1/6/2019

PRINTED: 12/15/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
						1	c '
		345442	B, WING			11/	20/2014
	PROVIDER OR SUPPLIER T OAKES HEALTHCA	RE CENTER		620	REET ADDRESS, CITY, STATE, ZIP CODE HEATHWOOD DRIVE BEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000 F 164 SS=D	There were no defithis complaint invest 483.10(e), 483.75(i PRIVACY/CONFID The resident has the confidentiality of his records. Personal privacy in medical treatment, communications, privacy of family and the confidential treatment.	iciencies cited as a result of stigation (NC97104).)(4) PERSONAL ENTIALITY OF RECORDS e right to personal privacy and s or her personal and clinical cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private		164	This Plan of Correction does not constitute and admission or agreemen by the provider of the truth of the fact alleged or conclusions set forth in thei Statement of Defliencies. This Plan of Correction is prepared solely because is required by state and federal law. F-164 1. Residents #66, #58 and #36 had privacy and confidentiality provided following intervention during the surve The nurse was immediately retrained the Director of Clinical Services on privacy and confidentiality on 11/19/2014.	s s ist	
	section, the resider release of personal individual outside the The resident's right and clinical records resident is transferr institution; or record. The facility must ke contained in the resident or storage release is required healthcare institution contract; or the resident REQUIREMENT.	to refuse release of personal does not apply when the ed to another health care I release is required by law. ep confidential all information sident's records, regardless of methods, except when by transfer to another n; law; third party payment			 All residents residing in the facilithave the potential to be affected. All nursing staff were retrained of the need to always maintain privacy at confidentiality during the provision of care and for personal information by the Director of Clinical Services on 12/16/2014. Any additional nurses will be trained on privacy and confidentiality before they are able to work. The Director of Clinical Services/Assistant Director of Clinical Services/Nurse Manager will conduct Quality Improvement monitoring of not less than 3 nurses on a given monitoring day, to encompass all three shifts and 	on he lity	
ADODATOD		ION AND STATE INTERVIEW, THE	ATURE		include at least one weekend date per	·	(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

Electronically Signed

Event ID: Z74U11

Facility ID: 923154

		& MEDICAID SERVICES	(X2) MUI	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
STATEMENT AND PLAN C	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					COMPLETED	
						0	0/2014
		345442	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	1 1112	0/2014
NAME OF	PROVIDER OR SUPPLIER				20 HEATHWOOD DRIVE		
FORRES	T OAKES HEALTHO	ARE CENTER			LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	CACH DESICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 164	facility failed to en and clinical record exposing the med (MARs) containing diagnoses and list (Residents # 66, # residents observed 1. On 11/19/14 at observed passing observed to enter administer the moserved on top on the in view of the open and the resumment of medications were of medication cart. On 11/19/14 at 8 to enter the room the medications.	sure that residents' personal is were kept confidential by ication administration records g the resident's name, it of medications for 3 #58 and # 36) of 3 sampled id. Findings included: 7:59 AM, Nurse #5 was g medications. She was the room of Resident #66 to edications. The MAR book was nurse. The book was wide ident's name, diagnoses and list ere exposed. Non licensed staff bserved walking by the 13 AM, Nurse #5 was observed to of Resident #58 to administer. The MAR book was observed dication cart and was not in view.		164	month .Quality Improvement will to place 5 times weekly for 2 months, 3 times weekly or 4 weeks, then 1 weekly for 2 months, then monthly months ensure that privacy and confidentiality is maintained. The Director of Clinical Services or Des will immediately retrain the Nurse any breech in privacy or confident The results of the Quality improve monitoring will be reported by the Director of Clinical Services/Assist Director of Clinical Services/Nurse Manager to the Quality Assurance Performance Improvement Commonthly for six months for continuously substantial compliance and/or results.	ignee ifor ciality. cment e ant e nittee nued	
	resident's name, medications wer	e book was wide open and the diagnoses and list of e exposed. Non licensed staff observed walking by the					
	was interviewed supposed to cov the MAR when u would talk to the	3:15 AM, Administrative staff #3 . She stated that nurses were rer the resident's information on unattended. She added that she nurse to remind her to cover the attended. At 8:20 AM, taff #3 was observed talking with	e				12-18-1

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ 11/20/2014 B. WING 345442

AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 620 HEATHWOOD DRIVE FORREST OAKES HEALTHCARE CENTER ALBEMARLE, NC 28001 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG DEFICIENCY) TAG F 164 Continued From page 2 F 164 Nurse #5. On 11/19/14 at 8:20 AM, Nurse #5 was observed in the room of Resident #36. The MAR book on top of the medication cart was observed wide open and the resident's name, diagnoses and list of medications were exposed. The medication cart was not in view of the nurse. Non licensed staff members were observed walking by the medication cart. At 8:21 AM, Nurse #5 went to the nurse's station to get blood pressure cuff and went back to the resident's room to check the blood pressure. After checking the blood pressure, she went back to the nurse's station to return the blood pressure cuff. F-278 On 11/19/14 at 8:23 AM, Nurse #5 was interviewed. She stated that she tried to close Resident #39 was the MAR or cover the information when she left evaluated by Physical the medication cart but she forgot. She further Therapy on 11/20/14. stated that she worked night shift with fewer Physical Therapy began distraction than day shift. F 278 treating Resident #39 on 483.20(g) - (j) ASSESSMENT F 278 ACCURACY/COORDINATION/CERTIFIED 11/20/2014 and plans to SS=D continue physical therapy The assessment must accurately reflect the times 30 days or as long as resident's status. necessary. 2. All residents residing in the A registered nurse must conduct or coordinate facility have a potential to each assessment with the appropriate be affected. participation of health professionals. Minimum Data Set Nurse

assessment is completed.

A registered nurse must sign and certify that the

Each individual who completes a portion of the

was retrained on accuracy of coding minimum data

sets by the Regional

Director of Nursing of

PRINTED: 12/15/2014

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY** PLETED
TATEMENT (ND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1	o 🧗 📗
		345442	B. WING			11/2	20/2014
	ROVIDER OR SUPPLIER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE ILBEMARLE, NC 28001		
FORRES	TOAKES HEALTHC		ID.	A	E SUMPERIO DI ANI DE CORRECTI	ONI D.BE	(X6) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
	Continued From p assessment must that portion of the	sign and certify the accuracy or	l.	278	by Director of Clinical Services on reporting		
	Under Medicare a willfully and know false statement in subject to a civil r	and Medicaid, an individual who ingly certifies a material and a resident assessment is money penaity of not more than			changes in range of motion and filling out referrals on 12/16/2014. A review for Range of Motion of all residents residing in the facility was completed by	÷	
	to certify a mater resident assessm penalty of not mo assessment.	vingly causes another individual lal and false statement in a nent is subject to a civil money ore than \$5,000 for each			the Unit Manager and a staff nurse on 12/17/2014 Any resident with a noted change or deficits in rang of motion was referred to	1. 1 e	
	material and fals			÷	therapy on 12/17/2014 b the Unit Manage. Additionally, the range of motion audit was	У	
	by: Based on staff i	MENT is not met as evidenced interview and record review, the accurately assess range of a sampled resident (Resident # gs included:			compared to the Minima Data Sets and Resident's Care Plan by the Unit Manager and Minimum Data Set Nurse and any	erzinen i francusken erinten erak zu	
	readmitted on 7 included flaccid dementia and c	vas admitted on 1/9/09 and 1/1/14. Cumulative diagnoses hemiplegia dominant side, erebral vascular accident.	The second secon		corrections needed were completed on 12/18/20 by the Unit Manager and Minimum Data Sheet Nurse.	14	
	dated 6/24/14 right knee extension was reviewed this dand interview was and interview was and interview was an extension of the control of th	Physical Therapy (PT) evaluation evealed that Resident #'s 39's nsion was - 45 and her left knee also -45. Physical Therapist #1 locument on 11/19/14 at 2:23 Pt with PT #1 at this time revealed to meant the resident's knee wall would need to extend a further	vi an		4. The Director of Clinical Services/Assistant Director of Clinical Services will conduct Quality Improvement monitoring on 3 Minimum Data Services and Care Plans per week	ng ts	12-187

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(Y2) MIH 3	CIPLE (CONSTRUCTION	(X3) DATE SU	RVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				}	
AND PLAN OF	CORRECTION	IDEM III IO WIEW I	/t. BOILE.			C	
		345442	B. WING			11/20/2	2014
	and output ICD	040112		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
1	ROVIDER OR SUPPLIER				HEATHWOOD DRIVE		
FORRES	T OAKES HEALTHC	ARE CENTER		AL	BEMARLE, NC 28001		(V6)
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRESS OF THE APPROPRIED TO THE		(X5) OMPLETION DATE
F 278	Continued From p degrees to have fir range of motion the 0). The Annual Minim Assessment date was cognitively in and had an upper impairment on on range of motion in During interview 1:40 PM she ack Physical Therapy 39 had bilateral I therefore decrea indicated that ba 7/8/14 MDS was motion. 483.20(d), 483.2 COMPREHENS A facility must us to develop, review comprehensive The facility must plan for each repolicetives and the medical pursion.	age 4 Ill range of motion (with full le knee extension would equal num Data Set (MDS) d 7/8/14 revealed Resident #39 hpaired, had not rejected care extremity range of motion in eside and a lower extremity mpairment on 1 side. With Nurse #2 on 11/20/14 at nowledged that the 6/24/14 evaluation indicated Resident accorded and a lower extremity contractures and sed range of motion. She sed on this information the inaccurately coded for range of the contracture of the	F:		ensure accuracy for 1 month, then 1 Minimum Data Set and Care Plan per week for 3 months, then 1 Minimum Data Sheet and Care Plan for two months. The results of the Quality Improvement monitoring will be reported by Director of Clinical Services/Assistant Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly for six months for continued substantial compliance and/or revision. F-279 1. Resident #52 longer resides the facility. Residents #51 a #16 Care Plans and Minimu Data Sets have been review for accuracy of interventior and medications for behavi by the Social Worker and th Unit Manager on 12/17/20 any needed corrections we made by the Social Worker	in nd m ved ns dors ne 114 ere and	
	needs that are assessment. The care plan reto be furnished highest practic	dentified in the comprehensive must describe the services that a to attain or maintain the resider able physical, mental, and reli-being as required under any services that would otherwis			Unit Manager on 12/17/14 2. All residents residing in the facility with behaviors and receiving psychoactive medications have the pote to be affected.	e /or ential	12-18-14 et Page 5 of 38

