTION IDENTIFICATION NUMBER: | | CONSTRUCTION | CX3) DATE SURVEY COMPLETED C | |
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| | | 345186 | B. WING | | | /01/2012 |
| | ROVIDER OR SUPPLIER | | 413 \ | r ADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD RCORD, NC 28027 | | |
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| F 323 | #1 was conducted find an in-service of 9/7/12 incident. She were the same as therapy department was no assessment to accident hazard for Depression. On 10/16/12 at 8: #18 was observed restraint attached observed walking At 3:45 PM, interrevealed that Resident #10 prevent him from walk and he was she had not receptoperly apply resident interviewed. She | She stated that she could not or staff education record for the se also stated that the weights what was recommended by the nt in April, 2012. Again, there nt for the need/effectiveness of event falls/accidents. There was identify the restraint as an or the resident. Sician's orders for October, at Resident #18 was on Haldolings (milligram)three times a sorder, Klonopin (antianxiety) 1 aday for Agitation and apressant) 100 mgs at bedtime 55 AM and 3:34 PM, Resident dup in broda chair with pelvic. The restorative aide was the resident using the gait belt. View with the restorative aide # 1 sident #18 was able to ambulate or gait. 10 AM, NA #1 was interviewed. The stated B was using a pelvic restraint to falling. He would stand up and very unsteady. She stated that inved an in-service on how to | F 323 | | | |

| | OF DEFICIENCIES - CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
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| | | 345186 | B. WIN | G | | 1 | 1/01/2012 |
| | ROVIDER OR SUPPLIER | <u> </u> | | 413 V | ADDRESS, CITY, STATE, ZIP CODE VINECOFF SCHOOL ROAD ICORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | , | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 323 | resident was very im level was high. She a (interdisciplinary tear incident and discuss place. She reported written in the incider in the kardex. On 10/17/12 at 11:1 member #1 was inte PBA (personal body lap belt were tried properties at the pelvic restraint was get up and slid down restraint had helped thought that the pelvic restraint had helped thought that the pelvic restraint was interviewed. She since were added a few in resident from tippinalso added that the positioning. On 10/17/12 at 4:20 interviewed. She since added that the positioning. On 10/17/12 at 4:20 interviewed. She since added that the positioning. | pulsive and his ammonia also indicated that the IDT m) would meet after the what interventions to put in that the interventions were at report, in the care plan and 55 AM, administrative staff erviewed. She stated that alarm), bed pad alarm and rior to pelvic restraint. She supervision was provided the in 2012. She indicated that was used because he tried to n. He also had falls and the it to prevent further falls. She vic restraint was the safest for 2 PM, therapist #2 was tated that the 10 lbs weights nonths ago to prevent the g the broda chair was used for 2 PM, Nurse Manager #1 was tated that she was new to the observed the pelvic restraint to correctly placed once. She if the nursing assistant on how the pelvic restraint. She stated member the exact date and ecords of the training. | F | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA · IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING | E CONSTRUCTION | (X3) DATE S COMPL | ETED |
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| | | 345186 | B. WNG | | 11 | C /01/2012 |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 323 | Jeopardy on 10/23/2 provided a credible at 10/24/2012 at 4:46 P compliance indicated. Resident #18 accide the Interdisciplinary. Director of Nursing, Resident Assessmer Social Services Director of Nursing and Dietary Manage discontinued and selector one observation at 10/17/12. Review of further falls as of 10/2 will be provided 24 h continue until reside significant change in Assurance Committed determines 1:1 contillonger necessary to 1:1 observation is decobserved at all times assigned will not be recorded as observed are determined to be reported to the charge. | o12 at 4:13 PM. The facility illegation of compliance on PM. The allegation of PM. The complete PM. | F 323 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | ONSTRUCTION | (X3) DATE SURV COMPLETED | |
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| F 323 | falls/accidents in the completed to ensurappropriate interverse and Camended to reflect were completed by review of charts an note was complete support findings of Measures and systems. The Corporate Registered Nurse in Team on 10/24/20 monitoring as it released to the control over. B. All assigned nunders and Nurses and Nurse in-serviced on faciliance accidents by providing accident out of 89 nursing serventing accider provide direct care facility existing providing an environment of the providing and environment of t | plete audit by the am of all residents with a last 30 days has been e all residents have notions in place to prevent care Plans have been current interventions. Audits review of Fall/Accident report, d updates to Care Plan. IDT d in each resident chart to audits. emic changes Clinical Nurse who is a n-serviced the Interdisciplinary (2 on accident prevention and ates to providing an om hazards that the facility rsing staff, to include Licensed and Assistants, will be ity policy on Preventing ding an environment that is free which the facility has control by sing and Staff Development N Supervisor. At this time 75 taff have been in-serviced on the colicy on preventing accidents by comment that is free from facility has control has been tation program for all new | F | 323 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUII | | CONSTRUCTION | COMPL | |
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| NAME OF PR | OVIDER OR SUPPLIER S MANOR | | | 413 V | FADDRESS, CITY, STATE, ZIP CODE MINECOFF SCHOOL ROAD ICORD, NC 28027 | | |
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| F 323 | reviewed in the daily morning meeting durensure proper interventions. D. All new hires will policy on preventing environment that is facility has control be Development during Monitoring A. The interdisciplin Development Coord Director, Director of MDS) will review all reports, 24 hour reputation falls/accided meeting during regular have proper interplans have been an B. Events involving harm will be reported immediately by way administrator will event to determine if policy not adhered to, the event to determine assure continued of | Interdisciplinary Team 's Interdisciplinary Team 's ring regular business hours to entions have been put in occurrence and Care Plans It to reflect current receive training on facility accidents by providing an free from hazards which y Registered Nurse/Staff orientation. ary team (DON, NHA, Staff linator, Social Services Rehab, Dietary manager and residents through incident forts, chart reviews who hats daily in the morning plar business hours to ensure reventions in place and Care mended. If accident, injury or potential and to the Administrator of cell phone. The valuate the event to: assure well- being of resident and was adhered to, if policy was Administrator will evaluate the further necessary actions to | F | 323 | | | |
| | 1 | , · | 1 | - | | | ļ <u> </u> |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE | CONSTR | UCTION | (X3) DATE SURVE | |
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| AND PLAN OF (| CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | | | С | |
| | | 345186 | B. WiN | | | | 11/01/2 | 2012 |
| NAME OF PRO | OVIDER OR SUPPLIER | | | 413 | WINECC | SS, CITY, STATE, ZIP CODE DFF SCHOOL ROAD , NC 28027 | | |
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| F 323 | falls/accidents into the daily. Result of Audi falls/accidents will be Quality Assurance Committee consists Medical Director, Nurse Assessment Consultant, Social Signature of Manager monthly to continued intervention. The credible allegat 3:00 PM, as evidence in-service training repreventing accident that is free from haz current facility staff and 10/24/2012. In 10/30/2012 for new added to the orientate IDT team was intraining received or Assurance Meeting Minutes reviewed reviewed. Resident the time of the valid hospitalized 10/31/483.25(n) INFLUEI | IN or Director of Nursing on the AHT Quality Assurance logs are ported to the facility committee by the Nursing. The Quality Assurance of Director of Nursing, the Quality Assurance of Director, and Dietary review the need for the or amendment of plan. It is not as verified 11/01/2012 at the death of the provided on accidents. The providing an environment the provided on 10/23/2012 the provided on 10/23/2012 the provided on 10/23/2012 the provided on 10/25/2012 the provided of 10/25/2012 the provide | | 323 F 334 | 1. | Corrective action(s) accomplis residents found to have been a alleged deficient practice: | 00 | an 1-9-12 |
| 33=L | The facility must de that ensure that | evelop policies and procedures he influenza immunization, ne resident's legal | | | | A. Resident #17 received the vaccine on 10/10/2012. Resident #130 received the vaccine on 10/30/2012. | | 12512 |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | | E CONSTRU | CTIÓN | (X3) DATE SUR' COMPLETE | |
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| | S MANOR | | | 413 | 3 WINECOF | S, CITY, STATE, ZIP CODE IF SCHOOL ROAD NC 28027 | | |
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| F 334 | representative receive benefits and potential immunization; (ii) Each resident is a immunization October annually, unless the contraindicated or the immunized during the fine contraindicated or the immunized during the fine contraindicated or the immunization; and (iv) The resident's medocumentation that following: (A) That the resident representative was the benefits and pottimmunization; and (B) That the resident influenza immunization on the facility must detend that ensure that— (i) Before offering the immunization, each legal representative the benefits and pottimmunization; (ii) Each resident is immunization; (iii) Each resident or representative has immunization; and | ves education regarding the al side effects of the offered an influenza er 1 through March 31 immunization is medically the resident has already been altered to be resident's legal to the opportunity to refuse the opportunity to refuse the indicates, at a minimum, the central side effects of influenza the effects of th | F | 334 | 3. Me ens rec A. B. C. | consents were mailed out to residents/resident's legal re in September 2012. 100% a been completed to ensure at that have returned the cons been given the influenza va Development Coordinator a consents that were mailed a facility ensures/systematic changes pure that the deficient practice cur: Corporate Clinical Consult serviced the Director of Nu Development Coordinator/Supervisors on facility poli "Influenza Vaccine" on 10/ | me deficient on taken: me influenza o be affected cetice. influenza a all current presentative audit has il resident's sent have ceine. Staff monitored back to the t in place to e does not ant/RN in- rsing, Staff Unit cy 31/2012. Development viced all cility policy 77/2012. aff will in- n by the Staff on facility to ensure the Development ators will esidents who nza vaccine za season to ne was | |
| EODM CHS. | 2587(02.00) Pravious Varsions | Obsolete Event ID: ZSN | AF11 | F | acility ID: 95 | 3488 I | f continuation she | eet Page 41 of |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | TIPLE CONSTRUCTION ING | (X3) DATE SUF COMPLET | |
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| F 334 | following: (A) That the resider representative was per the benefits and poten pneumococcal immusts. That the resider pneumococcal immusts pneumococcal immusts pneumococcal immusts pneumococcal immusts. As an alternative, and practitioner recompneumococcal immusts pneumococcal immu | ndicated, at a minimum, the at or resident's legal rovided education regarding intial side effects of inization; and at either received the inization or did not receive imunization due to medical ifusal. based on an assessment immendation, a second inization may be given after 5 rest pneumococcal is medically contraindicated or insident's legal representative | F 3: | B. Report of findings and su disciplinary action, if appreported to the facility Q Assurance Committee co Nursing Home Administs of Nursing, Medical Dire Supervisors, SDC/ Risk Nurse, Pharmacy Consul Care Nurse, Social Service and Dietary Manager more review the need for continintervention or amendments. | dicable, will be uality uality usisting of ator, Director ctor, Unit Aanager, MDS tant, Wound tes Director, onthly to | |

| STATEMENT O | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPI | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| F 334 | Continued From page October 1st and Mal vaccine within 5 word job assignment or the facility. Prior to the vaccine influence of the influence of the influence of the influence of vaccine, the date of vaccine, the date of vaccine, the date of vaccination will be resident's/employed 1. Resident # 17 with and was different failure. Resident was not a faccine to the immunication reconstitution of the immunication of the immunication reconstitution of the immunication of the immunication reconstitution rec | rch 31st shall be offered the king days of the employee's he resident's admission to the vaccination, the resident (or esentative) or employee will ation and education regarding a potential side effects of the Provision of such education ad in the resident's/employee's those who receive the fraccination, lot number, son administering and the site of documented in the e's medical record." as admitted to the facility on scharged to home on 9/26/11. e-admitted back to the facility altiple diagnoses including Hypertension and Congestive view of the resident's rd revealed no documentation and the influenza vaccine from 10/1/11 through 3/31/12. Simunization Informed Consent'' d. The form was signed by the essed by a staff member on a was giving the facility ninister the influenza vaccine. | F 334 | | | |
| | not find documen was administered | ewed. She stated that she could tation that the influenza vaccine I to the resident during the 11 through 3/3/1/12. She did not nation why the vaccine was not | | | | |

| | OF DEFICIENCIES FOORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | | STRUCTION | (X3) DATE SU COMPLET | |
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| F 334 | Continued From page administered to the re | | F 334 | | | | |
| F 356 SS=C | 7/7/11 with multiple di Congestive Heart Fail Diabetes Mellitus. Reimmunization record in that she had received the period from 10/1/10 On 10/18/12 at 5:10 F nurse was interviewed not find documentatio was offered to the residuring the period of 16 also could not find the Informed Consent for 483.30(e) POSTED NINFORMATION The facility must post a daily basis: o Facility name. o The current date. o The total number and by the following categ | ure, Hypertension and view of the resident's evealed no documentation influenza vaccine during in through 3/31/12. PM, the infection control d. She stated that she could in that the influenza vaccine ident/legal representative 0/1/11 through 3/31/12. She influenza Immunization in for the resident. URSE STAFFING the following information on indicate the actual hours worked ories of licensed and | F 356 | 1. | Corrective action(s) accomplished residents found to have been affect alleged deficient practice: A. No residents identified. B. Posted nursing staffing infor be completed by staffing coor and/or nursing supervisor will responsible for completion. C. Posted staffing information in accessible to residents/visitor. D. Staffing information will be | mation will rdinator hom is also s readily | 12-9-12 |
| | resident care per shift - Registered nurse - Licensed practica vocational nurses (as - Certified nurse a o Resident census. | es. al nurses or licensed defined under State law), | | 2. | staffing coordinator and or n management. Identify other residents who have potential to be affected by the sam practice and what corrective actio A. All residents who reside in th have the potential to be affected alleged deficient practice. | the e deficient n taken: e facility ted by this | |
| | specified above on a | daily basis at the beginning ust be posted as follows: | | 3, | Measures/systematic changes put i ensure that the deficient practice d recur: | n place to loes not | |

