DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES			AI "A" FORI		
STATEMENT	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY		
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:		
FOR SNFs AN	ID NFS	345186	B. WING	10/9/2014		
NAME OF PR	OVIDER OR SUPPLIER	STREET ADDRESS	, CITY, STATE, ZIP CODE			
FIVE OAKS MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC			
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	NCIES				
F 203	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE					
	Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.					
	Except as specified in paragraph $(a)(5)(ii)$ and $(a)(8)$ of this section, the notice of transfer or discharge required under paragraph $(a)(4)$ of this section must be made by the facility at least 30 days before the resident is transferred or discharged.					
	Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under $(a)(2)(iv)$ of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph $(a)(2)(i)$ of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph $(a)(2)(ii)$ of this section; or a resident has not resided in the facility for 30 days.					
	The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally is not met as evidenced by: Based on staff and physician interview and record review the facility failed to give the required discharge notice to 1 of 2 resident 's (Resident # 1) when the facility determined the resident no longer required skilled nursing care but the resident indicated she was not yet ready for discharge to a lower level of care. The findings included: Resident # 1 was admitted 2/21/14 with cumulative diagnoses including acute myelitis, shunted pseudotumor cerebri, depression and anxiety. Review of the Admission Minimum Data Set (MDS) dated 3/4/14 revealed Resident # 1 was cognitively intact. Review of the Participation in Assessment and Goal Setting section of the MDS revealed that Resident # 1 participated in the assessment and " expects to be discharge to a nother facility/institution. "					
	Review of the Care Plan revealed a pla Rehabilitation). " The approaches for with home health. Review of the 72 hour meeting notes what are the resident 's long term plan	cuses on strategies to dated 3/6/14 reveale	o facility discharge back home to the c ed the following documentation under	ommunity the heading "		

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

The above isolated deficiencies pose no actual harm to the residents

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	TOF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY		
NO HARM W	/ITH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:		
FOR SNFs A	ND NFs	345186	B. WING	10/9/2014		
NAME OF PROVIDER OR SUPPLIER FIVE OAKS MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD			
		CONCORD, NC				
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE	INCIES				
F 203	Continued From Page 1					
	 According to the signatures present on the Social Worker and 4 other staff me Further review of the Care Plan reveal hand written notation that it was discord in the Care Plan. Review of the Social Progress Notes ff 2/24/14: "Res in facility for STR." 3/25/14: "Res plans to be in facility in her home and states she wants to be 5/20/14: "Res has adjusted to being Review of the Medical Record from ad notice with the reason for discharge an Review of the North Carolina Medicai Resident # 1 's level of care was check was signed by the physician. Review of the Nursing Notes revealed During interview with the Ombudsmar resident had told her that she did not ff manage the level of care she still requia agreement with the Social Worker on 14 Resident #1 because the Resident 's pl Rehabilitation and then be discharged care as determined by the physician. Interview with the Administrator on 10 had been self-initiated because when s that he was not aware a Discharge Note discharged and question the facility 's closer. 	the form the resider mbers. ed the discharge pla ntinued on 3/25/14. rom 2/24/14 through for LTC (long term of transferred to an AI in facility. Enjoys I dmission on 2/21/14 dd information about d Program Long Ter- ced as domiciliary; t ed 7/2/14 revealed an le. Resident # 1 was di n, on 10/8/14 at 11:2 eel ready to leave the red. The Ombudsm she had met her max a said that staff at the uld receive a Discha 0/8/14 at 4 PM reve lan at admission had to an ALF and becau 0/9/14 at 8 AM revez he was first admitted ice was required wh (physician ' s) deter 4 at 10:49 AM reve with Resident # 1 in er because her function gress had plateaued n services. He also nd to appreciate the	ALF (Assisted Living Facility) - (name of facility) in Albemarle ". the form the resident and her mother attended the meeting along with nbers. d the discharge plan of care had a hand written strike through it and a tinued on 3/25/14. An updated discharge plan of care was not present om 2/24/14 through 5/20/14 (the date of the last entry) revealed: or LTC (long term care). States she is unable to care for herself alone ransferred to an ALF or another SNF near home once ready ". n facility. Enjoys her private room. " mission on 2/21/14 to discharge on 7/8/14 revealed that a Discharge l information about the resident 's right to appeal was not present. Program Long Term Care Services form dated 6/26/14 revealed ed as domiciliary; the SNF level of care was unchecked. This form 17/2/14 revealed an order to discharge Resident #1 to an Assisted			

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EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES	-		A "A" FOR
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O HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM DR SNFs AND NFs		A. BUILDING:	COMPLETE:
	345186	B. WING	10/9/2014
AME OF PROVIDER OR SUPPLIER		CITY, STATE, ZIP CODE	•
IVE OAKS MANOR	413 WINECOFF SCHOOL ROAD		
	CONCORD, NC		
) REFIX			
AG SUMMARY STATEMENT OF DEFICIE	ENCIES		
F 203 Continued From Page 2			
revealed that he explained to the resid Resident #1 then started asking about orthopedic related, the Physician said orthopedics. The Physician also indic discharge notice in this case	what her orthopedist there was no need to	thought of this, but since her limitatio delay discharge in order to complete a	ons were not a referral to
1099 E	vent ID: JEMN11		If continuation shee

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