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		1	c
			B. WING			•	20/2014
		345442	B, WING		TREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				20 HEATHWOOD DRIVE		
FORRES	T OAKES HEALTHC	ARE CENTER			LBEMARLE, NC 28001		
, 0, 1, 1, 1			ID	<u></u>	PROVIDER'S PLAN OF CORR	ECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	JEACH DESIGIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	DATE
					3. The interdisciplinary		,
F 279	Continued From p	age 5	F	279		/as	
1 2/0	be required under	§483.25 but are not provided			retrained on the need	to	.]
	due to the residen	t's exercise of rights under			individually plan for b	ehavioral	
	§483.10, including	the right to refuse treatment]		Interventions and for	the use of	i
	under §483.10(b)(4).	1		any psychoactive med	ications	
					by the Director of Clin		
		TAIT is not mot as evidenced	1		Services on 12/16/201	.4.	
[1	ENT is not met as evidenced			The Interdisciplinary		
	by:	review and staff interview, the			Departmental Team w		
	facility failed to ad	Idress the behavior in the care	1		weekly to review resid		
	I plan for 3 of 5 sar	nnled residents receiving	.		residing in the facility		
	psychotropic med	ications (Resident #52, #51 and	}		behaviors and/or psyc		
1	#16). Findings in	cluded:			medications to ensure Minimum Data Sets a		
					Plans are accurate.	ia care	
	The facility's polic	y and procedure on the use of			4. The Director of Clinica	.1	
	nevehotronic med	lications dated 2/20/2014 (last			Services/Assistant Dire		
-	review date) was	reviewed. The procedure			Clinical Services will a		
	included " plans	of care will be reviewed			affected residents for		
1	duarterly with the	inter disciplinary team and	į		of Minimum Data Sets	-	: [
	updated as indica	ated for management of			Plans weekly for 1 mo	nth, then	
	medications, ben	avior and interventions using d measurable goals for behavior	r Ì		1 affected resident we		į
	monagement and	psychotropic medication usage	e		months, then 1 affects	ed	
	and or reduction.	u u			resident monthly for 3	3 months.	
1			ļ		The results of the Qua	lity	
	1. Resident #52	was admitted to the facility on			Improvement monitor	ring will be	
	11/9/11 with mult	iple diagnoses including	1		reported by the Direct		
1	dementia with be	enaviors.			Clinical Services/Assis		!
	The opposed Minis	num Data Set (MDS)			Director of Clinical Ser		į
	assessment date	ad 9/11/14 indicated that			the Quality Assurance		
	Resident #52 ha	d memory and decision making	1		Performance Improve		
	problems and wa	as on antipsychotic medication.			Committee monthly to		
		4			months for continued		
	The care plan da	ated 9/11/14 was reviewed.			substantial compliand	e anoyor	
	There was no ca interventions for	are plan problem, goal and behavior management.			revision.		12-18-19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	` COM	SURVEY PLETED
		345442	B, WING	·	Military III - II	20/2014	
	PROVIDER OR SUPPLIER			62	TREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	The physician's or revealed that Res	age 6 ders for November, 2014 ident #52 was on Zyprexa 5 daily for dementia with	F	279			
	behaviors and dep psychosis.	pakote 250 mgs twice a day for				į	
	interviewed. She	47 PM, Nurse #2 was stated that the social worker or developing the care plan for	Management of the Principle of the Princ				
	was interviewed. was that residents	18 PM, administrative staff #1 She stated that her expectation s on medications for behaviors re plan developed to address ment.	The state of the s				
	was interviewed. was responsible f behavior manage	29 PM, administrative staff #4 She acknowledged that she or developing the care plan for ment. She indicated that she behavior care plan for Resident					
		vas admitted to the facility on ple diagnoses including haviors.					
	indicated that Residecision making p	S assessment dated 9/10/14 sident #51 had memory and problems and was on antianxiety drugs.					12-18-14

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		СОМІ	(X3) DATE SURVEY COMPLETED	
		345442	B. WING	i		C 11/20	
	PROVIDER OR SUPPLIER			62	REET ADDRESS, CITY, STATE, ZIP CODE 10 HEATHWOOD DRIVE LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	The care plan date There was no care interventions for be The physician's or revealed that Resi mgs at bedtime for Ativan 1 mgs at be for anxiety and de dementia with beh On 11/19/14 at 3:4 interviewed. She was responsible for behaviors. On 11/19/14 at 4: was interviewed. was that residents should have a car behavior manage On 11/19/14 at 5:2 was interviewed. was responsible for behavior manage	ed 9/10/14 was reviewed. It plan problem, goal and ehavior management. Iders for November, 2014 Ident #51 was on Seroquel 25 Ident dent with behaviors, editime and 0.5 mgs twice a day pakote 500 mgs at bedtime for aviors. If PM, Nurse #2 was stated that the social worker or developing the care plan for 18 PM, administrative staff #1 She stated that her expectations on medications for behaviors e plan developed to address		279			
	7/9/2004 with last 8/22/2008. Cumu anxiety and organ	was admitted to the facility readmission to the facility stative diagnoses included nic brain syndrome.					
	A Quarterly Minim	num Data Set (MDS) dated					12-18-14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345442	B. WING			i .	C 20/2014	
	PROVIDER OR SUPPLIER T OAKES HEALTHCA	ARE CENTER	L	6:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE LBEMARLE, NC 28001			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	and long term mem severely impaired in Inattention, disorgal level of consciousn continuously preseduring the assessmantipsychotic, anxiomedication. A care plan dated 2 9/19/14 was review problem, goal and management. The physician orderevealed that Residuality for depression medication) 12.5 medication 12.5 medicati	Resident #16 had short term nory impairment and was	F	279				
	was interviewed. S was that residents	8 PM, administrative staff #1 She stated that her expectation on medications for behaviors plan developed to address tent.						
	was interviewed. S	9 PM, administrative staff #4 She acknowledged that she r developing the care plan for	Park Annual Property Community Commu				12-18-14	

		* MEDICAID SERVICES	(VO) MIII.	TIPLE (CONSTRUCTION	(X3) DATE	SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ooko iko o	COMP	PLETED
AND PLAN OI	FCORRECTION		,,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				7
		345442	B, WING			11/2	0/2014
MANIE OF S	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
			ļ		HEATHWOOD DRIVE		
FORRES	T OAKES HEALTHC	ARE CENTER		AL	BEMARLE, NC 28001		NO.
0(0.10	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTE (EACH CORRECTIVE ACTION SHOU	ひしひ ちに こう	(X5) COMPLETION DATE
(X4) ID PREFIX	ACADA DEGICIENO	Y MUST BE PRECEDED BY FULL	PREFI TAG		CROSS-REFERENCED TO THE APPR	OPRIÁTE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY)		
F 279	Continued From p	age 9	F	279			
, •	hehavior manage	ment. She indicated that she			•		
	could not find the	behavior care plan for Resident					
	#16.		1	309	5 200	ţ	
F 309	483.25 PROVIDE	CARE/SERVICES FOR	-	308	F-309 1. The Fluid Restriction for reside	nt #50	
SS=D	HIGHEST WELL	BEING			was discontinued on 11/19/2014	by the	
	Facility and state of the state	st receive and the facility must	ļ	1	physician.	•	
	Each resident mu	ssary care and services to attain	1		2. No other residents residing in t	the	
ļ .	Lor maintain the hi	ghest practicable physical,	1	į	facility are on fluid restrictions.		
	I mental and nevel	hosocial well-being, in	1	1	3. Nursing Staff were retrained o	n the	
	accordance with	the comprehensive assessment			need for accurate Intake and Out	tput	
	and plan of care.			- 1	monitoring, as ordered by the ph	ıysician,	
Ì		•			as well as documentation when	a fluid	
			-		restriction is prescribed on 12/16	6/2014	
	This DECLUDEM	ENT is not met as evidenced			by the Director of Clinical Service	es.	
	bur		1.		4. If an order is received for a flu	ıid	
	Based on reside	int interviews, staff interviews,			restriction for a resident residing	g or	
	record reviews a	nd observations, the facility			admitted in the facility, the Dire	ctor of	
	failed to monitor	fluid intake for one of one	.		Clinical Services/Assistant Direct	or of	
.	sampled residen	t (Resident # 50) on dialysis with	1		Clinical Services will monitor for	proper	
	fluid restriction.	Findings Included:			documentation and ensure resid	lent is	
	Booldont #50 WS	as admitted to the facility on			not receiving additional free flui	ids 5	
	0/26/14 with mul	itinle diagnoses including end			times weekly for 1 month, then	3 times	
	stage renal dise	ase, renal dialysis and diabetes			weekly for 1 month, then 1 time	3 Weekly	
	mellitus.	•	1		for 2 months, then 1 time mont	inc on	
		4010144	.		months while the resident remains	alijis Oli Etho	
	A review of the I	Minimum Data Set dated 10/3/14	*		fluid restrictions. The results o	na will he	
1	revealed the res	sident was assessed as being			Quality Improvement monitoring	ical	
	cognitively intac	it. The resident was assessed as is as part of her medical	-		reported by the Director of Clin Services/Assistant of Director o	if Clinical	
	treatment.	is as part of nor modern			Services/Assistant of Director of Services to the Quality Assuran	ce	
	1				Performance Improvement Cor	mmittee	
	A review of the	Plan of Care dated 10/3/14			monthly times 6 months for co	ntinued	
	indicated the re	sident was dependent on			substantial compliance and/or	revision.	
	hemodialysis to	sustain life due to end stage	1		Substantial compliance and/or		12-18-1
	renal disease.		İ				10101