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| FIVE OAK | SMANOR | | | 41: | 3 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | | |
| (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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 356 | residents and visitors. The facility must, upo make nurse staffing d for review at a cost no standard. The facility must main staffing data for a min required by State law. This REQUIREMENT by: Based on observation interview, the facility of staff postings for 7 co. The findings include: On 10/14/12 at 5:00 pracility was conducted the 200 hall, near the daily staffing sheets of 10/14/12. The staffing bottom of the pile and individuals passing by staffing documents the for staff was not record census included residuance beds. On 10/15/12 at 5:25 placked the actual hou continued to combine | format. e readily accessible to n oral or written request, ata available to the public but to exceed the community stain the posted daily nurse imum of 18 months, or as whichever is greater. is not met as evidenced ns, record reviews and staff ailed to post accurate daily nsecutive days. om, an initial tour of the d. On the bulletin board on nurse's station, were three or 10/12/12, 10/13/12 and og for 10/14/12 was at the d was not readily visible to or it was noted on all of the at the actual hours worked | I.F. | 356 | A. Corporate Clinical Conserviced the Director of Development Coordinal Supervisors and staffing facility policy for Postin Staffing Information on B. All new licensed nursing serviced during oriental Development Coordinat policy Posting Nurse Stainformation. 4. Monitoring of corrective actideficient practice will not receive a clinical policy posting nurse staffing Coordinator/Unit Coordinator/Staffing Condinators/Staffing Condinators/Staffing Condinators/Staffing Condinators/Staffing Condinators/Staffing Condinators/Staffing Condinators/Staffing Conditations of Staffing Condinators or correct censure home residents) number actual hours worked dathen weekly x 4weeks the months to ensure continucompliance. B. Report of findings and section of Staffing Home Administical for Nursing Home Administical Home Admin | Nursing, Staff or/Unit (coordinator on g Nurse 10/30/2012. (staff will inion by the Staff or on facility offing on to ensure the ur: If Development coordinator will ing information (excluding rest of staff and ily x 2 weeks en monthly x 3 ued ubsequent oplicable, will be Quality onsisting of trator, Unit Manager, MDS clitant, Wound ices Director, onthly to inued | |

| STATEMENT O | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE (| CONSTRUCTION | (X3) DATE SURVEY · COMPLETED |
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| F 356 | Continued From pag On 10/16/12 at 5:25 | pm and 10/17/12 at 9:25 am, | F 356 | | |
| | rest home residents actual hours worked posting. | f posting continued to contain in the census count and the were not listed on the staff | | | |
| | The Staffing Coordinator was interviewed on 10/18/12 at 8:56 am. She stated that she started completing the daily staff posting last month and that it was previously done by several employees. She shared that she had professional experience completing the document; therefore, she did not have any training before she took on the assignment. She then shared that when she recorded the information it was essential to capture the total number of nurse aides, license practical nurses (LPN) and RNs who do hands on patient care. | | | | |
| | She pointed out the the Director of Nurs Coordinator (SDC) under RN staff. Shourse was administ was included under acknowledged that scheduled to give credited her today. Coordinator stated working in the cap | the SDC nurse was not shots for the 8 hours she In addition, the Staffing that today she was also acity of a nurse aide but had hours into the formula for the | | | |
| | census, the Staffir | she determined the resident ng Coordinator commented that esident census from the | | | |

| STATEMENT O | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SUR COMPLETE | |
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| FIVE OAKS | | PATCHENT OF DEFINITIONS | 413 | ET ADDRESS, CITY, STATE, ZIP 3 WINECOFF SCHOOL ROAD ONCORD, NC 28027 PROVIDER'S PLAN | | (X5) |
| (X4) ID PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | EACTION SHOULD BE TO THE APPROPRIATE DIENCY) | COMPLETION DATE |
| F 431 SS=D | residents in the rest that she should exclusive form. She further stadaily staff postings for and left them at the issupervisor to post do the Staffing Coording 11:45am with a mode had corrective meass. On 10/19/12 at 12:4 (D.O.N) was interviews the has taken meas nurse managers of the daily nursing states at the daily nursing states a | was aware that it contained home beds but did not know ade them on the daily posting ated that she completed the or the weekend on Fridays nurse's station for the aily. Nator returned on 10/18/12 at iffed daily staffing form that tures in place. 8 pm, the Director of Nursing weed. The D.O.N stated that tures to inform her weekend heir new duties to complete ffing and post the form daily. RUG RECORDS, JGS & BIOLOGICALS Apploy or obtain the services of its who establishes a system and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically als used in the facility must be not with currently accepted ales, and include the | F 431 | residents found to alleged deficient pi A. No residents B. Identified out discarded. 2. Identify other resipotential to be affe practice and what A. All residents orders for In be affected by practice. B. 100% audit of completed by ensure all Inlappropriately. 3. Measures/systema | tuateu miniter 3 nave 500m | 13-5-12 |

| | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | - [| | E CONSTRUCTION | (X3) DATE SURV | |
|-------------|--|--|-------------------|-----------|--|--|----------------------------|
| AND ALWN OE | CORRECTION | today to the today | A. BUIL | | | С | |
| | | 345186 | B. WIN | G | | 11/01/ | 2012 |
| NAME OF PR | SUMMARY S | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | 41: CC | EET ADDRESS, CITY, STATE, ZIP CODE 3 WINECOFF SCHOOL ROAD ONCORD, NC 28027 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLE) CROSS-REFERENCED TO THE APPRODEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| F 431 | locked compartment controls, and permit have access to the last three terms of the last terms of the l | s under proper temperature only authorized personnel to keys. Invide separately locked, compartments for storage of ed in Schedule II of the ag Abuse Prevention and and other drugs subject to a the facility uses single unit oution systems in which the inimal and a missing dose can | F | 431 | A. Staff Development Coordin (SDC)/Director of Nursing in serviced all Nursing licer "Medication Storage Policy 10/26/2012. B. All new licensed nurses wil service on" Medication Storage in orientation by the Staff I Coordinator/RN. 4. Monitoring of corrective action deficient practice will not recur: A. DON/Unit Supervisor will of medication carts, weekly then monthly x 3 to ensure medication storage policy is followed. B. Report of findings and sub disciplinary action, if apply reported to the facility Qu Assurance Committee con Nursing Home Administration of Nursing, Medical Direct Supervisors, SDC/ Risk M Nurse, Pharmacy Consult Care Nurse, Social Service and Dictary Manager mor review the need for continuater vention or amendment. | (DON) have used staff on "" I be in rage Policy" Development to ensure the audit 100% of x 4 weeks facility as being sequent icable, will be ality sisting of ator, Director for, Unit anager, MDS ant, Wound as Director, athly to ued | |

PRINTED: 11/14/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | TIPLE ÇONSTRU NG | CTION | (X3) DATE SURVEY COMPLETED | | | | |
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| | r | 345186 | B. WNG_ | | | C 11/01/2012 | | | | |
| | ROVIDER OR SUPPLIER | | s | | S, CITY, STATE, ZIP CODE F SCHOOL ROAD NC 28027 | | 112012 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | HOULD BE | (X5) COMPLETION DATE |
| F 431 | Continued From pag | e 48 en 10/18/12 at 2:20 PM, | F 43 | 1 | | | | | | |
| | good for 1 month after | t1 stated Advair Diskus was er opening, and she ate Advair Diskus when | | | | | | | | |
| F 441 SS=D | 483.65 INFECTION (SPREAD, LINENS | CONTROL, PREVENT | F 44 | 1. C | orrective action(s) ac | | 12-5-12 | | | |
| - | Infection Control Prog safe, sanitary and co to help prevent the do of disease and infection (a) Infection Control I The facility must esta | Program blish an Infection Control | | be de | or those residents four cen affected by the all efficient practice: No residents identi glucometers are be cleaned/sanitized p policy. | fied. All | | | | |
| | in the facility; (2) Decides what pro should be applied to (3) Maintains a reconactions related to infection (b) Preventing Spread (1) When the Infection | rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective actions. d of Infection n Control Program | | th sa co | lentify other residents the potential to be affect the deficient practice the deficient practice the deficient practice the deficient swho r blood glucose test if facility have the po affected by this allo | cted by the and what : eccives in the stential to be | | | | |
| | prevent the spread of isolate the resident. (2) The facility must prommunicable disease from direct contact will transport (3) The facility must resident contact with the facility must resident contact will transport to the facility must resident contact will be supported to the facility must resident contact with the facilit | equire staff to wash their ct resident contact for which ated by accepted | | in pı | leasures/systematic chaptace to ensure that ractice does not recur. Director of Nursing nurse #7 a one to o service on 10/17/20 facility policy for ce /sanitizing glucome | the deficient : g provided ne in- 12 on leaning | | | | |

4.

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SU COMPLE | | |
|--------------------------|---|--|---|------|--|---|----------------------------|--|
| | , | 345186 | B. WIN | G | | 444 | C | |
| NAME OF PE | ROVIDER OR SUPPLIER | | | OTO | PETADDDECO OTV STATE TO SOFT | 1 11/0 | 01/2012 | |
| FIVE OAK | S MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | OULD BE | (X5) COMPLETION DATE | |
| F 441 | infection. This REQUIREMENT by: Based on observation interviews, the facility a glucometer for one or receiving blood glucos #55). Resident #55 was adr Diabetes Mellitus and for blood glucose more The Centers for Disease Prevention and Guide read in part: "Any time equipment is shared to a risk of transmitting to blood borne pathogen environmental surface regularly and any time or body fluids occurs of test meters approved one person must be confollowing disinfection of Review of the facility pranufacturer for the gracility was dated 10-10 cleaning shared glucos. | le, store, process and to prevent the spread of is not met as evidenced in, record review and staff failed to clean and disinfect of five sampled residents se monitoring, (Resident mitted with a diagnosis of was to receive fingersticks nitoring prior to meals. The Control (CDC) lines for Glucose Monitoring the blood glucose for the use with more than bleaned and disinfected guidelines. " Dolicy, provided by the plucometers used in the lat-12. The policy for meters is outlined as | F | 4411 | Development Coordin serviced all licensed m staff on facility policy cleaning/sanitizing glu on 10-26-12. C. All licensed nurses wi successfully complete glucometer cleaning/s competencies by11/7/2012 D. All new licensed nursi will in-serviced during orientation by the Sta Development Coordin facility policy for gluc cleaning/sanitizing. E. All staff will be in-service of Infection Complete infection Complete infection Complete infection Completed by representative from Staff will be conducting informable to attend SPIC representative from Staff in the completed by representative from Staff in the complete infection Completed by representative from Staff in the complete infection of Nursing Staff in the coordinator/Unit Coordinator/Unit Coordinator/Staffing | nator in- ursing for ucometer Il have d anitizing ing staff g ff nator on ometer viced on trol. SPICE service. vill staff CE on or ing will PICE on ction to ce will aff | | |
| , | | r between the device and | | ı | Coordinators/Staffing Coordinator will audit | | | |