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		LE CONSTRUCTION	COM	E SURVEY PLETED
		345442	B. WING	i	-440-4-100 - 100 -		C 20/2014
	PROVIDER OR SUPPLIER	ARE CENTER		6	STREET ADDRESS, CITY, STATE, ZIP CODE 520 HEATHWOOD DRIVE ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X6) COMPLETION DATE
F 309	order dated 10/28/centimeters per da hemodialysis." A review of the Phyorder dated 11/17/cubic centimeters centimeters nursin evenings)/1100 cucubic centimeters centimeters lunch/ A review of the Me (MAR) dated Octobated 10/28/14 wh Information: 1400 There was no doctifuid consumed by MAR dated Octobated 10/28/14 wh Information: 1400 centimeters (cc) = nursing 150 cc dobreakfast + 240 = was no documentated to summed by the redated November 2 A review of the Nu 11/19/14 was consisted "Order for " A note dated 10/1400 cc fluid restricted to the summer of the summer of the nutility of the nutility of the nutility of the nutility of the Nu 11/19/14 was consisted "Order for " A note dated 10/1400 cc fluid restricted to the nutility of the nut	ysician's Orders revealed an 14 which stated " 1400 cubic by fluid restriction due to ysician's Orders revealed an 14 which stated " Clarify 1400 fluid restriction: 300 cubic g (150 days/150 bic centimeters dietary (620 breakfast/240 cubic 240 dinner). " dication Administration Record ber 2014 revealed an entry ich stated " For Your fluid restriction per day. " umentation of the amount of the resident recorded on the er 2014. AR dated November 2014 which stated " For Your fluid restriction 300 cubic days/150 cc evenings/ 620 cc = lunch 240 = dinner. " There ation of the amount of fluid resident recorded on the MAR 2014. Tress Notes from 10/28/14 until ducted. A note dated 10/28/14 until ducted. A note dated 10/28/14 until ducted. A note dated 10/28/14 1400 cc fluid restriction today. (29/14 stated " Resident is on ctions. Able to voice needs."	F	309			
		7/14 stated " Clarify 1400 cc					12-18-14

NAME OF PROVIDER OR SUPPLIER FORREST OAKES HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I (DESITIONATION III)			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
FORREST OAKES HEALTHCARE CENTER (XA) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 11 fluid restriction and made notation." No documentation regarding the amount of fluid consumed by the resident was observed. No documentation of the resident receiving education regarding the fluid restriction was observed. No documentation of the resident was observed. No documentation of the resident was observed. No documentation of the resident receiving education regarding the fluid restriction was observed. A review of the Interdisciplinary Progress Notes was conducted. A dietary note dated 11/17/14 stated "Will clarify fluid restriction to 1400 cc. 300 cc nursing (150 day/150 evening) and 1100 cc dietary (620 breakfast/240 dinner/240 lunch)." An interview was conducted with Nurse #3 on 11/19/14 at 10:53 AM. Nurse #3 stated that fluids were to be measured by the nursing staff before being offered to the resident. Nurse #3 observed an ice pitcher on the resident's bedside table and stated that the ice pitcher should not have been in the resident's meal trays and additional fluids were to be measured by the nursing staff before being offered to the resident. Nurse #3 observed an ice pitcher on the resident's bedside table and stated that the ice pitcher and the resident was on compliant with the fluid restriction. An interview was conducted with Nursing Assistant (NA) #1 on 11/19/14 at 11:01 AM. NA #1 stated the resident was son compliant with the fluid restriction.			345442				l	- 1
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 11 fluid restriction and made notation. "No documentation regarding the amount of fluid consumed by the resident was observed. No documentation of the resident being non compliant with the fluid restriction was observed. No documentation regarding the risks associated with being non compliant with the fluid restriction was observed. A review of the Interdisciplinary Progress Notes was conducted. A dietary note dated 11/17/14 stated "Will clarify fluid restriction to 1400 cc: 300 cc nursing (150 day/150 evening) and 1100 cc dietary (620 breakfast/240 dinner/240 lunch). " An interview was conducted with Nurse #3 stated the resident was on fluid restrictions. She stated the fluids were provided on the resident's meal trays and additional fluids were to be measured by the nursing staff before being offered to the resident. Nurse #3 observed an ice pitcher on the resident's send that the ice pitcher should not have been in the resident's accognitively intact and was capable of drinking from an ice pitcher without assistance from the staff. Nurse #3 stated the resident was not compliant with the fluid restriction. An interview was conducted with Nursing Assistant (NA) #1 on 11/19/14 at 11:01 AM. NA #1 stated the resident was serviced to 1400 cc			ARE CENTER	ı	E	320 HEATHWOOD DRIVE	1 1/2	
fluid restriction and made notation. "No documentation regarding the amount of fluid consumed by the resident was observed. No documentation of the resident being non compilant with the fluid restriction was observed. No documentation of the resident reciving education regarding the risks associated with being non complaint with the fluid restriction was observed. A review of the Interdisciplinary Progress Notes was conducted. A dietary note dated 11/17/14 stated "Will clarify fluid restriction to 1400 cc: 300 cc nursing (150 day/150 evening) and 1100 cc dietary (620 breakfast/240 dinner/240 lunch). " An interview was conducted with Nurse #3 on 11/19/14 at 10:53 AM. Nurse #3 stated the resident was on fluid restrictions. She stated that fluids were provided on the resident's meal trays and additional fluids were to be measured by the nursing staff before being offered to the resident. Nurse #3 observed an ice pitcher on the resident's room. She stated that en the resident's bedside table and stated that the ice pitcher should not have been in the resident's room. She stated the resident was given ice upon request only. She stated the resident was cognitively intact and was capable of drinking from an ice pitcher without assistance from the staff. Nurse #3 stated the resident was not compliant with the fluid restriction. An interview was conducted with Nursing Assistant (NA) #1 on 11/19/14 at 11:01 AM. NA #1 stated the resident was restricted to 1400 cc	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	(X5) COMPLETION DATE	
came on her meal trays and the nursing staff	F 309	fluid restriction and documentation regionsumed by the redocumentation of the compliant with the redocumentation regarding being non complain observed. A review of the Interview of the Intervi	made notation. "No arding the amount of fluid esident was observed. No he resident being non fluid restriction was observed. of the resident receiving gothe risks associated with hit with the fluid restriction was redisciplinary Progress Notes dietary note dated 11/17/14 fluid restriction to 1400 cc: 0 day/150 evening) and 1100 akfast/240 dinner/240 lunch). "Onducted with Nurse #3 on M. Nurse #3 stated the did restrictions. She stated that do not he resident's meal trays is were to be measured by the being offered to the resident. In the resident was given ice upon tated the resident was given ice upon tated the resident was not divid restriction. Inducted with Nursing without assistance from the red the resident was not fluid restriction.	F	309			1.2-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345442	B. WING				C 20/2014
	PROVIDER OR SUPPLIER	<u> </u>		6	STREET ADDRESS, CITY, STATE, ZIP CODE 520 HEATHWOOD DRIVE ALBEMARLE, NC 28001	1 1172	20/2014
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	administration. NA requested addition were expected to in resident did not existated the nursing pitcher three times #1 picked up the ic resident's bedside was approximately An interview was c Staff #3 on 11/19/1 intake and output with the resident becaudrink water. An interview was c Staff #1 on 11/19/1 nursing staff was of fluid with each admistated the nursing sto give the resident during the evening given at night. Admiamount of fluids conot being document was cognitively interfluid restriction. Shoompliant with the stated the nursing the resident regard restriction. An interview was c on 11/19/14 at 3:48 was aware her fluid restricted. She stated to its construction of the stated the stated the nursing the resident regard restriction.	#1 stated if the resident al fluid, the nursing assistants inform the nurse to ensure the ceed her daily amount. She assistants fill the resident's ice a day with water and ice. NA e pitcher located on the table and stated the pitcher a little less than half full. onducted with Administrative 4 at 12:31 PM. She stated was not being documented on se the resident had the right to onducted with Administrative 4 on 2:11 PM. She stated the ffering approximately 120 cc of inistration of medication. She staff was aware they were only at 150 cc during the day, 150 cc and that no fluids were to be inistrative Staff #1 stated the insumed by the resident was not fluid restriction. She further staff was expected to educate ling the need for the fluid onducted with Resident #50 B PM. The resident stated she dintake was supposed to be ed she had requested to have did and the staff was filling the	F	309			12-18-14

		& MEDICAID SERVICES	(X2) MUL	TIPLE	CONSTRUCTI	ON	(X3) DATE	SURVEY LETED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						<u> </u>
WAD LEVIA OF	COMMEDMAN						11/2	0/2014
		345442	B, WING			S, CITY, STATE, ZIP CODE	1 11/2	012014
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRES HEATHWO			
		ADE CENTER			BEMARLE,			
FORRES	T OAKES HEALTHC				222	ADEDIC DI AN OF CORRECTIO	NC	(X5) COMPLETION
(X4) ID PREFIX TAG	ALAND DECIDIENT	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		/FACH	CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROL DEFICIENCY)	.טוב נ	DATE
<u> </u>			 F	309				
F 309	Continued From p	age 13	•	303				
	pitcher at least twi	ce a day.	F	318	F-318			
F 318	483.25(e)(2) INCF IN RANGE OF M	REASE/PREVENT DECREASE				D. 111. 111. 1120	ad by	
SS=D	IN RANGE OF ME	JION			1.	Resident #39 was evaluate Physical Therapy on 11/20		
	Based on the com	prehensive assessment of a				Physical Therapy began tre		
	resident the facili	ty must ensure that a residerit		^ {		Resident #39 on 11/20/20		
	with a limited rand	ne of motion receives	1	l		and plans to continue phy		
	appropriate treatr	nent and services to increase ind/or to prevent further				therapy times 30 days or a	s long	
	decrease in range	e of motion.				as necessary.	:	
	decrease in range	3 Of Motions			2.	All residents residing in th		
			İ			facility have a potential to	be be	
		, , , , , , , , , , , , , , , , , , ,	Ì			affected.		
	This REQUIREM	ENT is not met as evidenced			3.	All nursing staff have been		
1	by:	vation, staff interview and record			ļ,	retained by the Director o		
	the facilit	v failed to continue interventions)			Clinical Services on 12/16		
	I in provent a fifth	iar decline in tallue di lliquoti idi				on reporting changes in ra		
	1 of 1 sampled re	esident (Resident # 39). The				motion and filling out the referrals. A review for Rar		
1	findings included	!:				Motion of all residents re		
		-ttd on 4/0/00 and		•	`	in the facility was comple		
	Resident # 39 W	as admitted on 1/9/09 and 1/14. Cumulative diagnoses	Ì			the Unit Manager and a s		
	readmitted on //	hemiplegia dominant side,				nurse on 12/17/2014. An		
	dementia and ce	erebral vascular accident.				resident with a noted cha		
	1					deficit in range of motion		
	The Annual Mini	mum Data Set (MDS)	0			referred to therapy on	ı	
	Assessment dat	ed 7/8/14 revealed Resident #3	٦			12/17/2014 by Unit Mana		
	was cognitively	impaired, had not rejected care er extremity range of motion				and/or staff nurse. Resto		
	impairment on 0	one side and a lower extremity			1	nurse, Restorative Aid an		
	range of motion	impairment on 1 side.				Director of Therapy have		
	` %	*				retrained on 12/17/2014		
	Review of the C	Care Plan dated 7/16/14 revealed	,			Director of Clinical Servic		!
	Resident #39 re	equired assistance with self-care	"			training the Restorative A residents released from t		
	toileting, transfe	erring and mobility.				to restorative to maintain		12-18
	Review of the F	Physical Therapy (PT) Discharge	,			to restolative to maintain		1210
1	1 TO VIOTE OF WILL I		ţ		1 .			

PRINTED: 12/15/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

NAME OF PROVIDER OR SUPPLIER FORREST OAKES HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP GODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	COMPL	
FORREST OAKES HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DERICHENCY MUST BE PERCEDED BY FULL TAGE) Facility of the Derichency Must be Preceded by Full Regulatory of LSC Identifying Information) Tage			345442	B. WING			_	2014
PREFIX TAG F 318 Continued From page 14 Summary dated 7/5/13 (2013) revealed that Resident # 39's right knee extension was also -5. Physical Therapist #1 reviewed this document on 11/19/14 at 5:15 PM and interview at with time revealed mersident's provided on -1/10/14. Administrative Staff #7 reviewed this Restorative Report on 11/19/14 at 5:15 PM and interview at with time revealed the resident's splinting were last provided on -1/10/14. Administrative Staff #7 reviewed this Restorative Report on 11/19/14 at 5:15 PM and interview at this time revealed that Resident # 39's right knee extension was -45 and her left knee extension was also -6. Physical Therapy Discharge Summary dated 7/5/13 revealed that Resident # 39's right knee extension was also -6. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -45. Physical Therapy evaluation dated 6/24/14 revealed that Resident # 39's right knee extension was also -4					620	HEATHWOOD DRIVE BEMARLE, NC 28001	IN I	(X5)
Summary dated 7/6/13 (2013) revealed that Resident # 39's right knee extension was -5 and her left knee extension was also -5. Physical Therapist #1 reviewed this document on 11/19/14 at 2:23 PM and interview at with PT #1 at this time revealed an extension of -5 meant the resident's knee had a slight contraction and would need to extend a further 5 degrees to have full range of motion (with full range of motion the knee extension would equal 0). Further review of the Physical Therapy Discharge Summary dated 7/6/13 revealed the resident was discharged from PT services to the Restorative Nursing Program for maintenance. Review of a Restorative Report for the dates 1/1/14 - 2/16/14 on 11/19/14 at 5:15.PM revealed Passive and Active Range of Motion Services were last provided to the resident on 1/12/14 and that Restorative services for splinting were last provided on -1/10/14. Administrative Staff #7 reviewed this Restorative Report on 11/19/14 at 5:15.PM and interview at this time revealed that Resident # 39 old not receive Restorative Report on 11/19/14 at 6:14. Pwised His Restorative Report on 11/19/14 at 6:15.PM and interview at this time revealed that Resident # 39 old not receive Restorative Services provided prior to 1/1/14. Review of the Physical Therapy evaluation dated 6/24/14 revealed that Resident #s 39's right knee extension was also -45. Physical Therapy evaluation dated this document on 11/19/14 at 2:23 PM and interview with PT #1 at this time revealed an extension of -5 meant the resident on 11/19/14 at 2:23 PM and interview with PT #1 at this time revealed an extension of -6 meant the resident on 11/19/14 at 2:23 PM and interview with PT #1 at this time revealed an extension of -6 meant the resident of short at the resident on 11/19/14 at 2:23 PM and interview with PT #1 at this time revealed an extension of -6 meant the resident on 11/19/14 at 2:23 PM and interview with PT #1 at this time revealed an extension of -6 meant the resident on 11/19/14 at 2:23 PM and interview with PT #1 at this time	PREFIX	JEACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	
degrees to have full range of motion (with full range of motion would equal The results of the Quality	F 318	Summary dated 7/ Resident # 39's righer left knee exter Therapist #1 revie at 2:20 PM and infitime revealed and resident's knee hawould need to extra full range of motio knee extension with the Physical Thera 7/5/13 revealed the PT services to the for maintenance. Review of a Reston 1/1/14 - 2/16/14 or Passive and Active were last provided that Restorative services determined the Resident # 39 did Nursing Services facility did not masservices provided extension was - 4 was also - 45. Provided extension was - 4 was also - 45. Provided extension of - 45 contracted and was reviewed to have degrees to have	15/13 (2013) revealed that 15th knee extension was -5 and 16 nsion was also -5. Physical wed this document on 11/19/14 terview at with PT #1 at this extension of -5 meant the 16 a slight contraction and 16 nend a further 5 degrees to have 17 nsion of 18 nsion the 18 nsion was discharged from 18 nsion was discharged from 18 nsion was discharged from 18 nsion was discharged from 17 nsion was discharged from 17 nsion was discharged from 17 nsion was discharged from 17 nsion was discharged from 17 nsion was discharged from 17 nsion was discharged from 18 nsion was		118	daily living. The restorative nurse will continue to asses residents on restorative nur weekly with the assist of the restorative aid, this will incle the need to continue on restorative nursing/refer batherapy or to discharge from restorative nursing for a continued functional maintenance/decrease or increase in the resident's functional status or activities daily living. 4. The Director of Clinical Services/Assistant Director of Clinical Services/Assistant Director of Clinical Services (Unit Managuill conduct Quality Improvement monitoring of Range of Motion Assessmen per week for 2 months to eatherapy has received a refer and completed a "hands on screen (resident permitting), then Range of Motion Assessmen per week for 2 months to ensure therapy received a referral and completed a "hands on" screen (resident permitting), then Range of Motion Assessmen per week for 2 months to eatherapy has received a refer and completed a "hands on" screen (resident permitting) then Range of Motion Assessmen per week for 2 months to eatherapy has received a refer and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident permitting) and completed a "hands on screen (resident	s rising e ude ude uck to m es of ger f 3 ants es erral es erral es erral erra	12-18-14

PRINTED: 12/15/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COMP	LETED
		345442	B. WING			11/2	0/2014
	PROVIDER OR SUPPLIER	ARE CENTER		(STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE [(X5) COMPLETION DATE
F 318	O). Review of the Qua 10/8/14 revealed f impaired, had not upper extremity im lower extremity im	nterly MDS Assessment dated Resident #39 was cognitively rejected of care and had an apairment on one side and a pairment on both sides.		318	Clinical Services/Assistant of Director of Clinical Services the Quality Assurance Performance Improvement Committee monthly times months for continued substantial compliance and	f to	·
	2:42 PM revealed receiving Restoral Passive and Active discharge from Pt 2013). She stated discharged from F some point becaus provided splints be	Restorative Aide on 11/19/14 at that Resident #39 had been tive Nursing services for e Range of Motion post hysical Therapy services (July d that Resident #39 was Restorative Nursing Services at use the resident had been ut was non-compliant with		_	revision.		
	them, and would Aide also said that compliant with the both range of modiscontinued because discharged from Aide was uncertate continued on Research Motion, even the	take them off. The Restorative at Resident #39 had been a range of motion services but tion and the splints were ause the resident was Restorative. The Restorative in why Resident #39 was not storative for Passive Range of ugh she was only non-compliant.					
	Nurse made the resident but was In addition she re Restorative Care maintained in the facility. The providing Restoronly information to the Restorativ	She added that the Restorative decision to discharge the no longer working at the facility evealed that there were no Plans or Progress Notes e resident's medical record or in time spent with the resident ative Nursing services was the that was maintained according e Aide.					12-18-1