| 0211121 | OT OIL MEDIONIL & | MEDICAID SEKVICES | | | | OMB M | <i>).</i> 0938-0391 |
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| | OF DEFICIENCIES FCORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MI A. BUIL | | LE CONSTRUCTION | (X3) DATE SUI COMPLET | ED |
| | r | 345186 | B. WN | B. WING | | C 11/01/2012 | |
| NAME OF PE | ROVIDER OR SUPPLIER | | • | | EET ADDRESS, CITY, STATE, ZIP CODE | 7 7 170 | |
| FIVE OAK | S MANOR | | | 1 | 13 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X6) COMPLETION DATE |
| F 441 | apply gloves, Obtain a specimen, discard the glucometer with an approve time, discard your glo your hands. An observation of a mass completed on 10 observed using a block Resident #55. She the strip and removed help preparation for the following glucometer. She falled glucometer prior to make the president strong to the next resident. In an interview with N am, she revealed she | ce is placed on the or sanitize your hands, a blood specimen, check the especimen, clean the oproved product (Alcoholed), allow applicable drying ves and wash or sanitize nedication pass on 100 hall -16-12. Nurse # 7 was od glucose monitor on en discarded the glucose of gloves. She began lowing resident receiving a curse #7 applied her gloves cose test strip in the distort to the next resident. | F | 441 | nurses performing ble glucose testing to ensifacility policy on clear glucometers adhered x 4 weeks then month months to ensure concompliance Monitorinoccur on all three shift weekends by audits/observations. B. Report of findings an subsequent disciplinatif applicable, will be referred to the facility Quality Assurance Committee consisting of Nursing Administrator, Direct Nursing, Medical Director, Medical Director, Modern Subsequent Care Nurse, Social Sedirector, and Dietary Manager monthly to the need for continued intervention or amend plan. | to weekly ly x 3 tinued ng will fts and on d ry action, reported Home for of ector, C/Risk c, Wound rvices review | |
| F 499 SS=D | 10-17-12 at 8:20am, r for cleaning the glucor was written. This wou glucometer between r fingersticks by using t | he provided Sani-wipes on waiting a two minute drying the next resident. UALIFIED | F | 199 | · | su sur | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--|---|---|--|
| | | | A. BUILDING | | | |
| | · | 345186 | B. WING | | C 11/01/2012 | |
| NAME OF PROVIDE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION | |
| The or co to ca Profit regis laws This by: Bas facili staff on o Find A rev Nurs curre Virgi Caro of 4- The for n as fo resid state home privil licen perio An e starte | essional staff mustered in accordate stered in accordance in accordance stered in accordance in accord | loy on a full-time, part-time ose professionals necessary ions of these requirements. In the licensed, certified, or note with applicable State is not met as evidenced ew and staff interviews, the exthat all licensed nursing orth Carolina nursing license employees reviewed. files revealed one (1), ia nursing license and no a nursing license and no a nursing license. The extra was current with a North ecord and an expiration date over a full control of the cord and an expiration date over a full control of the cord and an expiration date over a full control of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the new home state for a full consumer of the nurse is on the nurse is on the new home state for a full consumer of the nurse is on the nurse | | 1. Corrective action(s) accomplisher residents found to have been affer alleged deficient practice: A. No residents identified. All nurses are licensed appropring the N.C Board of Nursing. B. Nurse #5 obtained a North of Nursing License on 10/24/26. C. All new licensed nursing states serviced during orientation Development Coordinator of policy on obtaining a NC nursing troma compact state. 2. Identify other residents who have potential to be affected by the same practice and what corrective action. A. All residents who reside in the have the potential to be affected by the Director of Nursing/Staff Development Coordinator by 11/7/2012 to licensed nurses have current Nursing license. 3. Measures/systematic changes put ensure that the deficient practice recur: A. Business office/ Human Resource responsible for verifying N.C Nursing at the time of employment. In-service of credentialing of Nursing Service Person completed on 11-1-12. Andits are compverifying nursing licensure prior to hir expiration date. Documentation will be N.C license audit tool. | cted by the licensed iately with Carolina 1/12. If will in- by the Staff on facility rrsing multi- c the ne deficient on taken: he facility cted by this urses will be f c ensure all t NC in place to does not will be Licensure on nnel was sleted by e including kept on | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 345186 11/01/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD **FIVE OAKS MANOR** CONCORD, NC 28027 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 499 Continued From page 52 F 499 as her address of record. Director of Nursing/Staff Development Coordinator/Unit Coordinators/Human In an interview on 10-18-12 at 6:15pm, Resource will audit all new licensed nurses weekly x 6 then monthly x 3 to Administrative staff #1 stated her expectation was ensure continued compliance with that all nursing licenses be verified for current policy. Audits will verify license nurses state licensure prior to employment. with compact license are in compliance with North Carolina Board of Nursing On 10-22-12 at 8:00am, a telephone interview statutes Report of findings and subsequent was conducted with Nurse #5. She revealed that disciplinary action, if applicable, will be she had not been aware that she had to transfer reported to the facility Quality her Virginia nursing license to a North Carolina Assurance Committee consisting of license once her primary address was Nursing Home Administrator, Director of Nursing, Medical Director, Unit established as North Carolina. Supervisors, SDC/ Risk Manager, MDS Nurse, Pharmacy Consultant, Wound Care Nurse, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.

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PRINTED: 11/26/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A. BUILDING | PLE CONSTRUCTION O 01 - MAIN BUILDING 01 | (X3) DATE SI COMPLE | |
|---|---|--|----------------------------|---|--|---------------------------|
| | 34 | 345186 | B. WING | | 11/19/2012 | |
| | ROVIDER OR SUPPLIER | 1 | 4 | EET ADDRESS, CITY, STATE, ZIP COI 13 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETIO DATE |
| K 000 | INITIAL COMMEN | rs | K 000 | | | |
| | conducted as per 1 at 42CFR 483.70(a Care section of the publications. This b | ode(LSC) survey was The Code of Federal Register I); using the Existing Health LSC and Its referenced outliding is Type III(211) tory, with a complete system. | | DEC (| 7 2012 | |
| K 012 SS=D | are as follows: NFPA 101 LIFE SA Building construction | etermined during the survey AFETY CODE STANDARD on type and height meets one 0.1.6.2, 19.1.6.3, 19.1.6.4, | K 012 | Corrective action(s) accorrect the deficient pr A. Janitor closet located hitchen will have holes repaired on or before clate. Repairs will be cofacility Maintenance D | actice: behind the in walls ompletion ompleted by | 1-2-13 |
| K 029 SS=D | Based on observa approximately 11:0 was noted. 1) The janitor closs accessible from outhat were not repair condition. 42 CFR 483.70(a) NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 prothe approved autor | is not met as evidenced by: tion on Monday 11/19/12 at 0 AM onward the following et located behind the kitchen, tside has holes in the walls red and maintained in goood AFETY CODE STANDARD construction (with ¾ hour an approved automatic fire im in accordance with 8.4.1 tects hazardous areas. When matic fire extinguishing system areas are separated from | К 029 | Identify other life safet having the potential to residents by the same dipractice: Facility will inspect all closets weekly x4 then assure maintained in given condition. Inspection we completed by Mainten and/or Administrator, will be documented on closet audit tool. Measures will be put in what systemic change finake to ensure that the practice does not recur | janitor's monthly to ood vill be ance Director Inspections janitor's to place or acility will e deficient | |

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 surject 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: ZSMF21

Facility ID: 953488

If continuation sheet Page 1 of 5

PRINTED: 11/26/2012 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | E CONSTRUCTION (X3) DATE S COMPL 01 - MAIN BUILDING 01 | ETED | |
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| | , • | 345186 | B, WING | 11/1 | 11/19/2012 | |
| | ROVIDER OR SUPPLIER KS MANOR | | 413 | ET ADDRESS, CITY, STATE, ZIP CODE B WINECOFF SCHOOL ROAD INCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K 000 | INITIAL COMMEN | TS | K 000 | · | | |
| | conducted as per at 42CFR 483.70(a Care section of the publications. This b | ode(LSC) survey was The Code of Federal Register a); using the Existing Health LSC and its referenced building is Type III(211) story, with a complete r system. | | | | |
| ·K 012 SS=D | are as follows: NFPA 101 LIFE SA Building constructi | etermined during the survey AFETY CODE STANDARD on type and height meets one 9.1.6.2, 19.1.6.3, 19.1.6.4, | K 012 | | | |
| | Based on observation approximately 11:0 was noted. 1) The janitor clost accessible from our control of the con | is not met as evidenced by: ution on Monday 11/19/12 at 00 AM onward the following et located behind the kitchen, utside has holes in the walls ired and maintained in goood | | | | |
| K 029 SS=D | One hour fire rated fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro the approved auto | AFETY CODE STANDARD I construction (with ¾ hour r an approved automatic fire em in accordance with 8.4.1 btects hazardous areas. When matic fire extinguishing system areas are separated from | K 029 | Corrective action(s) accomplished to correct the deficient practice: The corridor door to the laundry room will have needed repairs completed to ensure it is sealed and closes properly. | (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.

If continuation sheet Page 1 of 5

 $= (1/2\sqrt{\pi})^2 \sum_{i=1}^n (1/2\pi)^2 (1/2\pi)^2 \sum_{i=1}^n (1/2\pi)^2 \sum_{i=1}$

PRINTED: 11/26/2012 FORM APPROVED OMB NO. 0938-0391

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) N A. BU | | PLE CONSTRUCTION G 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | |
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| | r | 345186 | B. WI | NG_ | | 11/19/2012 | |
| | PROVIDER OR SUPPLIER KS MANOR | | | 4 | REET ADDRESS, CITY, STATE, ZIP CODE 13 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | (TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIEMENT) | ULD BE | (X5) COMPLETION DATE |
| K 029 | other spaces by sm doors. Doors are s field-applied protec 48 inches from the permitted. 19.3.2 This STANDARD I Based on observal approximately 11:0 was noted. 1) The corridor door close and seal. The top of the door. 2) The corridor door room in the kitchen 42 CFR 483.70(a) NFPA 101 LIFE SA A fire alarm system installed, tested, an with NFPA 70 Natio 72. The system has and testing program | noke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are | | 029 | A. Facility will inspect all jan closets weekly x4 then more assure maintained in good condition. Inspections will completed by Maintenance and/or Administrator. Inspections will be documented on jan closet audit tool. B. Any identified non-complication concerns will be reported to Administrator. Concerns we corrected in a timely manner of the concerns will be meat our monthly Quality Ass Meeting. Report of findings reported to our QA commit review for continued intervamendment of plan. | be e Director pections itor's ance to vill be aer. onitored urance s will be ttee to | |
| | This STANDARD is | not met as evidenced by: | | | | | |

Event ID: ZSMF21

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIF | PLE CONSTRUCTION O1 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | |
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| | ,, | 345186 | B. WING | | 11/19/2012 | |
| | ROVIDER OR SUPPLIER | | 41 | EET ADDRESS, CITY, STATE, ZIP CODE 13 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | /FACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETION | |
| K 052 SS=F | doors. Doors are signed-applied protect 48 inches from the permitted. 19.3.2 This STANDARD Based on observa approximately 11:0 was noted. 1) The corridor doc close and seal. The top of the door. 2) The corridor doc room in the kitcher 42 CFR 483.70(a) NFPA 101 LIFE SAAA fire alarm system installed, tested, as with NFPA 70 Nation 72. The system has and testing program. | noke resisting partitions and self-closing and non-rated or stive plates that do not exceed bottom of the door are | K 029 | B. Corridor door in the kite self closure installed. C. Repairs will be complete before completion date. D. Repairs will be complete facility Maintenance Directors will be complete facility Maintenance Directors by the same definition of the practice: A. Facility will inspect all doweekly x4 then monthly to they are sealed and close according to life safety constandards. Inspections will be documed oor inspection audit too. 3. Measures will be put into what systemic change face make to ensure that the depractice does not recur. A. Facility will inspect all doweekly x4 then monthly to they are sealed and close according to life safety constandards. Inspections will be documed to they are sealed and close according to life safety constandards. Inspections will be documed oor inspections will be documed oor inspection audit too | d on or d by ector. ssues fect icient oors to assure properly ode ill be ce trator. nented on l. place or ility will deficient oors to assure properly ode ill be ce trator. nented on ce trator. nented on | |
| | This STANDARD | is not met as evidenced by: | | | | |