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COV	MPLETED C		
		345442	B. WING				/20/2014		
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP C 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001						
(X4) ID PREFIX TAG	ACACH DESIGNER	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	COMPLETION DATE		
F 318	11/19/14 at 4 PM nursing staff to range of motion Rehabilitation The Department was screen on Residents with do On 11/20/14 at measuring the dresident's knees had -55 extention extension. The procedure. 483.25(I) DRUGUE UNNECESSAR Each resident's unnecessary drug when used duplicate therapy without adequal indications for in adverse consessionald be reduced by the same of t	revealed that she expected eport identified decreases in so they could be referred to herapy. The Therapy also responsible for a quarterly ent that was expected to identify eveloping contractures. I PM observation of PT #1 legree of contractures in the at this time revealed one knee on and the other had -75 resident was cooperative with the PRUGS AREGIMEN IS FREE FROM Y DRUGS drug regimen must be free from ugs. An unnecessary drug is any in excessive dose (including by); or for excessive duration; or the monitoring; or without adequate to use; or in the presence of quences which indicate the dose ced or discontinued; or any if the reasons above. Imprehensive assessment of a cility must ensure that residents used antipsychotic drugs are not ugs unless antipsychotic drug essary to treat a specific condition and documented in the clinical sidents who use antipsychotic gradual dose reductions, and erventions, unless clinically	e	318	in the facility. residents #51, were reviewe Interdisciplina Team on 12/1 pharmacologi have been car of these resid monitoring sh implemented residents by t Director of Ci the Director of on 12/17/203 in the medica book going fo	ary Departmental 1.7//2014 and non- ical interventions re planned for each ients. Behavioral neets have been on each of these the Assistant inical Services and of Social Services 1.4 and will be kept ation administration orward. residing in the behaviors and/or	12-15-		
	contraindicated	d, in an effort to discontinue these			have the pote affected.	ential to be	121		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		0.48440	B. WING			11/2	0/2014
		345442	B. WIING		REET ADDRESS, CITY, STATE, ZIP CODE	1 1112	0,2014
	PROVIDER OR SUPPLIER T OAKES HEALTHC			62	10 HEATHWOOD DRIVE LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 329	Continued From p	age 17	F	329	On 12/1/2014 the Interdisciplinary Departmental Team was retrained on monitoring behaviors, psychoactive medications, non-		
	by: Based on record facility failed to try pharmacological i administering an (Resident # 40) a behaviors of resident for 5 40) of 5 sampled	review and staff interview, the and or to consider non intervention before antipsychotic medication and failed to monitor the lents receiving psychotropic (Residents # 52, 51, 16, 58 and residents reviewed for lications. Findings included:		-	pharmacological interventions and Behavioral Monitoring sheets. All nurses have were educated on the Behavioral Monitoring sheets by the Director of Clinical Services on 12/10/2014 and no nurses have worked prior to education on Behaviors/Psychoactive Medications/non-pharmacological interventions/Behavioral		
	facility on 10/18/1 including psychos The quarterly Mir assessment date Resident #40 had problems and had antidepressant m The care plan da One of the care psychotropic drug monitor behavior The doctor's order there was an order by mouth daily as	vas originally admitted to the 1 with multiple diagnoses sis and anxiety. imum Data Set (MDS) d 10/23/14 indicated that I memory and decision making directived antianxiety and edications. ted 10/23/14 was reviewed. It is approaches included to all symptoms and side effects. ers were reviewed. On 3/27/14, er for zyprexa 2.5 mgs 1 tablet is needed (PRN) for psychosis. The was an order to discontinue			Monitoring sheets. On 12/17/2014, the Interdisciplinary Departmental Team met and reviewed all resident care plans for behavior and/or psychoactive medications. All residents residing in the facility were reviewed and the care plans were updated by the Social Worker, Unit Manager or Minimum Safety Data Sheet Nurse to reflect the need for psychoactive medications and/or non-pharmacological interventions as indicated by th Interdisciplinary Departmental Team. In addition on		12-18-14

PRINTED: 12/15/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		& MEDICAID SERVICES	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE S	ETED
STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI			c	
		345442	B. WING			11/2	0/2014
			<u> </u>	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		1	620	0 HEATHWOOD DRIVE		
FORRES'	T OAKES HEALTHC	ARE CENTER	1	AL	BEMARLE, NC 28001		are)
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE))		(X5) COMPLETION DATE
TAG	REGULATORY ON						
					12/17/2014 Unit Manager an	ď	
F 329	Continued From p	page 18	F	329	Social Worker advised the		
1 020	the suprove 2.5 m	ngs PRN and to start zyprexa		1	Medical Director of		
ĺ	2.5 mgs by mouth	every evening.			psychoactive medications that	t	
	1			1	have not been used in the pa	st	
į	The current nhys	ician's orders (November, 2014))	1	30 days or longer with reques	st	
	Leave alad that Res	SIGANT #40 Was OII ON 2) Prond		1	for discontinuing these		
	I tambia a cabatia diri	ial 2 5 mas in the evening.			medications.		
1	/ A F was no bit	AND A MONTON SIDDIERY, ACIDIE 191	"	1	4. The Social Services		
1	I mas daily for dep	ression and desylet of may at			Director/Director of Clinical		
	bedtime for depre	ession.			Services will conduct Quality	{	
Ì	1		l		improvement monitoring to	ļ	
	The Medication	Administration Records (MARs)			ensure Behavioral Monitorin	ıg	
1	The same residence of T	THE BUILDING TO 14 WITH TOVORS	4 1		sheets are completed by		1
	Ale at Displayorf #1	n han received Zybi cxa 2.4a	• į		exception for each resident		
	Law Assessed & 11	43 14 18 22 Z4 and 20 100			having behaviors and/or on	ļ	
	I MAD for Sentem	her 2014 did fiot illulcate that	ļ		psychoactive medications 3	1	
1	Resident #40 ha	d received Zyprexa 2.5 mgs.	1		times a week for 2 months,	then	
	The MAR for Oc	tober, 2014 indicated that			times a week for 2 months		
•	Resident #40 na	and received Zyprexa 2.5 mgs on and 27. The MAR indicated that	t		1 time a week for 2 months	' \	
	October 14, 21	iving Zyprexa was yelling and			then 1 time a month for 2		
	the reason for y	Ivilia Sypicka Mae Yemio			months to ensure that non-		
-	- agitation.				pharmacological intervention)115 	
	Poviou of the re	ecords from August to October,			are being implemented price	א נט	
	1 004 4 including f	ika nurse's notes did flut levear			administering medications	anu	
]	that non nharms	acological interventions were ur	ed		that behaviors are being	ı	
	or concider price	ir to administerific tile Lypieka.			addressed appropriately. T	ne	
	The records als	so did not indicate that the	ļ		results of the Quality		
	resident's beha	vior had been monitored			Improvement monitoring v	vili be	
	consistently.	<u> </u>	-		reported by the Social Serv	rices	
		and and above all fluore			Director/Director of Clinica).	
	On 11/19/14 at	10:30 AM, Nurse # 5 was	ha		Services to the Quality		
	interviewed. S	he stated that that the facility us			Assurance Performance		
1	to have a beha	vioral monitoring form to	oic		improvement Committee		
	document beh	aviors of residents on psychotro were not using the form anymo	re.		monthly times 6 months for	or	
	drugs but they	was exhibiting a behavior, she	Ì		continued substantial		
	It the resident	in the nurse's notes. Nurse #5	Ì		compliance and/or revision	ก.	12-18
	also stated the	at for residents who were exhibit	ing		'	•	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		0.154.0				· ·	
		345442	B. WING			11/2	20/2014
	PROVIDER OR SUPPLIER T OAKES HEALTHCA	ARE CENTER		62	TREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE ILBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	a behavior, she foll PRN drug. On 11/19/14 at 4:13 was interviewed. Sthe nurses to monit document it on the shift on all resident drugs. Administratic could not find any state of the shift on all resident drugs.	age 19 owed the doctor's order for the 8 PM, administrative staff #1 She stated that she expected tor the behavior and to behavior flow sheet every s receiving psychotropic ve staff #1 revealed that she behavior flow sheets for the last three months.	F3	329			
		as admitted to the facility on le diagnoses including aviors.			·	ţ	
	assessment dated Resident #52 had a problems and was The care plan date There was no care	om Data Set (MDS) 9/11/14 indicated that memory and decision making on antipsychotic medication. d 9/11/14 was reviewed. plan problem, goal and			·		
	The physician's ordevealed that Residential milligrams (mgs) d	chavior management. ders for November, 2014 dent #52 was on Zyrexa 5 aily for dementia with akote 250 mgs twice a day for					
	On 11/19/14 at 10:	30 AM, Nurse # 5 was					12-18-14

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345442	B. WING		11	C /20/2014
	PROVIDER OR SUPPLIER	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH 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 APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	to have a behavior document behavior drugs but they were If the resident was documented it in the Review of the recorfrom August to Nov The notes did not he that behavior had behavior had be On 11/19/14 at 4:18 was interviewed. So the nurses to monit document it on the shift on all residents drugs. Administrative could not find any be Resident #52 for the 3. Resident #51 was 6/25/13 with multiple dementia with behavior had behavior had behave the country of the care plan dated. The care plan dated.	tated that that the facility used al monitoring form to a monitoring form to a feet of residents on psychotropic and using the form anymore. exhibiting a behavior, she are nurse's notes. The including the nurse's notes ember, 2014 was conducted. Have documentation to indicate the en monitored consistently. The property of the property of the behavior and to behavior flow sheet every are receiving psychotropic are staff #1 revealed that she behavior flow sheets for a last three months. The admitted to the facility on the diagnoses including aviors. The assessment dated 9/10/14 dent #51 had memory and oblems and was on	F 3:	29		
	The physician's ord	lers for November, 2014				12-18-14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY PLETED
		345442	B. WING _		11/2	0/2014
	PROVIDER OR SUPPLIER T OAKES HEALTHCA	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	mgs at bedtime for Ativan 1 mgs at bed for anxiety and dep dementia with beha	lent #51 was on Seroquel 25 dementia with behaviors, dtime and 0.5 mgs twice a day akote 500 mgs at bedtime for aviors .	F 32	9		
	interviewed. She s to have a behaviora document behavior drugs but they were If the resident was documented it in the Review of the reconstruction.	30 AM, Nurse # 5 was tated that that the facility used all monitoring form to re of residents on psychotropic e not using the form anymore. exhibiting a behavior, she e nurse 's notes. rds including the nurse's notes rember, 2014 was conducted.				
	The notes did not he that behavior had behavior had been so monit document it on the shift on all resident drugs. Administrative could not find any be Resident #51 for the 4. Resident #58 wa 7/5/12 and readmitt diagnoses including Alzheimer's, psychological psychologi	ave documentation to indicate been monitored consistently. B PM, administrative staff #1 the stated that she expected for the behavior and to behavior flow sheet every as receiving psychotropic we staff #1 revealed that she behavior flow sheets for the last three months. It is admitted to the facility on the ted 10/3/12 with multiple go senile dementia, totic disorder, depression and the immum Data Set (MDS) dated the resident was assessed as a saired for cognitive skills for				· 111
		ng. The resident was g a dally occurrence of				12-18-14