PRINTED: 11/26/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIS | PLE CONSTRUCTION 3 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED |
|--|--|---|---------------------|--|---|
| | 345186 | | B. WING | | 11/19/2012 |
| | ROVIDER OR SUPPLIER | 1 | 4 | EET ADDRESS, CITY, STATE, ZIP CODE 13 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | |
| (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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE COMPLETIC |
| K 029 | doors. Doors are s | noke resisting partitions and self-closing and non-rated or tive plates that do not exceed bottom of the door are | K 029 | | |
| K 052 SS=F | Based on observa approximately 11:0 was noted. 1) The corridor doc close and seal. The top of the door. 2) The corridor doc room in the kitchen 42 CFR 483.70(a) NFPA 101 LIFE SAAA fire alarm system installed, tested, ar with NFPA 70 Nation 72. The system has and testing program | is not met as evidenced by: tion on Monday 11/19/12 at 0 AM onward the following or to the laundry room did not ere is an excessive gap at to or to the mechanical/chemical was not self closing. AFETY CODE STANDARD or required for life safety is not maintained in accordance onal Electrical Code and NFPA is an approved maintenance or complying with applicable FPA 70 and 72. 9.6.1.4 | K 052 | Corrective action(s) according to correct the deficient p A. Repairs have been complire alarm system to assifire/smoke door hold op and exit doors will not rwith the fire alarm contactive trouble alarm. B. Repairs were completed 12 by Simplex Grinnel. Identify other life safety having the potential to a residents by the same de | pleted to ure en devices ee-energize rol panel in l on 11-20- issues uffect |
| ; | This STANDARD | is not met as evidenced by: | | practice: | Page 2 |

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

Event ID: ZSMF21

Facility ID: 953488

If continuation sheet Page 2 of 5

QW 12-3-12

| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION 3 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | |
|--|--|--|-------------|---|---|----------------------------|
| | r | 345186 | B. WING | | 11/19 | /2012 |
| NAME OF PROVIDER OR SUPPLIER FIVE OAKS MANOR (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | 4 | EET ADDRESS, CITY, STATE, ZIP CODE 13 WINECOFF SCHOOL ROAD ONCORD, NC 28027 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| K 052 | Based on observa approximately 11:0 was noted. 1) The fire alarm s specific findings in facility fire alarm sy and the audible ala Alarm Control Panhold open devices re-energized with t (FACP) in active to 42 CFR 483,70(a) NFPA 101 LIFE SA All required smoke activating door hold maintained, inspec | tion on Monday 11/19/12 at 0 AM onward the following system was non-compliant, clude, during testing of the restem the alarm was initiated rms were silenced at the Fire el (FACP) the fire/smoke doors and exit doors would the fire alarm control panel | K 052 | B. Any identified non-comp concerns will be reported Administrator. Concerns corrected in a timely man C. Maintenance Director haprovided education on the topic: K029 42 CFR 483. Education was provided Administrator. D. Education was completed 12 4. Corrective action will be at our monthly Quality A Meeting. Report of finding report to our QA commit review for continued integrammendment of plan. | to will be mer. s been e following 70 (a). by d on 11-30- monitored assurance ng will be tee to | |
| K 056 SS=F | Based on observation approximately 11:0 was noted. 1) The smoke due HVAC unit in the killing clean and in good. 42 CFR 483.70(a) NFPA 101 LIFE S/ If there is an autominstalled in accordate the Installation provide complete of the second approvide complete of the second approximately second approximately second approximately second approximately second approximately 11:0 the second approximately 11:0 th | is not met as evidenced by: tion on Monday 11/19/12 at 10 AM onward the following It detectors located in the tichen was not maintained operating condition. AFETY CODE STANDARD matic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to coverage for all portions of the em is properly maintained in | K 056 | | | |

| STATEMENT | TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | | LE CONSTRUCTION 0.1 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | |
|---|--|--|-------------------|-----|--|--|----------------------------|
| | , | 345186 | B. WING | | | 11/19/2012 | |
| , | NAME OF PROVIDER OR SUPPLIER FIVE OAKS MANOR | | | 41 | EET ADDRESS, CITY, STATE, ZIP CODE 3 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| K 054 SS=D K 056 SS=F | Based on observar approximately 11:0 was noted. 1) The fire alarm s specific findings independent of audible alarm Control Panehold open devices re-energized with the (FACP) in active trous to the control Panehold open devices re-energized with the (FACP) in active trous 42 CFR 483,70(a) NFPA 101 LIFE SA All required smoke activating door hold maintained, inspect with the manufacture. This STANDARD Based on observation approximately 11:0 was noted. 1) The smoke due HVAC unit in the kind clean and in good and the clean and in good and the clean and the c | tion on Monday 11/19/12 at 0 AM onward the following ystem was non-compliant, clude, during testing of the estem the alarm was initiated rms were sllenced at the Fire el (FACP) the fire/smoke doors and exit doors would ne fire alarm control panel | K | 054 | A. Facility will inspect/test fi system weekly x4 then mo assure maintenance and to comply with applicable requirements of NFPA 70 Inspections/test will be comply Maintenance Director. of inspections/test will be documented on fire alarmation and tool. 3. Measures will be put into what systemic change facing make to ensure that the depractice does not recur: A. Facility will inspect/test fi system weekly x4 then mo assure maintenance and to comply with applicable requirements of NFPA 70 Inspections/test will be comply with applicable requiremented on fire alarmation of inspections/test will be documented on fire alarmation. B. Any identified non-completon concerns will be reported Administrator. Concerns corrected in a timely man deting. Report of findin reported to our QA commented to the province of th | and 72. mpleted Outcome a system place or lity will efficient are alarm onthly to esting and 72. mpleted Outcome a system liance to will be mer. monitored ssurance gs will be | |
| de la constant de la | installed in accordate for the Installation provide complete of | ance with NFPA 13, Standard of Sprinkler Systems, to coverage for all portions of the em is properly maintained in | | | review for continued inter amendment of plan. | vention or | et Page 3 of 5 |

PRINTED: 11/26/2012 FORM APPROVED OMB NO. 0938-0391

| CENTERS FOR MEDICARE & MEDICARD SERVICES | | (X2) MULTIPLE CONSTRUCTION (X3) | | | VEY | |
|--|--|---|---------------------|--|---|----------------------------|
| STATEMENT AND PLAN O | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A BUILDING | | COMPLETE | |
| | 345186 | | | | 11/19/ | 2012 |
| | PROVIDER OR SUPPLIER | | 413 | EET ADDRESS, CITY, STATE, ZIP CODE 3 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | SUMMARY ST | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | 00000- | (X5) COMPLETION DATE |
| | approximately 11: was noted. 1) The fire alarm specific findings in facility fire alarms and the audible al Alarm Control Pai hold open devices re-energized with (FACP) in active 142 CFR 483,70(a NFPA 101 LIFE STANDARD Based on observating door homaintained, inspectivating door homaintained, inspectivating door homaintained, inspectivating door homaintained, inspectivating approximately 11 was noted. 1) The smoke defer approximately 11 was noted. 1) The smoke defer and in good 42 CFR 483,70(a NFPA 101 LIFE approximately 11 was noted. 1) The smoke defer and in good 42 CFR 483,70(a NFPA 101 LIFE approximately 11 was noted. 1) The smoke defer and in good 42 CFR 483,70(a NFPA 101 LIFE approximately 11 was noted. | ation on Monday 11/19/12 at 00 AM onward the following system was non-compliant, nolude, during testing of the system the alarm was initiated arms were silenced at the Fire nel (FACP) the fire/smoke doors is and exit doors would the fire alarm control panel trouble alarm. SAFETY CODE STANDARD to detectors, including those cold-open devices, are approved, acted and tested in accordance aturer's specifications. 9.6.1.3 Is not met as evidenced by: vation on Monday 11/19/12 at 1:00 AM onward the following uct detectors located in the akitchen was not maintained and operating condition. SAFETY CODE STANDARD to safety conditions with NFPA 13, Standard on of Sprinkler Systems, to a coverage for all portions of the | K 052 | A. Smoke duct detector's I HVAC unit in the kitcher cleaned and being main good operating condition 2. Identify other life safety having the potential to a residents by the same depractice: A. Facility will inspect smodetectors located in HV the kitchen weekly x4 to assure clean and in gonerating condition in with life safety code states. | ocated in en has been tained in in. vissues affect efficient Oke duct VAC unit in hen monthly good accordance indard 42 tions will be ance sistrator. s will be duct | 1-2-13 |
| | building. The sy | stem is properly maintained in | | | If continuation sh | eet Page 3 of |

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

Event ID: ZSMF21

Facility ID: 953488

If continuation sheet Page 3 of 5

PRINTED: 11/26/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ULTIPLI LDING | E CONSTRUCTION 01 - MAIN BUILDING 01 | COMPLET | |
|--------------------------|--|---|--|------------------|---|--|----------------------------|
| | | 345186 | B. W11 | IG | | 11/19 | /2012 |
| | ROVIDER OR SUPPLIER | | | 413 | ET ADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD NCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | SUMMARY S | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY) | TOULD BE | (X5) COMPLETION DATE |
| K 052 K 054 · SS=D | Based on observapproximately 11 was noted. 1) The fire alarm specific findings if acility fire alarm and the audible a Alarm Control Pahold open device re-energized with (FACP) in active 42 CFR 483,70(a NFPA 101 LIFE and the audit alignment of the property of the prope | ation on Monday 11/19/12 at 100 AM onward the following system was non-compliant, include, during testing of the system the alarm was initiated larms were silenced at the Fire nel (FACP) the fire/smoke doors is and exit doors would the fire alarm control panel trouble alarm. | | 052 | | | |
| K 056 SS=F | Based on obser approximately 1 was noted. 1) The smoke d HVAC unit in the clean and in good 42 CFR 483.70(NFPA 101 LIFE If there is an autinstalled in according to the installation provide complete. | o is not met as evidenced by: vation on Monday 11/19/12 at 1:00 AM onward the following uct detectors located in the kitchen was not maintained d operating condition. a) SAFETY CODE STANDARD comatic sprinkler system, it is rdance with NFPA 13, Standard on of Sprinkler Systems, to e coverage for all portions of the vistem is properly maintained in | ************************************** | (056 | Corrective action(s) actor correct the deficient A. Sprinklers will have be under exterior canopie both exits door going tand exit door next to r B. Sprinklers will be instaqualified outside vend | practice: een installed es outside to parking lot oom #125. alled by | 1-2-13 |

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

Event ID: ZSMF21

Facility ID: 953488

If continuation sheet Page 3 of 5

ON 12-3-12

PRINTED: 11/20/2012 FORM APPROVED OMB NO. 0938-0391

| A PROPERTY OF SECURITIONS | RE & MEDICAID SERVICES | | | | | |
|--|--|---------------|---|--|---|-------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILI | | CONSTRUCTION 02 - BUILDING 02 | COMPLETE | |
| | 345186 | B. WING | | | 11/19/2 | 012 |
| NAME OF PROVIDER OR SUPPLIE | R | · · | 413 | ADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD ICORD, NC 28027 | į | · |
| FIVE OAKS MANOR | | | - 605 | THE STREET OF AN OF CORR | ECTION | (X5) OMPLETION |
| Marie I amount of the control of the | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | (| (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY) | NOULD UL | DATE |
| K 052 Continued From was noted. | | К0 | 52 | | · | |
| specific findings facility fire alarn and the audible Alarm Control F hold open devic | m system was non-compliant, include, during testing of the a system the alarm was initiated alarms were silenced at the Fire anel (FACP) the fire/smoke doors ses and exit doors would the the fire alarm control panel e trouble alarm. | | | | | |
| SS=E All required sm | SAFETY CODE STANDARD oke detectors, including those | | 054 | | | |
| I maintained ins | pected and tested in accordance acturer's specifications. 9.6.1.3 | | *************************************** | • | | |
| Based on obs approximately was noted. 1) The smoke | RD Is not met as evidenced by: ervation on Monday 11/19/12 at 11:00 AM onward the following duct detector installed in the first nechanical room on 200 hall was legrees out of alignment. | | | | | |
| 42 CFR 483.7 K 056 NFPA 101 LIF | 0(a) E SAFETY CODE STANDARD | K | 056 | Corrective action(s) a to correct the deficient | accomplished nt practice: | 1-2-13 |
| Installed in action for the Installed provide computibilities. The | nutomatic sprinkler system, it is cordance with NFPA 13, Standard ation of Sprinkler Systems, to lete coverage for all portions of the system is properly maintained in with NFPA 25, Standard for the esting, and Maintenance of | | - | A. Showers on 200 hall sprinkler coverage v of additional sprinkl Repairs/installation sprinklers will be cobefore completion departments. | ia installation ers. of additional mpleted on or | ef Page 3 of |

The control of the state of the

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

Event ID: ZSMF21

Facility ID: 953488



| CENTERS FOR MEDICAL | RE & MEDICAID SERVICES | CYON MUST THE | LE CONSTRUCTION | (X3) DATE SURVEY | ′ |
|--|--|---------------------|---|--|------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | |
| , | 345186 | | | 11/19/20 | 12 |
| NAME OF PROVIDER OR SUPPLIE | R | 4 | EET ADDRESS, CITY, STATE, ZIP CODE 13 WINECOFF SCHOOL ROAD | • | |
| FIVE OAKS MANOR | | | ONCORD, NC 28027 PROVIDER'S PLAN OF CORRE | CTION | (X5) APLETION |
| (A4) IV I WASHINGTONES | STATEMENT OF DEFICIENCIES LCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | 005000 | APLETION DATE |
| Inspection, Test Water-Based Fi supervised. The supply for the sy systems are equ switches, which building fire alar | NFPA 25, Standard for the ng, and Maintenance of the Protection Systems. It is fully the is a reliable, adequate water stem. Required sprinkler stem with water flow and tamper are electrically connected to the m system. 19.3.5 | K 056 | Identify other life safety in having the potential to afresidents by the same despractice: Facility will inspect all end canopies weekly x4 monthly to assure comply NFPA 13 section 5-13.8. Inspection will be comply Maintenance Director and Administrator. Inspection documented on exterior | sterior roof then iance with t. eted by ad/or on will be | |
| Based on observations of the facility was noted. 1) (Sprinklers of the roofs or canople per NFPA 13 sentrance outside outside the exit outside the exit 42 CFR 483.70 NFPA 101 LIFE Cooking facilitity with 9.2.3. 1 This STANDAL Based on observations of the facility protected in a contract of the roofs o | D is not met as evidenced by: rvation on Monday 11/19/12 at 1:00 AM onward the following thall be installed under exterior es exceeding 4 ft (1.2 m) in depth ection 5-13.8.1.) Location front e both exit doors and canopy door located next to room 125. (a) E SAFETY CODE STANDARD es are protected in accordance 9.3.2.6, NFPA 96 RD is not met as evidenced by: ervation on Monday 11/19/12 at 11:00 AM onward the following es cooking system was not coordance with NFPA 96 - ntrol and Fire Protection of ooking Operations. gs include; the deep fryer was | K 06 | anopy audit tool. 3. Measures will be put int what systemic change fa make to ensure that the practice does not recur: A. Facility will inspect all and canopies weekly x4 | o place or cility will deficient exterior roof then oliance with and/or lon will be roof and opliance ed to as will be | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/26/2012 FORM APPROVED OMB NO. 0938-0391

| | | A WEDICAID SERVICES | (X2) MI | ILTIPLE CO | ONSTRUCTION | (X3) DATE SU | |
|---------------------------------------|--|---|---------------------|------------|--|--|----------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUIL | | 01 - MAIN BUILDING 01 | COMPLE | red · |
| | | 345186 | | | | 11/18 | 2/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET A | DDRESS, CITY, STATE, ZIP CODE ' NECOFF SCHOOL ROAD | | |
| FIVE OAI | KS MANOR | | | | ORD, NC 28027 | | |
| (X4) ID PREFIX TAG | /FACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | DULD BE | (X5) COMPLETION DATE |
| K 056 | Inspection, Testing Water-Based Fire I supervised. There supply for the systems systems are equipped. | PA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water are. Required sprinkler bed with water flow and tamper a electrically connected to the | . K0 | 56 | | | |
| K 069 SS=D | Based on observa approximately 11:0 was noted. 1) (Sprinklers shall roofs or canoples of per NFPA 13 section entrance outside boutside the exit doutside the | ls not met as evidenced by: ition on Monday 11/19/12 at 00 AM onward the following | Κ¢ | | having the potential to at | ractice: oved from issues ifect | 1-0-13 |
| · · · · · · · · · · · · · · · · · · · | The facility's control protected in accord Ventilation Control Commercial Cook | oking system was not dance with NFPA 96 - and Fire Protection of ing Operations. iclude; the deep fryer was | | | residents by the same des practice: | icient | |

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

Event ID: ZSMF21

Facility ID: 953488

If continuation sheet Page 4 of 5

ON 3-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| CENTERS | FOR MEDICARE | WAY BROWDER/SUPPLIER/CLIA | (X2) MUL | TIPLE | CONSTRUCTION | (X3) DATE SUF COMPLET | RVEY ED |
|----------------------------|---|--|---------------------|---|--|---|----------------------------|
| TATEMENT O ND PLAN OF ' | F DEFICIENCIES CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | | 01 - MAIN BUILDING 01 | 11/19 | /2012 |
| NAME OF PRO | OVIDER OR SUPPLIER | 345186 | B, WING | TREET | ADDRESS, CITY, STATE, ZIP CODE VINECOFF SCHOOL ROAD CORD, NC 28027 | | |
| (X4) ID PREFIX TAG | SUMMARY STA | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APPORT OF THE APPORT | | (X5) COMPLETION DATE |
| K 056 | K 056 Continued From page 3 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 | K 0 | | 3. Measures will be put into what systemic change fac make to ensure that the d practice does not recur: A. Facility will inspect smod detectors located in HVA the kitchen weekly x4 the to assure clean and in go operating condition in a with life safety code stan CFR 483.70 (a). Inspecticompleted by Maintenar | ke duct AC unit in en monthly od eccordance adard 42 lons will be | | |
| K 069 SS=E | Based on observapproximately 11 was noted. 1) (Sprinklers shroofs or canoples per NFPA 13 secontrance outside the exit of the | is not met as evidenced by: vation on Monday 11/19/12 at :00 AM onward the following that is exceeding 4 ft (1.2 m) in depth of exceeding 4 ft (1.2 m) in depth of both exit doors and canopy door located next to room 125. a) SAFETY CODE STANDARD s are protected in accordance 3.2.6, NFPA 96 | | (069 | Director and/or Admini Outcome of inspections documented on smoke of detector (kitchen) audit B. Any identified non-come concerns will be reported Administrator. Concerns corrected in a timely m 4. Corrective action will be at our monthly Quality Meeting. Report of find reported to our QA correview for continued in amendment of plan. | strator. will be luct form. upliance ed to ns will be anner. e monitored Assurance lings will be nmittee to | |
| | Based on obse approximately 1 was noted, 1) The facility's protected in act Ventilation Con- | D is not met as evidenced by: evation on Monday 11/19/12 at 11:00 AM onward the following a cooking system was not cordance with NFPA 96 - trol and Fire Protection of booking Operations. as include; the deep fryer was | | | | If continuation | sheet Dane |

PRINTED: 11/26/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 A. BUILDING 11/19/2012 B. WING 345186 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 FIVE OAKS MANOR PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE ID DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG Corrective action will be monitored K-069 at our monthly Quality Assurance Continued From page 4 K 069 located next to a gas stove top without the Meeting. Report of findings will be required splash guard in the dietary kitchen. reported to our QA committee to review for continued intervention or 42 CFR 483.70(a) amendment of plan. K.072 NFPA 101 LIFE SAFETY CODE STANDARD K 072 Means of egress are continuously maintained free SS=E of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) In front of the exit door in in corridor on 400 hall and in the corridor in front of the exit door next to the maintained office there was storage on the exit corridors. (soiled linen barrels) 42 CFR 483.70(a)

| CENTER | S FOR MEDICARE | & MEDICAID SERVICES | (X2) MULTI | PLE CONSTRUCTION | (X3) DATE SUI | RVEY |
|--|--|---|---------------|--|-------------------|----------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUI IDENTIFICATION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDIN | | | . [|
| | | 345186 | B. WING _ | | 11/19 | /2012 |
| · | ROVIDER OR SUPPLIER | 345100 | 4 | REET ADDRESS, CITY, STATE, ZIP CODE 13 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | |
| FIVE OAT | | ATEMENT OF DEFICIENCIES | ID ID | PROVIDER'S PLAN OF CORRE | | COMPLETION |
| (X4) ID PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APP DEFICIENCY) | PROPRIATE | DATE |
| K 069 | required splash gu | as stove top without the lard in the dietary kitchen. | K 069 | at our monthly Quality A Meeting, Report of findin reported to our QA comm review for continued inte | | |
| K 072 | 1 | AFETY CODE STANDARD | K 072 | amendment of plan. | | |
| SS=E | of all obstructions use in the case of | are continuously maintained free or impediments to full instant fire or other emergency. No rations, or other objects obstruct egress from, or visibility of exits. | | | | |
| | Based on observations approximately 11 was noted. 1) In front of the hall and in the content to the maintenance of the mainten | is not met as evidenced by: vation on Monday 11/19/12 at :00 AM onward the following exit door in in corridor on 400 varidor in front of the exit door ained office there was storage ors. (solled linen barrels) | | | | |
| | | · | | | | |
| | | | | | | |
| | | | | Facility ID: 953488 | If continuation s | sheet Page 5 t |

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIF | | ONSTRUCTION | (X3) DATE SU COMPLET | |
|--------------------------|--|--|---------------------|--------|---|--|----------------------------|
| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | G | 01 - MAIN BUILDING 01 | | |
| | | 345186 | B. WING | | | 11/19 | /2012 |
| • | ROVIDER OR SUPPLIER | | 41 | 13 Wil | DDRESS, CITY, STATE, ZIP CODE NECOFF SCHOOL ROAD ORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | 1 | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE. | (X5) COMPLETION DATE |
| K 069 K 072 SS=E | located next to a garequired splash guard 42 CFR 483.70(a) NFPA 101 LIFE SA Means of egress a of all obstructions of use in the case of furnishings, decorated as a second specific spe | age 4 as stove top without the ard in the dietary kitchen. AFETY CODE STANDARD re continuously maintained free or impediments to full instant fire or other emergency. No attorns, or other objects obstruct gress from, or visibility of exits. | K 069 | A. 3. | Inspections of dietary kitche be completed weekly x4 the monthly to assure facility's system is protected in accor with NFPA 96- Ventilation and Fire Protection of Com Cooking Operations. Inspection of the completed by Dietar Supervisor and/or Adminis Inspections will be document Dietary Cooking System au Measures will be put into p what systemic change facility make to ensure that the despractice does not recur: | n cooking dance Control mercial etions y trator. atted on dit form. | |
| | Based on observation approximately 11:0 was noted. 1) In front of the equal hall and in the corrupt to the maintal | is not met as evidenced by: tion on Monday 11/19/12 at 00 AM onward the following xit door in in corridor on 400 idor in front of the exit door ned office there was storage 's. (soiled linen barrels) | | | Inspection of dietary kitcher completed weekly x then massure facility's cooking syprotected in accordance wing 6- Ventilation Control and Protection of Commercial Operations. Inspections with completed by Dietary Superand/or Administrator. Inspection of Cooking System audit form Dietary Supervisor has receducation on the following Facility's cooking system is protected in accordance wing 6-Ventilation Control and Protection of Commercial Operations. Training will a completed by Administrator Training was completed on 12. | onthly to stem is th NFPA I Fire Cooking II be rvisor sections tary 1. eived topic: 5 ith NFPA I Fire Cooking be or. | |