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY PLETED
		345442	B. WING_			C 20/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	others. The reside of antipsychotic management of the care conducted. The reside of management of included to monitor assist in determinity of the phronger dated 3/27/15 milligrams 1 tables needed for psychological order dated 8/2 Seroquel 150 milligrams by disorder. A review of the Medical Mark of the M	ms not directed towards nt was assessed with the use edication. re plans dated 9/16/14 was view revealed a care plan for of behaviors. The interventions r the resident for behaviors to ng the cause. ysician's orders revealed an 4 stating to administer Zyprexa et by mouth twice a day as osis. The review also revealed '8/14 stating to administer grams by mouth every morning der and to administer Seroquel mouth at bedtime for psychotic edication Administration Record of this of October 2014 and vas conducted. No the monitoring of behaviors he MAR for the months of	F 3:	29		
	7/9/2004 with last	vas admitted to the facility readmission to the facility lative diagnoses included				12-18-14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		SURVEY PLETED
		345442	B. WING			1	20/2014
	PROVIDER OR SUPPLIER	ARE CENTER		62	TREET ADDRESS, CITY, STATE, ZIP CODE 20 HEATHWOOD DRIVE LBEMARLE, NC 28001		20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	anxiety and organic A Quarterly Minimu 9/19/14 indicated R and long term mem severely impaired in Inattention, disorgal level of consciousn continuously preseduring the assessmantipsychotic, anxiemedication. A care plan dated 2 9/19/14 was review problem, goal and imanagement. The physician order revealed that Resid (antidepressant medication) 12.5 m two tablets (50 mg) (anxiety medication) On 11/19/14 at 10:3 interviewed. She s to have a behavior drugs but they were if the resident was documented it in the Review of the reconfrom August to Nov	m Data Set (MDS) dated Resident #16 had short term fory impairment and was in decision-making. Inized thinking and altered ess was noted as behavior int. Medications administered field and antidepressant with the following and antidepressant interventions for behavior interventions for behavior interventions for behavior interventions for behavior interventions for behavior interventions for behavior interventions for behavior in the formal and the facility and at 25 mg. In daily at 8:00PM and Xanax in 0.25 mg. at bedtime.	F3	329			
		een monitored consistently.					12-18-14

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		c
		345442	B. WING		11/20/2014
	ROVIDER OR SUPPLIER		620	REET ADDRESS, CITY, STATE, ZIP CODE HEATHWOOD DRIVE BEMARLE, NC 28001	:
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	COULD BE LOOM HELD
F 329 F 332 SS=D	On 11/19/14 at 4: was interviewed. the nurses to mon document it on the shift on all resider drugs. Administra could not find any Resident #16 for 483.25(m)(1) FRE RATES OF 5% O	Is PM, administrative staff #1 She stated that she expected litor the behavior and to be behavior flow sheet every has receiving psychotropic tive staff #1 revealed that she behavior flow sheets for the last three months. EE OF MEDICATION ERROR	F 329	F-332 1. Resident # 64 is now recomedication appropriately supper on 11/19/2014 a on 7/24/2014. Resident received prescribed medications.	y with as prescribed #88
	by: Based on record interview, the fact medication error following the doctorers of 26 opport. 1. Resident #64 7/24/14 to increat 10 milligrams (management of the fact of th	ENT is not met as evidenced review, observation and staff ility failed to maintain the rate at 5% or below by not tor's orders. There were 2 ortunities for error resulting in a Findings included: had a doctor's order dated ase prednisone (steroid drug) to gs) daily and to give it with the respiratory failure and chronic conary disease (COPD). were reviewed. Supper trays to be served on the hall where sided at 5:50 PM.		ordered on 11/19/2014 required time frame as a staff nurse assigned to t at that time. 2. All residents residing in have the potential to be 3. All nurses were retraine 11/18/2014 – 12/17/20 concerning the six Right Medication Pass and the accuracy for medication administration when a a specifically supposed to administered with food Clinical Services/Assista of Clinical Services/Nurchas conducted Medicat Observation with each 12-17-14. No nurses ha worked/will work prior the required retraining Medication Pass Obser	within the given by the the resident, the facility e affected. and the soft eneed for medication is to be to

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345442	B. WING		11/2	0/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
	ST OAKES HEALTHO		1	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DESIGNATION)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	IN SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 35	observed during to was observed to president's medica mgs tablet. Resident she did not. So trays were served #2: A review of the Resident #88 revented which stated "Con 11/19/14 at 8: during medication to administer Colduring medication for administer Colduring medication." An interview was 11/19/14 at 8:50 was written on the record to be given during 483.30(e) POST INFORMATION The facility must a daily basis: o Facility name. o The current da o The total number the following the following the following the side of the total number the following the foll	the medication pass. Nurse #6 prepare and to administer the stions including prednisone 10 dent #64 had not had supper 10.5 PM, Nurse #6 was acknowledged that she should death the prednisone with supper 10 on the hall at 6:00 PM. The physician's orders for the physician's orders for the physician's orders for the administration. Nurse #3 failed ace 100 milligrams by mouth 10.22 AM, Nurse #3 was observed a administration. Nurse #3 failed ace 100 milligrams by mouth 10.22 AM, Nurse #3 stated Colace 100 milligrams by mouth 10.22 AM, Nurse #3 stated Colace 10.22 AM, Nurse #3 stated Colace 10.22 AM, Nurse #3 stated Colace 10.22 AM, Nurse #3 stated Colace 10.22 AM, Nurse #3 stated Colace 10.22 AM, Nurse #3 stated Colace 10.22 AM, Nurse #3 stated Colace 10.23 AM, Nurse #3 stated Colace 10.24 AM, Nurse #3 stated Colace 10.25 AM, Nurse #3 stated 10.25 AM, Nurse #3 stated 10.25 AM, Nurse #3 stated 10.25 AM, Nurse #3 stated 10.25 AM, Nurse #3 stated 10.25 AM, Nurse #3 stated 10.25 AM, Nurse #3 stated 10.25 AM, Nurse #3 stated 10.25 AM, Nurse #3 stated	F 35	Any notable errors during the medical observation will be immediately by the Clinical Services/As of Clinical Services, and the nurse will 4. The Director of Clinical Services with random medication observations with each week for 3 m nurse per shift 1 the months. The result improvement mon reported by the Di Services/Assistant Clinical Services to Assurance Perform improvement Com times 6 months for substantial complia revision.	urse Manager. I made by a nurse tion pass I addressed I Director of Issistant Director I Nurse Manager, I be retrained. Inical Director of II complete In pass I nurse per shift I nurse per shift I me monthly for 3 Is of the Quality Itoring will be I rector of Clinical I of Director of I the Quality I the Quality I the Quality I the Continued I the	12-18-15	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY MPLETED
		345442	B. WING			11	C /20/2014
NAME OF F	PROVIDER OR SUPPLIER	V40442			DRESS, CITY, STATE, ZIP CODE	1 111	20/2014
	T OAKES HEALTHC	ARE CENTER			WOOD DRIVE RLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	χ (E/	PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOU ISS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 356	- Licensed practivocational nurses - Certified nurse o Resident census The facility must proposed above or of each shift. Data o Clear and readar o In a prominent presidents and visit. The facility must, unake nurse staffinfor review at a cosstandard.	ctical nurses or licensed (as defined under State law). e aides. cost the nurse staffing data a daily basis at the beginning a must be posted as follows: ble format. lace readily accessible to ors. upon oral or written request, g data available to the public t not to exceed the community	F	356 2	Services/Nurse Manager values to legible and accurate Staffing Sheet in a promin place accessible to the result and visitors Monday — Frictinen the Weekend Nurse Supervisor/Nurse Manage post a legible and accurate Staffing Sheet in a promin place accessible to the resund visitors on Saturday a Sunday. The Daily Staffing will be updated and main throughout the day by the Director of Clinical Services Weekend Nurse	e Daily ent sidents day er will e Daily ent sidents and g Sheet tained e es/	
	staffing data for a required by State by: Based on record interviews, the factorise staffing information was staffing Form data stated there was a (RN) and three lice working during the licensed practical	ded: as made of the Daily Nursing ed 11/17/14. The staffing form a total of one registered nurse ensed practical nurses (LPN) e first shift. There were three nurses observed working on			Supervisor/Nurse Manage The Facility Interdisciplina Departmental Team was retrained by the Executive Director on 12/17/2014 of importance of posting a lead accurate Daily Staffin Sheet in a prominent place accessible to the resident visitors. The Human Resource Professional will conduct Improvement monitoring Monday — Friday for the presence of the posting of legible and accurate Daily Staffing Sheet in a promin place accessible to the resident	e on the egible og ce cs and Quality	
		e first shift. A registered nurse working on 11/17/14 on the			and visitors. The Clinical		12-18-14