PRINTED: 11/26/2012 FORM APPROVED OMB NO. 0938-0391

| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL' A. BUILDI | TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01 | (X3) DATE S COMPL | |
|--|--|------------------------|--|--|----------------------------|
| p | 345186 | B. WING | | 11/ | 19/2012 |
| (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | - | TREET ADDRESS, CITY, STATE, ZIP C 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ORRECTION ON SHOULD BE. IE APPROPRIATE | (X5) COMPLETION DATE |
| required splash guide and a control of the case of furnishings, decorate exits, access to, eg 7.1.10 This STANDARD Based on observa approximately 11:0 was noted. 1) In front of the exhall and in the corrinext to the maintain | age 4 as stove top without the ard in the dietary kitchen. AFETY CODE STANDARD re continuously maintained free or impediments to full instant lire or other emergency. No attons, or other objects obstruct press from, or visibility of exits. Is not met as evidenced by: tion on Monday 11/19/12 at 0 AM onward the following att door in front of the exit door ned office there was storage is. (soiled linen barrels) | K 069 | | at practice: facility are e of all ediments in ency. ety issues o affect e deficient Il cooridors reekly x4 then inpliance with f egress free of pediments. inpleted by r, Nursing ions will be taining egress r impediments into place or facility will he deficient | 1-2-13 |

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

Event ID: ZSMF21

Facility ID: 953488

If continuation sheet Page 5 of 5

JW 3-12

| TATEMENT ND PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | LE CONSTRUCTION 6 02 - BUILDING 02 | (X3) DATE SU COMPLE | |
|--------------------------|---|---|---------------------|--|---|----------------------------|
| | <i>y</i> . | 345186 | B. WING 11/19 | | /19/2012 | |
| | ROVIDER OR SUPPLIER | | 41 | EET ADDRESS, CITY, STATE, ZIP CODE 3 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | , | |
| (X4) ID PREFIX TAG | /FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | QULD BE | (X5) COMPLETION DATE |
| K 000 K 012 SS=D | This Life Safety C conducted as per at 42CFR 483.70(a Care section of the publications. This is construction, one automatic sprinkle The deficiencies d are as follows: NFPA 101 LIFE Same and the construction construction. | ode(LSC) survey was The Code of Federal Register a); using the Existing Health LSC and its referenced building is Type III(211) story, with a complete | K 000 | C. Any indentified non-components will be reported Administrator. Concerns corrected in a timely man. 4. Corrective action will be at our monthly Quality A Meeting. Report of findin reported to our QA compreview for continued interamendment of plan. | to will be ner. monitored ssurance gs will be nittee to | |
| K 029 SS=D | Based on observe approximately 11:0 was noted. 1) The sheetrock corridors that is pacorridor was not many there were hole in the attle area that 42 CFR 483.70(a) NFPA 101 LIFE S One hour fire rate fire-rated doors) of extinguishing syst and/or 19.3.5.4 pr the approved automatical transfer of the systems. | is not met as evidenced by: ation on Monday 11/19/12 at 20 AM onward the following in the attic area above the art of the one hour fire rated naintained in good condition. In the top layer of sheetrock in was not repaired, 200 hall. AFETY CODE STANDARD In a construction (with ¾ hour or an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When matic fire extinguishing system | K 029 | TITLE | | (X6) DATE |

In the institution may be excused from correcting providing it is determined that where 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.



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| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION 9 02 - BUILDING 02 | (X3) DATE SI COMPLE | |
|--------------------------|--|---|---------------------|--|---|---------------------------|
| | <i>a</i> | 345186 | B. WING | | 11/1 | 9/2012 |
| . , | ROVIDER OR SUPPLIER | | 41 | EET ADDRESS, CITY, STATE, ZIP CO 3 WINECOFF SCHOOL ROAD ONGORD, NC 28027 | DDE | |
| (X4) ID PREFIX TAG | IEACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETIO DATE |
| | conducted as per T at 42CFR 483.70(a Care section of the publications. This b construction, one s automatic sprinkler The deficiencies de are as follows: | ode(LSC) survey was the Code of Federal Register); using the Existing Health LSC and its referenced building is Type III(211) tory, with a complete system. etermined during the survey | K 000 | A. Facility will inspect all daily x30 days then we monthly to assure commaintaining means of all obstructions or implications will be conMaintenance Director Administrator and/or Supervisor's. Inspection documented on maintaintess of obstructions or audit tool. | eekly x4 then apliance with egress free of pediments. In the pediments of | |
| K 012 SS=D | Building construction of the following. 19.3.5.1 This STANDARD Based on observa approximately 11:0 was noted. 1) The sheetrock is corridors that is participated in the attic area that were hole in the attic area that were hole. | on type and height meets one 0.1.6.2, 19.1.6.3, 19.1.6.4, is not met as evidenced by: tion on Monday 11/19/12 at 0 AM onward the following in the attic area above the tof the one hour fire rated aintained in good condition. the top layer of sheetrock in was not repaired, 200 hall. | K 012 | B. Facility staff will receion the following topic: cooridor's clear at all Education will be come Administrator and/or Development Coordin Education will be come before completion date. C. Any identified non-conconcerns will be reported in a timely management of fin reported to our QA coreview for continued in amendment of plan. | Keeping times. pleted by Staff ator. pleted on or e. npliance ted to rns will be nanner. be monitored y Assurance dings will be mmittee to | |
| K 029 SS=D | One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro | construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system | K 029 | monument or partie | , | (X6) DAYE |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days alowing 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.

Facility ID: 953488



PRINTED: 11/20/2012 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPL | E CONSTRUCTION | (X3) DATE SU COMPLE | |
|--------------------------|--|--|--------------------|--------|--|---|----------------------------|
| AND PLAN O | F CORRECTION | IDENTIFICATION NUMBER: | A BUII | DING | 02 - BUILDING 02 | | |
| | | 345186 | B, WIN | G | | 11/19 | /2012 |
| | ROVIDER OR SUPPLIER | | | 413 | ET ADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD NCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| K 000 | This Life Safety Co | rs ode(LSC) survey was he Code of Federal Register); using the Existing Health | Κ¢ | 000 | | | |
| | Care section of the publications. This be construction, one s automatic sprinkler | LSC and its referenced building is Type III(211) tory, with a complete system. | | | • | | |
| K 012 SS=D | are as follows: NFPA 101 LIFE SA Building construction | on type and height meets one 0.1.6.2, 19.1.6.3, 19.1.6.4, | K | 012 | Corrective action(s) according to correct the deficient product. The top layer of sheetrock attic area above corridor? | actice: c in the | 1.2-13 |
| K 029 SS≂D | Based on observa approximately 11:0 was noted. 1) The sheetrock is corridors that is paracorridor was not material than the attic area that was a correctly and the attic area that was not material to the attic area that was a correctly and the attic area than the a | is not met as evidenced by: tion on Monday 11/19/12 at 0 AM onward the following In the attic area above the rt of the one hour fire rated aintained in good condition. the top layer of sheetrock in was not repaired, 200 hall. AFETY CODE STANDARD I construction (with ¾ hour an approved automatic fire im in accordance with 8.4.1 | Κ (| 029 | hall will have needed repacempleted to maintain in condition. Repairs will be completed on or before condition. Repairs will be completed on or before condition. Repairs will be completed on the completed of the complete of the same deficient practice. A. Facility will inspect attict corridor on 200 hall moncompletion of needed repassure being maintained condition and in compliantife Safety Code Standar Inspections will be completed on the complete on the c | nirs good ompletion pleted by ector. issues residents ctice: area above thly post airs to in good nce with ed. leted by utcome of nented on | |
| · | the approved autor | ntects hazardous areas. When matic fire extinguishing system DER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | | attic area above corridor audit tool. | ZOV HAH | (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.

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PRINTED: 11/20/2012 FORM APPROVED OMB NO. 0938-0391

| TATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A BUILDING | | (X3) DATE SUF COMPLETI | ĔD |
|--------------------------|---|---|---------------------|---|---|----------------------------|
| | •• | 345186 | i | | 11/19/ | 2012 |
| | ROVIDER OR SUPPLIER | | 413 | ET ADDRESS, CITY, STATE, ZIP COD 3 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | | · |
| (X4) ID PREFIX TAG | LEACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMEN | ITS | K 000 | | | |
| | conducted as per at 42CFR 483.70(Care section of th publications. This construction, one automatic sprinkle The deficiencies of | rode(LSC) survey was The Code of Federal Register a); using the Existing Health building is Type III(211) story, with a complete or system. | · | | | |
| K 012 SS=D | are as follows: NFPA 101 LIFE S | AFETY CODE STANDARD ion type and height meets one 19.1.6.2, 19.1.6.3, 19.1.6.4, | K 012 | | , | |
| | Based on observapproximately 11 was noted. 1) The sheetrock corridors that is processed to the corridor was not there were hole. | is not met as evidenced by: ration on Monday 11/19/12 at 200 AM onward the following at in the attic area above the art of the one hour fire rated maintained in good condition. In the top layer of sheetrock in t was not repaired, 200 hall. | | | | |
| K 029 SS=D | One hour fire ratifire-rated doors) extinguishing sys | ed construction (with ¾ hour or an approved automatic fire stem in accordance with 8.4.1 protects hazardous areas. When comatic fire extinguishing system | K 029 | Corrective action(s) a to correct the deficient A. Self closures have be chemical rooms loca Self closures were in facility Maintenance | nt practice: en installed to ted on 200 hall. stalled by | (Xe) 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.

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If continuation sheet Page 1 of 5

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | | E CONSTRUCTION 02 - BUILDING 02 | (X3) DATE SU COMPLET | |
|--------------------------|--|---|--------------------|---|---|--|----------------------------|
| | | 345186 | B, WING | G | | 11/19 | /2012 |
| | ROVIDER OR SUPPLIER | | | 413 | ET ADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD NCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFD TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE [| (X5) COMPLETION DATE |
| K 029 | other spaces by sm doors. Doors are s field-applied protect | areas are separated from noke resisting partitions and self-closing and non-rated or dive plates that do not exceed bottom of the door are | КО | 29 | Measures will be put into p what systemic change facil make to ensure that the de practice does not recur: A. Facility will inspect attic a corridor on 200 hall montic completion of needed repa assure being maintained in condition and in complian | ity will ficient rea above ily post irs to a good ce with | |
| Қ 052 SS=F | Based on observa approximately 11:0 was noted. 1) The chemical rehall were not self curve and the self curv | AFETY CODE STANDARD n required for life safety is and maintained in accordance onal Electrical Code and NFPA is an approved maintenance on complying with applicable | к 0 | 052 | Life Safety Code Standard Inspections will be comple Maintenance Director. Ou inspections will be docume attic area above corridor 2 audit tool. B. Any indentified non-comp concerns will be reported Administrator. Concerns corrected in a timely manual 4. Correction action will be a at our monthly Quality As Meeting. Report of finding reported to our QA comm review for continued inter amendment of plan. | ted by tcome of ented on 200 hall liance to will be ner. monitored surance gs will be ittee to | |
| | | | | | · | | |
| | Based on observa | is not met as evidenced by: ation on Monday 11/19/12 at 00 AM onward the following | | *************************************** | · | | |

| CENTERS | S FOR MEDICARE | & MEDICAID SERVICES | 000 344 | n TIDI S | E CONSTRUCTION | (X3) DATE SUR COMPLETE | VEY |
|--------------------------|--|--|-------------|-------------|---|---|----------------------------|
| TATEMENT / | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: | A, BUIL | | | COMPLETE | |
| | * | 345186 | B. WIN | | | 11/19/ | 2012 |
| | OVIDER OR SUPPLIER | 340100 | <u> </u> | 413 | ET ADDRESS, CITY, STATE, ZIP CO WINECOFF SCHOOL ROAD NGORD, NG 28027 | DE | |
| FIVE OAK | S MANOR | ATEMENT OF DEFICIENCIES | ID | $\neg \top$ | PROVIDER'S PLAN OF COL | | (X5) COMPLETION DATE |
| (X4) ID PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREF TAG | iX | CROSS-REFERENCED TO THE DEFICIENCY) | APPROPRIATE | |
| K 029 | other spaces by s doors. Doors are field-applied prote 48 inches from the permitted. 19.3 This STANDARD Based on observ approximately 11 | a areas are separated from moke resisting partitions and self-closing and non-rated or extive plates that do not exceed to bottom of the door are .2.1 Is not met as evidenced by: vation on Monday 11/19/12 at :00 AM onward the following | | 029 | Identify other life safe having the potential to residents by the same practice: A. Facility will inspect a room doors weekly x to ensure self closure and working properl Life Safety Code Sta Inspections will be comaintenance Directed Administrator. Outcinspections will be defined. | deficient Il chemical 4 then monthly 5 are present 9 according to ndard, 1 mpleted by 1 and/or 1 ome of 1 occumented on | |
| K 052 SS=F | hall were not sell 42 CFR 483.70(a NFPA 101 LIFE A fire alarm syst installed, tested, with NFPA 70 N 72. The system and testing prog requirements of | saysaysaysaysaysaysaysaysaysaysaysaysays | | ⟨ 052 | 3. Measures will be put what systemic chang make to ensure that practice does not red. A. Facility will inspect room doors weekly to ensure self closur and working proper Life Safety Code St Inspections will be Maintenance Direct Administrator. Our inspections will be door inspection and B. Any identified non concerns will be re Administrator. Co corrected in a time | into place or e facility will the deficient cur: all chemical x4 then monthly res are present rly according to andard. completed by tor and/or come of documented on lit tool. compliance ported to neerns will be | 1 |
| | 1 m 1 ahaa | RD is not met as evidenced by: ervation on Monday 11/19/12 at 11:00 AM onward the following | | | Foolisty ID: 953488 | If continuation | sheet Page 2 |

PRINTED: 11/20/2012 FORM APPROVED OMB NO. 0938-0391

| CENTE | RS FOR MEDICARE | E & MEDICAID SERVICES | | | | OPI GIVIO | . 0930-039 |
|--------------------------|--|---|-------------------|--------------------|---|---|---------------------------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | ULTIPLE (LDING | CONSTRUCTION 02 - BUILDING 02 | (X3) DATE S COMPLE | URVEY ETEO |
| | ø. | 345186 | B, WIN | IG | | 11/1 | 9/2012 |
| | PROVIDER OR SUPPLIER | | • | 413 W | ADDRESS, CITY, STATE, ZIP CODE VINECOFF SCHOOL ROAD CORD, NC 28027 | | |
| (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 CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETIC DATE |
| K 029 | other spaces by sn doors. Doors are s field-applied protect | areas are separated from noke resisting partitions and self-closing and non-rated or stive plates that do not exceed bottom of the door are | K | 029 | | | |
| K 052 \$S=F | Based on observa approximately 11:0 was noted. 1) The chemical rohall were not self chall were not self c | is not met as evidenced by: tion on Monday 11/19/12 at 10 AM onward the following com corridors located on 200 tosing. AFETY CODE STANDARD In required for life safety is and maintained in accordance conal Electrical Code and NFPA as an approved maintenance in complying with applicable EPA 70 and 72. 9.6.1.4 | K | 1. A. B. | to correct the deficient pr Repairs have been compl fire alarm system to assure fire/smoke door hold open and exit doors will not rewith the fire alarm control active trouble alarm. Repairs were completed of 12 by Simplex Grinnell. | eted to re n devices energize ol panel in on 11-20- | 1-2-13 |
| | Based on observat | s not met as evidenced by: tion on Monday 11/19/12 at 0 AM onward the following | | | residents by the same defi practice: | cient | |
| | | i | | | | | |

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

Event ID: ZSMF21

Facility ID; 953488

If continuation sheet Page 2 of 5

12-3-12

PRINTED: 11/20/2012 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| CENTER | S FOR MEDICARE | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | LTIPLI | CONSTRUCTION | (X3) DATE SUF COMPLET | ED |
|--------------------------|--|---|--------------------|--------|--|--------------------------|--------------------|
| ATEMENT (| OF DEFICIENCIES CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | | | | |
| | ! | 245495 | B. WING | Э | | 11/19 | /2012 |
| AME OF PR | ROVIDER OR SUPPLIER | 345186 | -1 | 413 | ET ADDRESS, CITY, STATE, ZIP COL WINEGOFF SCHOOL ROAD | DE | |
| IVE OAK | S MANOR | | | | NCORD, NC 28027 PROVIDER'S PLAN OF COR | RECTION | (X5) COMPLETION |
| (X4) ID PREFIX TAG | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | | DATE |
| K 052 | specific findings in facility fire alarm s and the audible al Alarm Control Par | system was non-compliant, nelude, during testing of the system the alarm was initiated arms were silenced at the Fire nel (FACP) the fire/smoke doors and exit doors would the fire alarm control panel | | 052 | 4. Corrective action will I at our monthly Quality Meeting. Report of fin reported to our QA co review for continued is amendment of plan. | dings will be | - |
| K 054 SS=E | 42 CFR 483,70(a NFPA 101 LIFE S All required smol- activating door he | | | .054 | | • | |
| | Based on obser approximately 1 was noted. 1) The smoke of the model o | O is not met as evidenced by: vation on Monday 11/19/12 at 1:00 AM onward the following duct detector installed in the first echanical room on 200 hall was grees out of alignment. | | | | | |
| K 05 | If there is an au installed in according for the Installati provide comple building. The s | Itomatic sprinkler system, it is ordance with NFPA 13, Standard on of Sprinkler Systems, to see coverage for all portions of the NEPA 25. Standard for the | e | K 05 | 6 | | |
| | Inspection, Tes | sting, and Maintenance of | | | Facility ID: 953488 | if continuation | sheet Page 3 |

The state of the s

| ST. TEMENT AND PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | ULTIPI LDING | LE CONSTRUCTION 02 - BUILDING 02 | (X3) DATE SU COMPLE | |
|--------------------------|--|--|--------------------|--|--|---|----------------------------|
| | y* | 345186 | B. WN | 1G | | 11/1 | 9/2012 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | Ē | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFIGIENCY) | HOULD BE | (X5) COMPLETION DATE |
| K 052 | was noted. 1) The fire alarm s specific findings including facility fire alarm sy and the audible ala Alarm Control Panchold open devices | system was non-compliant, clude, during testing of the restem the alarm was initiated irms were silenced at the Fire el (FACP) the fire/smoke doors and exit doors would he fire alarm control panel | K | 052 | A. Facility will inspect/test system weekly x4 then n assure maintenance and comply with applicable requirements of NFPA. Inspections/test will be to by Maintenance Director of inspections/test will be documented on fire alar audit tool. | 70 and 72. completed ar. Outcome e | |
| K 054 SS=E | All required smoke activating door hole maintained, inspec | AFETY CODE STANDARD detectors, including those d-open devices, are approved, ted and tested in accordance arer's specifications. 9.6.1.3 | К | 054 | Measures will be put int what systemic change fa make to ensure that the practice does not recur: Facility will inspect/test system weekly x4 then massure maintenance and comply with applicable | cility will deficient fire alarm nonthly to | |
| K 056 SS=F | Based on observa approximately 11:0 was noted. 1) The smoke duction the mech installed 180 degree 42 CFR 483.70(a) NFPA 101 LIFE SA If there is an auton installed in accordance with N accordance with N | is not met as evidenced by: tion on Monday 11/19/12 at 10 AM onward the following at detector installed in the first anical room on 200 hall was sees out of alignment. AFETY CODE STANDARD matic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to coverage for all portions of the em is properly maintained in FPA 25, Standard for the g, and Maintenance of | K | 056 | requirements of NFPA Inspections/test will be oby Maintenance Director of inspections/test will be documented on fire alar audit tool. B. Any identified non-come concerns will be reported Administrator. Concerns corrected in a timely material way of the concerns will be at our monthly Quality Meeting. Report of finding reported to our QA comerciew for continued integral amendment of plan. | completed or. Outcome e e m system pliance ed to as will be anner. e monitored Assurance angs will be mittee to | |

PRINTED: 11/20/2012 FORM APPROVED OMB NO. 0938-0391

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | | 0930-0391 |
|--------------------------|---|--|-------------------|-----|--|---|----------------------------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) N A. BU | | PLE CONSTRUCTION B: 02 - BUILDING 02 | (X3) DATE SU COMPLE | rvey Ted |
| | | 345186 | B. Wi | 4G | | 11/19 | 0/2012 |
| NAME OF | PROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| FIVE OA | KS MANOR | | | | 3 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | I FACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X6) COMPLETION DATE |
| K 052 K 054 SS=E | was noted. 1) The fire alarm s specific findings ind facility fire alarm sy and the audible alar Alarm Control Panchold open devices re-energized with the (FACP) in active trous the control LIFE SA All required smoke activating door hold maintained, inspecific | ystem was non-compliant, clude, during testing of the stem the alarm was initiated rms were silenced at the Fire el (FACP) the fire/smoke doors and exit doors would ne fire alarm control panel | K | 052 | Corrective action(s) according to correct the deficient p Smoke duct detector in the HVAC in the mechanica 200 hall has been correct simplex Grinnell on 11-3 | ractice: he first l room on ted by | 1-2-13 |
| K 056 SS=F | Based on observation approximately 11:0 was noted. 1) The smoke duction the mech installed 180 degrees 42 CFR 483.70(a) NFPA 101 LIFE SA If there is an auton installed in accordation the installation provide complete coulding. The systems accordance with N | is not met as evidenced by: tion on Monday 11/19/12 at to AM onward the following at detector installed in the first anical room on 200 hall was tes out of alignment. AFETY CODE STANDARD that a sprinkler system, it is tence with NFPA 13, Standard of Sprinkler Systems, to the systems of the term is properly maintained in FPA 25, Standard for the ty, and Maintenance of | | 056 | Identify other life safety having the potential to a residents by the same de practice. Facility will inspect smol detector installed in the in the mechanical room weekly x4 then monthly smoke duct detector is n in accordance with Life Code Standard. Inspecticompleted by Maintenar Director. Outcome of inswill be documented on stated and in the detector (200 hall) audit | issues ffect ficient ce duct first HVAC on 200 hall to assure naintained Safety ons will be ace spections moke duct | |

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

Event ID: ZSMF21

Facility ID: 953488

JW 12-3-12

PRINTED: 11/20/2012 FORM APPROVED OMB NO. 0938-0391

| | TO TOT THE DIOTAL | . A MEDIONID SERVICES | | | | 01410 110 | . 0300-003 |
|--------------------------|--|--|-------------------|-----|---|--|----------------------------|
| | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BU | • | PLE CONSTRUCTION G 02 - BUILDING 02 | (X3) DATE S COMPL | |
| | | 345186 | B, Wil | √G | | 11/1 | 9/2012 |
| | ROVIDER OR SUPPLIER | | • | 41 | EET ADDRESS, CITY, STATE, ZIP CODE 13 WINECOFF SCHOOL ROAD ONCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | supervised. There supply for the systems are equipp switches, which are building fire alarm supply s | Protection Systems. It is fully is a reliable, adequate water m. Required sprinkler ed with water flow and tamper electrically connected to the ystem. 19.3.5 Is not met as evidenced by: ion on Monday 11/19/12 at 0 AM onward the following ers in the 200 hall resident a protected with sprinkler equipped with mag lock requires the facility to be have erage. FETY CODE STANDARD the water was a contracted with sprinkler equipped with mag lock requires the facility to be have erage. | K (| ·04 | 3. Measures will be put into what systemic change fact make to ensure that the dipractice does not recur: A. Facility will inspect smoke detector installed in the first in the mechanical room of weekly x4 then monthly the smoke duct detector is make in accordance with Life Standard. Inspection completed by Maintenand Director. Outcome of inspection will be documented on small detector (200 hall) audit for the Any identified non-completed Administrator. Concerns corrected in a timely man at our monthly Quality Assenting. Report of finding reported to our QA communication or amendment of plan. | te duct irst HVAC n 200 hall o assure nintained afety ns will be ce pections noke duct form. liance to will be ner. monitored ssurance gs will be ittee to | |
| -* | Based on observati approximately 11:00 was noted. 1) The smoke dami | not met as evidenced by: on on Monday 11/19/12 at AM onward the following per located in the smoke wall 00 hall did not close upon alarm system. | | | | | |

the section of the section of the property of the section of the s

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION | (X3) DATE SU COMPLE | |
|--------------------------|---|---|----------------------|---|--|----------------------------|
| | | 0.174.00 | A, BUILDI B, WING | | 1.11 | Non to |
| | ROVIDER OR SUPPLIER | 345186 | S1 | REET ADDRESS, CITY, STATE, ZIP CODE 413 WINEGOFF SCHOOL ROAD CONCORD, NC 28027 | |)/2012 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| K 058 | supervised. There supply for the syste systems are equipp | Protection Systems. It is fully is a reliable, adequate water m. Required sprinkler ed with water flow and tamper electrically connected to the | K 056 | B. Installation of sprinkler completed by qualified yendor. 2. Identify other life safety having the potential to a residents by the same depractice: | outside issues ffect | |
| | Based on observat approximately 11:00 was noted. 1) There are show rooms that were no coverage. Facility is equipped door that 100% sprinkler cove 42 CFR 483.70(a) NFPA 101 LIFE SA | FETY CODE STANDARD oke barriers by ducts are | K 104 | A. Facility will inspect all s 200 hall weekly x4 then assure sprinkler coveras properly maintained in with NFPA 25, standard inspection, testing, and maintenance of Water-I Protection System. Inspection of the completed by Mainte Director and/or Admini. Outcome of inspections documented on showers sprinkler coverage audit 3. Measures will be put into place or what sy change facility will make that the deficient practic recur: | monthly to ge is accordance i for the Based Fire ections will nance strator. will be (200 hall) tool. stemic to ensure | , |
| | Based on observation approximately 11:00 was noted. 1). The smoke dam | o not met as evidenced by: on on Monday 11/19/12 at 0 AM onward the following per located in the smoke wall 200 hall did not close upon alarm system. | | A. Facility will inspect all second assure sprinkler coverage properly maintained in a with NFPA 25, standard inspection, testing, and maintenance of Water-b Protection System. Inspection System. Inspection Completed by Mainten Director and/or Administrations. | nonthly to te is accordance for the ased Fire actions will | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| CENTE | VO LOK MEDICAKE | & MEDICAID SERVICES | | <u>,</u> | | OM GIMO | , 0930-038 |
|--------------------------|--|---|-------------------|----------|---|--|-------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | - | ONSTRUCTION 02 - BUILDING 02 | (X3) DATE S COMPL | |
| | | 345186 | B. Wil | IG | · · · · · · · · · · · · · · · · · · · | 11/1 | 9/2012 |
| | PROVIDER OR SUPPLIER | | | 413 WI | DDRESS, CITY, STATE, ZIP COD NECOFF SCHOOL ROAD ORD, NC 28027 | PE . | • |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | x | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ADDESIGENCY) | SHOULD BE | COMPLETIO DATE |
| K 056 | supervised. There supply for the syste systems are equipp | Protection Systems. It is fully is a reliable, adequate water m. Required sprinkler ed with water flow and tamper electrically connected to the | К | 056 | | | |
| | Based on observat approximately 11:00 was noted. 1) There are shown rooms that were no coverage. Facility is equipped door that 100% sprinkler cove 42 CFR 483.70(a) | _ | | | | | |
| K 104 SS=F | NFPA 101 LIFE SA Penetrations of smo | | K1 | 1. | smoke damper located wall in the attic area on will have needed repair and/or replacement on completion date. | practice: in the smoke 1 200 hall is completed or before | 1-2-13 |
| | Based on observation approximately 11:00 was noted. 1) The smoke dam | on on met as evidenced by: on on Monday 11/19/12 at AM onward the following oer located in the smoke wall old hall did not close upon alarm system. | , | B. 2. | Repairs will be comple qualified outside vendo Identify other life safety having the potential to a residents by the same de practice: | r. Vissues affect | |



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIED/CLA

| 27077117 | TO FOR WEDICARE | & MEDICAID SERVICES | | <u> </u> | OMB NO | :APPRO\ . 0938-0: |
|--------------------------|---|--|---------------------|---|--|-------------------------|
| NO PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . · | TIPLE CONSTRUCTION | (X3) DATE S | URVEY |
| | | ••• | A BUILDI | NG 02 - BUILDING 02 | COMPLE | ETED |
| · | ······································ | 345186 | B. WING | | 4414 | 0/00-2-0 |
| AME OF | PROVIDER OR SUPPLIER | | 97 | REET ADDRESS, CITY, STATE, ZIP CODE | 1 11/1 | 9/2012 |
| FIVE OA | KS MANOR | | 0, | 413 WINECOFF SCHOOL ROAD | | |
| | T | | | CONCORD, NC 28027 | | |
| (X4) ID PREFIX TAG | { CACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTOR (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRICIENCY) | II D'RE | (X5) COMPLET DATE |
| | ' | FETY CODE STANDARD | K 104 K 147 | located in the smoke wall i attic area on 200 hall to as closes properly upon activ | in the sure it ation of | |
| | This STANDARD is | equipment is in accordance anal Electrical Code. 9.1.2 not met as evidenced by: | | the fire alarm system. Mai Director will complete inspectly x4 then monthly. O of inspections will be documented on smoke damper attic are hall) audit tool. | ntenance pections putcome mented | |
| | approximately 11:00 was noted. 1) The exhaust fans 223, 221 and other re did not operate when | on on Monday 11/19/12 at AM onward the following in the resident bathrooms esident bathroom on the hall checked. | | 3. Measures will be put in or v systemic change facility will to ensure that the deficient does not recur: | lmake | |
| . ' | nad did not operate w | n the soiled utility room 200 when checked. | | A. Facility will inspect smoke of located in the smoke wall in attic area on 200 hall to assicloses properly upon activate the fire alarm system. Main Director will completed inspected weekly x4 then monthly. Out of inspections will be docum on smoke damper attic area hall) audit tool. B. Any identified non-compliant concerns will be reported to Administrator. Concerns will corrected in a timely manner. | the ure it tion of tenance pections tcome ented (200 | • |
| - | | | | 4. Corrective action will be mon at our Quality Assurance mon meeting. Report of findings we reported to our QA committee review for continued intervent amendment of plan. | nthly /ill be e to | |

| CENTE | RS FOR MEDICARE | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | D: 11/20/2012 AAPPROVED D: 0938-0391 | |
|---|--|---|--|--|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | i | (X2) MULTIPLE CONSTRÚCTION A. BUILDING 02 - BUILDING 02 | | (X3) DATE | (X3) DATE SURVEY COMPLETED | |
| 345186 | | B. Wi | B. WING | | 44/40/2042 | | | |
| NAME OF PROVIDER OR SUPPLIER FIVE OAKS MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027 | | | | 19/2012 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ix | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY) | SHOULD BE COMPLETION | | |
| K 104 K 147 SS=F | 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD | | | 104 | Outcome of inspections documented on shower sprinkler coverage aud any identified non-conconcerns will be report Administrator. Concerns corrected in a timely m | | | |
| | This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The exhaust fans in the resident bathrooms 223, 221 and other resident bathroom on the hall did not operate when checked. 2) The exhaust fan in the solled utility room 200 had did not operate when checked. | | · · | | 4. Corrective action will be at our Quality Assurant meeting. Reported of finds the reported to our QA or review for continued in amendment of plan. | ce monthly adings will committee to | | |
| | 42 CFR 483.70(a) | ÷ | | | | | | |
| | | | | And the second s | | | | |
| | | | | | | | | |

| STATEMEN | NT OF DEFICIENCIES | WINDOWS TO SERVICES | | · | | OMB NO | <u> </u> | |
|------------------------------|--|---|------------|----------------------------|---|-------------------|--------------------|-----|
| AND PLAN | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 4 7 | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
| * | | | A. BUILD | DING | 02 - BUILDING 02 | COMP | LETED | |
| 3, | · | 345186 | B. WING | · | | | | |
| NAME OF PROVIDER OR SUPPLIER | | | 11/19/201 | | | | 19/2012 | |
| FIVE OA | AKS MANOR | | ľ | 413 V | ADDRESS, CITY, STATE, ZIP CODE VINECOFF SCHOOL ROAD | | | |
| | | | | | CORD, NC 28027 | | | |
| (X4) ID PREFIX | I CACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | lD | T | PROVIDER'S PLAN OF CORRECT | ПОИ | (VE) | |
| TAG | REGULATORY OR LS | GC IDENTIFYING INFORMATION) | PREFIX TAG | | (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | ILD'RE | COMPLETION DATE | ¥ ; |
| Ķ 104 | i man i i om bag | ge 4 | K 104 | 4 | | | | |
| K 147 | 42 CFR 483.70(a) NFPA 101 LIFE SAF | ETY CODE STANDARD | 1 | | • | | | |
| SS=F | | • | K 147 | 1 . | Community of the second | | | |
| | Electrical wiring and with NFPA 70, Natio | equipment is in accordance onal Electrical Code, 9.1.2 | | | Corrective action(s) accommode to correct the deficient practice. | plished ctice: | 1-2-13 | |
| | • | | | A | . Exhaust fans in resident ba | throoms | | |
| | • | | | | #223, #221 and any other re | esident | | İ |
| - | This STANDARD is | not met as evidenced by: | | | bathrooms which do not on | erate | | |
| | approximately 11.00 | on on Monday 11/19/12 at | | В. | properly will be replaced. Exhaust fan in the soiled uti | 1114. | | |
| 1 | was noted. | AM onward the following | | | room 200 hall will be replace | nty red. | | 1 |
| . | 1) The exhaust fans | in the resident bathrooms | · | C. | Replacement of exhaust fan | s will be | | |
| | 223, 221 and other red did not operate when | esident bathroom on the hall | | | completed by Maintenance | | | |
| [] | The exhaust fan ir had did not operate w | the solled utility room 200 | | | Director on or before compl date. | letion | | |
| • 1 | | | | 2. | other me atter than | es | | |
| 1 | 42 CFR 483.70(a) | | | | having the potential to affect | t 1 | | |
| 1 | | , | | | residents by the same deficie practice: | nt | | |
| | , | * | | | practice. | | 1 | |
| | | | į | A. | Facility will inspect weekly x | 4 then | | |
| .] | | | | | monthly, all exhaust fans loc | ated on | | l |
|] | | | | | 200 hall to assure operating properly and in compliance | | | ļ |
| | | | | | according to Life Safety Cod | | | |
| | | | | | Standard. Inspections will be | | | |
| | | | | | completed by Maintenance | 1 | | |
| | | 70 | . | | Director. Outcome of inspect will be documented on exhau | ions | | |
| | | | | | 200 hall audit tool. | st tans | | |
| | | | | 3. | Measures will be put into place | e or | | |
| | | | - | | what systemic change facility make to ensure that the defici | will | | |
| - | | | | | practice does not recur: | ent | | |
| | | | - | | | | . | |

| STATEMEN | OF DEFICIENCIES | & MEDICAID SERVICES | | | OMB NO | 0.0938-039 | |
|--|---|--|------------|--|---|-------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | | A. BUILDI | NG 02-BUILDING 02 | | | |
| | • | 345186 | B. WING | | | | |
| NAME OF | PROVIDER OR SUPPLIER | | | | | 19/2012 | |
| FIVE O | AKS MANOR | | 1 | reet address, city, state, zip cod 113 Winecoff school road CONCORD, NC 28027 | Ē | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORF | · | _ | |
| PRÉFIX TAG | 1 (EACH DELICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION S GROSS-REFERENCED TO THE AI DEFICIENCY) | HOURDE | (X5) COMPLETION DATE | |
| | 42 CFR 483.70(a) NFPA 101 LIFE SAF Electrical wiring and with NFPA 70, Natlo This STANDARD is Based on observation approximately 11:00 was noted. 1) The exhaust fans 223, 221 and other redid not operate when | equipment is in accordance conal Electrical Code, 9.1.2 not met as evidenced by: on on Monday 11/19/12 at AM onward the following in the resident bathrooms esident bathroom on the hall checked. | K 104 | A. Facility will inspect week monthly, all exhaust fans 200 hall to assure operat properly and in complian according to Life Safety Standard. Inspections will completed by Maintenan Director. Outcome of ins will be documented on ex 200 hall audit tool. B. Any identified non-comp concerns will be reported Administrator. Concerns corrected in a timely man at our Quality Assurance meeting. Report of finding reported to our QA comm review for continued inter amendment of plan. | dy x4 then s located on ing nce Code ill be ce pections chaust fans liance to will be ner. unonitored monthly s will be | | |
| The state of the s | | | | | | | |
| [| | | | | ſ | | |