PRINTED: 12/15/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		345442	B. WING			11/20	/2014
	ROVIDER OR SUPPLIER	ARE CENTER		620	REET ADDRESS, CITY, STATE, ZIP CODE D HEATHWOOD DRIVE BEMARLE, NC 28001	 -	òrn
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
F 356	An observation was Staffing Form date stated there was a licensed practical shift. There were to observed working shift. A registered working on 11/18/ An interview was 11/18/14-at 2:54-F not a RN working An interview was Staff #6 on 11/19/ Nurse Unit Manapatient care. An interview was Staff #1 on 11/19/ Nurse Unit Manapatient care. An interview was Staff #1 on 11/19/ Nurse Unit Manapatient care. An interview was Staff #1 on 11/19/ Nurse Unit Manapatient care. An interview was Manager on 11/1 performed admin	conducted with Nurse #4 on M. Nurse #4 stated there was during the first shift. It is made of the Daily Nursing at 11/18/14. The staffing form a total of one RN and four nurses working during the first four licensed practical nurses on 11/18/14 during the first nurse was not observed 14 during the first shift. Conducted with Nurse #4 on 2M. Nurse #4 stated there was during the first shift. Conducted with Administrative #14 at 9:13 AM. She stated the ger did not administer direct Conducted with Administrative #14 at 9:20 AM. She stated the ger was a RN and was he Daily Nursing Staffing Form and 11/18/14 as working on first Conducted with the Nurse Unit 9/14 at 9:27 AM. She stated she positive duties on 11/17/14 and		356	Liaison will conduct Quality improvement monitoring Saturday and Sunday for the presence of the posting of a legible and accurate Daily Staffing Sheet in a prominen place accessible to the reside and visitors. The results of the Quality Improvement monitoring will be reported the Human Resources Professional/Executive Direct to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and revision.	t ents ne by ctor	
F 43 ⁻ SS=1	11/18/14. 1 483.60(b), (d), (e 1 LABEL/STORE I) DRUG RECORDS, DRUGS & BIOLOGICALS	F	431			12-18-14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
							l .	o į
		345442	B. WING				11/2	20/2014
	PROVIDER OR SUPPLIER TOAKES HEALTHOA	ARE CENTER		6:	STREET ADDRESS, CITY, STATE, ZIP COI 120 HEATHWOOD DRIVE ALBEMARLE, NC 28001	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD	8E	(X5) COMPLETION DATE
F 431	The facility must er a licensed pharmac of records of receip controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled. Drugs and biologic labeled in accordar professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment controls, and perment have access to the The facility must propermanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whe package drug distriguantity stored is not can be readily determined.	mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the cory and cautionary e expiration date when State and Federal laws, the all drugs and biologicals in the under proper temperature it only authorized personnel to keys. Tovide separately locked, dompartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit ibution systems in which the ninimal and a missing dose acted.	F	431	1. On 11/19/14 the Direct Clinical Services remove bottles of expired ear drops/earwax remova patches of nicotine trace 21 milligrams patch are bottles of Novolog 70/17 These medications we returned to the pharm discarded per facility patched to the pharm discarded per facility patched to the pharm discarded per facility patched to the potent affected. All medication/treatment medication/treatment medication/storage routhe facility were check expired medications be Director of Clinical Services Manager on 11/20/2014 medication biologicals were discareturned to the pharm facility policy on 11/20/3. All nurses were retrain 12/10/2014 regarding for expired medication administering the treatment medication and remove this education also incomproper labeling of mu	l aid, 4 insderind 2 /30 ins re nacy or policy it I Service In the stial to c carts coms in ced for y the vices a /20/20 is and/ rded o in acy pe 0/2014 ined on c check ins prio atment oving/ dication cluded Iti dose	be and and and and and and and and and and	12-18-14
		eview, observation and staff ty failed to discard expired			vials/liquids/ointment			

PRINTED: 12/15/2014 FORM APPROVED, OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		345442	B. WING			11/	20/2014
1	PROVIDER OR SUPPLIER			62	REET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	nedications on 1 medication carts a Findings included 1. On 11/19/14 at was observed. The drops/earwax rennicotine transderr were observed in date of 10/2014. On 11/19/14 at 3: interviewed. She staff was responsible to the medication relevery Monday and last time she che on Monday and the medications found in the medications for the medication for the medic	(A/E hall medication cart) of 3 and 1 of 1 medication room. 2:45 PM, the medication room hree bottles of ear noval aid and 4 patches of mal 21 milligrams (mgs) patch the drawers with the expiration 05 PM, Nurse # 5 was stated that the central supply sible for checking the expiration cations in the medication room. 00 PM, the central supply staff She stated that she checked from for expired medications of Friday.—She indicated that the cked the medication room was here were no expired d.		431	insulin, Tuberculin, Pneumon Prostat, eye drops, nasal sper facility policy. Nurses we taught to use the guide for recommended medication storage located on their Middetermine if a particular medication expires prior to expiration date located on a packaging. 4. The Director of Clinical Services/Assistant Director Clinical Services will conduct Quality Improvement monitoring of each cart 2 till weekly for 2 months, then time weekly for 2 months, then time weekly for 2 months the results of the Quality Improvement monitoring we reported by the Director of Clinical Services/Assistant of Director of Clinical Services the Quality Assurance Performance Improvement Committee monthly times	ray) ere AR to the the of then ns. vill be of	
	Recommendation Novolog 70/30 ex	ne Insulin Storage ns Policy dated 3/31/14 revealed xpired 28 days after the opening d at room temperature.			months for continued substantial compliance and revision.	l/or	
	cart on 11/19/14 vial of Novolog 7 opened date of 1 revealed one open	of the A and E Hall medication at 2:45 PM revealed one opened 0/30 insulin labeled with an 0/14/14. The observation also ened vial of Novolog 70/30 ith an opened date of 10/19/14.					12-18-14

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		С	
		345442	B. WING			11/20	0/2014
NAME OF P	ROVIDER OR SUPPLIE		-		REET ADDRESS, CITY, STATE, ZIP CODE		
	T OAKES HEALTHO				0 HEATHWOOD DRIVE _BEMARLE, NC 28001		ļ
FURRES				LAL	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLÉTION DATE
F 441 SS=D	An interview was 11/19/14 at 2:46 know how long a be used after the Nurse #3 also stamember response medication carts stated if an expirated i	conducted with Nurse #3 on PM. She stated she did not vial of Novolog insulin was to date the vial was opened. Atted there was not a staff lible for routinely checking the for expired medications. She ed vial of insulin was found on a the nurse was expected to rom the cart. It conducted with Administrative was expected to the nurses were expected to the nurses were expected to the nurses were expected to the nurses were expected to the nurses were expected to the nurses were expected to had to pull expired medications when cart and send them back to ON CONTROL, PREVENT INS Restablish and maintain an and Program designed to provide a had comfortable environment and the development and disease and infection. Introl Program the establish an Infection Control which it - controls, and prevents infections at procedures, such as isolation, and to an individual resident; and record of incidents and corrective to infections.	F	431	1. On 10/29/2014 Resider received a PPD skin test however the resident hallergy to Aplisol. The final Director and Responsible were notified staff nurse chest x-ray was obtained 11/3/2014 and the Medictor and Responsible were notified of the result of the result of the result of the resident was in the fasee Resident #54 and resident has had no addeffects from the PPD signiven on 10/29/2014. Physician documented	t, has an Medical ble Party se. A ed on dical e Party sults staff the cility to noted that liverse kin test	12-18-14
	(b) Preventing	Spread of Infection			Physician documented	in his	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATI COM	E SURVEÝ PLETEĎ
		245442	B. WING			1	C 20/2014
		345442	O. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	111/	20/2017
NAME OF F	ROVIDER OR SUPPLIER			i	20 HEATHWOOD DRIVE		. 1
FORRES	T OAKES HEALTHCA	ARE CENTER		_	LBEMARLE, NC 28001		
				μ			0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULLSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
		!			11/5/2014 progress note	that į	
F 441	Continued From page	age 31	F	441	resident #54 stated that s	he has	
' '''	•	tion Control Program			had some reaction in the	past	
	determines that a	resident needs isolation to			but no history of Tubercu	losis.	1
		of infection, the facility must	ŀ		New orders were receive	d from	
	isolate the residen				the physician on 11/4/20	L4 to	
	(2) The facility must	st prohibit employees with a			obtain sputum for Acid Fa	st	
	communicable dis	ease or infected skin lesions		•	Bacilli in the am times 3 d	ays to	
		t with residents or their food, if			start on 11/5/2014; howe	ver	
		ransmit the disease.			the resident was asympto	matic	
	(3) The facility mu	st require staff to wash their			and was unable to give sp	utum	
		direct resident contact for which			sample. On 11/6/2014 a s		
		ndicated by accepted	1		sample was obtained and	sent	
	professional practi	ice.			to the laboratory with res		
	(c) Linens				no Acid Fast Bacilli seen.		1
		andle, store, process and	ĺ		11/7/2014, a sputum sam		
	transport linens so	as to prevent the spread of			was obtained and sent to	•	
	infection.				laboratory with results of		
		•			Acid Fast Bacilli seen, Res		
					was unable to produce sp	utum	
					culture from 11/8/2014-		
	i	ENT-is not met-as evidenced			11/9/2014 due to non-		
	by:	the state of the s			productive cough, howev	er e	7
	Based on record	review and staff interviews, the evelop a policy and procedure to			resident was able to prod		
· ·	address residents	with positive tuberculosis			sputum culture on 11/10/		
	testing for one of	one sampled resident (Resident	.1		which was sent to the		
	#54). The finding				laboratory with results of	no	
	1,01/1.	•			acid fast bacilli noted. On		
1	North Carolina Pu	ıblic Health State guidelines			11/18/2014 resident #54	was	
	titled Control Mea	sures-Tuberculosis effective 🔪			sent to the hospital for a		
	8/1/2012 stated, i	n part, "(e) Persons with a			x-ray which showed no ev		
		skin test or IGRA (interferon			of Tuberculosis.		
	gamma release a	ssay) shall be evaluated by an			2. All residents residing in th	e	
1	Interview to scree	n for symptoms and a chest			facility have the potential		1 14
	x-ray if they do no	ot have a documented chest			affected. An audit of all re		12-18-14
	x-ray mat was pe	rformed on the date of the ter. (f) Treatment and follow-up			charts was completed by		ļ
	for tuberculosis in	fection or disease shall be in			Director of Clinical Service		:

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			
		345442	B. WING _		ー C デーー 11/20/2014
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 441	accordance with guidelines from the and Prevention." There was no fact addressed resident #54 was Cumulative diagramment of the immunization reviewed and review	the recommendations and the Centers for Disease Control cility policy/ procedure that ents with positive tuberculin admitted to the facility 12/6/11. noses included: hypertension, and chronic cough. In record for Resident #54 was wealed a tuberculin skin test (test the if a resident has/ has been	F 44	Nurse Manager on 11/17/2 to ensure that PPD has bee administered to residents accordingly and that the residents' allergies are lis the medical records. 3. Retraining was provided licensed nurses on check allergies before administ PPD to residents on 11/1 by the Director of Clinica Services. This retraining included proper docume of PPD on residents' cha Director of Clinical Service educated on the facility'	to all ing ering 9/2014 Il galso entation rts. The ces also
	10/29/14 with resinduration of greclassified as posprevious tubercu 12/6/11 with resinduration (an almoted on her phythat she had an A review of physindicated Reside A chest x-ray resuccession: riginatelectasis (colla or pneumonia. excluded." A physician's on a sputum AFB (collassion)	rculosis) was administered on sult 30 mm. induration. An ater than or equal to 15 mm. is attive. Resident #54 had a ulin skin test administered on ult 30 mm. (millimeters) onormal hard spot) and it was ysician orders for January 2012 allergy to Aplisol (tuberculin test). Sician orders for November 2014 ent #54 had an allergy to Aplisol. Isult dated 11/3/14 stated, in part, the lower lobe and left upper lobe apsed or airless state of the lung) Tuberculosis cannot be der dated 11/4/14 stated to obtain acid fast bacillus) x 3 days. This ned to determine if a person has		Tuberculosis policy which included the Center for I Control guidelines on for administration of the tuil skin test and the steps to in the instance of a poten positive screen (i.e. notical health care provided local health department follow recommendation given to the facility by the health care provider and health department). 4. The Director of Clinical Services/Assistant Direct Clinical Services will cortain Quality Improvement monitoring of 5 residen 1 time weekly for 2 more demands of the turn of turn of the turn of turn o	Disease r berculin o follow ential fy the er and as/orders he local d local stor of nduct ts' charts 12-18-14

	TO T OIT MEDIONALE	. WINEDIONID GENVIOLG				1 7.10 10.	0000-0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTR		(X3) DATE SURVEY COMPLETED	
		345442	B. WING_			1	C 20/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADI	DRESS, CITY, STATE, ZIP CODE	<u>,</u>	
	THE STATE OF THE S				WOOD DRIVE		
FORRES	T OAKES HEALTHCA	RE CENTER					
				ALBEWAR	RLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E.	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	A review of the med revealed there were the chart. On 11/17/14 at 4:30 stated she knew the tuberculin skin test getting a chest x-ra aware of the chest Administrative staff received the results and she would call had been complete nursing staff to folloresident had a posi Administrative staff the facility had a position of the staff the facility had a position of the staff	dical record for Resident #54 e no sputum culture results on OPM, Administrative staff #1 at Resident #54 had a positive and that the facility was y. She said she was not x-ray results dated 11/3/14. #1 stated they had not so of the AFB sputum culture the laboratory to see if results d. She stated she expected ow physician orders if a tive tuberculin skin test. #1 stated she did not know if olicy and procedure regarding skin testing results and what	F 44	41	documented allergies and vaccinations & also to ensure that vaccinations have given documented appropriately, to 5 resident charts 2 times a month for 2 months, then 5 resident charts monthly for 2 months. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Assistant of Director Clinical Services to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	and hen	
	was interviewed an tuberculin skin test 10/29/14. He state second tuberculin sprevious test had be The physician state results done on 11/quality x-ray and state been repeated and done on 11/18/14.	d. 6PM, Resident #54's physician d stated he had not ordered a to be administered on d he would never order a skin test to be administered if a een determined to be positive. If he was aware of the x-ray 3/14 and felt it was not a good ated the x-ray should have he would order one to be					
	administered the tu #54 on 10/29/14. S that Resident #54 h	berculin skin test to Resident she stated she was not aware ad a previous positive rculin skin test in 2011. Nurse					12-18-14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED	
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		345442	B. WING				11/	20/2014	
	PROVIDER OR SUPPLIER	ARE CENTER		6:	TREET ADDRESS, CITY, STATE, ZIP CO 20 HEATHWOOD DRIVE ALBEMARLE, NC 28001)DE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE	
F 441	#1 stated she was needed annual tub administered the tulist and did not revi administration to deprior positive test. On 11/18/14 at 3:3 stated they had reviegarding tuberculinot find a policy regtesting and she felt (Center for Disease On 11/18/14 at 5:00	given a list of residents who erculin skin tests and aberculin skin tests from that ew the charts prior to etermine if that resident had a 7 PM, Administrative staff #2 riewed all the facility's policies in skin testing and they could garding positive tuberculin skin they would refer to the CDC of Control) guidelines.	F4	141					
F 520 SS=E	of a chest x-ray dorevidence of pulmor accumulation in the consolidation (fluid 483.75(o)(1) QAA COMMITTEE-MEN QUARTERLY/PLAI A facility must mair assurance committ nursing services; a facility; and at least facility's staff. The quality assess committee meets a issues with respectand assurance actidevelops and imple	e lungs) and bibasilar lung in the bottom of both lungs). IBERS/MEET	F	520	F – 520 1. An Impromptu Quality A Performance Committee was held on 11/19/2014 by the Executive Directo the Interdisciplinary Tea overseen by the Regions Clinical Services to discu Carolina State Survey Te findings/suggestions an 2567 and Plan of Correc 2. All residents residing in have the potential to be	e meeting food conduct for to inclus for and food conduct	B ted ide or of orth	12-1844	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATI	E SURVEY - T PLETED	
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		345442	B. WING			11/:	20/2014	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		·	
EODDES	T OAKES HEALTHCA	ARE CENTER	620 HEATHWOOD DRIVE					
FORRES	I OAKES REALIROA	ARE CENTER		Α	LBEMARLE, NC 28001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 520	A State or the Sec disclosure of the re except insofar as s compliance of such requirements of thi	retary may not require cords of such committee uch disclosure is related to the n committee with the	F \$	520	3. During the Impromptu Quality Assurance Performance Commit- meeting held on 11/19/2014 additional plans for correction w discussed including retraining, corrective action and follow up monitoring for previous deficien- (2012 and 2013) F-279, F-309, F- and F-441 as well as additional	ere cies 356,		
		deficiencies will not be used			deficiencies for 2014 recertificat survey, F-164, F-278, F-318, F-32 332, F-431 and F-520. F – 279 Resident #52 longer residents #51 and	9, F- des		
	by: Based on record re interview, the facilit	NT is not met as evidenced eview, observation and staff by's Quality Assessment and the failed to ensure that action			Care Plans and Minimum Data Something the have been reviewed for accuracy interventions and medications for behaviors. Retraining has been completed with the Interdiscipling	ets y of or		
	plans developed for recertification surver monitored and revi- compliance was act facility had a patter development of cat (2013) and posted	or the 8/22/13 and 7/22/12 eys were implemented, sed as needed to ensure chieved and sustained. The roof repeat deficiency in re plans, and infection control nurse staffing information and n wellbeing (2013 and 2012).			Team and the nursing staff for accuracy of Care Plans and Minlmum Data Sheets additiona audits will be conducted and reported to the Quality Assurant Performance Committee month F-309 the FI Restriction for resident #50 was discontinued on 11/19/2014 by physician. Retraining has been	i ce ly. Juid		
	record review and failed to address the 3 of 5 sampled resided medications (Resided During a recertifications cited for F279)	ment of Care Plans: Based on staff interview, the facility ne behavior in the care plan for idents receiving psychotropic dent #52, #51 and #16). Ition survey 8/22/13 the facility for failing to care plan for dications and swallowing			completed by the Director of Cli Services completed with the Interdisciplinary Team and the nursing staff for regarding fluid restrictions and appropriate documentation of Intake and Ou when ordered. Additional audits be conducted and reported to the Quality Assurance Performance Committee monthly. F — 356 on 11/19/2014 the daily staffing sheet was posted in a	utput s will he	12-18+4	

		COMPLETED
	DING	c
345442 B. WIN	3	11/20/2014
NAME OF PROVIDER OR SUPPLIER FORREST OAKES HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES IE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TA	FIX (EACH CORRECTIVE ACTION SHOULD	D BE COMPLETION
F 520 Continued From page 36 problems. 2. F309 - Services to Maintain Wellbeing: Based on resident interviews, staff interviews, record reviews and observations, the facility failed to monitor fluid intake for one of one resident (resident # 50) on dialysis with fluid restriction. During a recertification survey 8/22/13 the facility was cited for F309 for failing to ensure a diuretic medication was administered as ordered. During a recertification survey 7/26/12 the facility was cited for F309 for failing to put pain interventions in place and for not providing skin care services as ordered. 3. F356: Posted Nurse Staffing Information: Based on observations and staff interviews, the facility failed to accurately post the nurse staffing information. The F356 citation for the 11/20/14 survey was for inaccuracy in the accounting of Registered Nursing staff. During a recertification survey 8/22/13 the facility was cited for inaccurate census on the posted nurse staffing information. During a recertification survey 7/26/12 the facility was cited for inaccurate census on the posted nurse staffing information. 4. F441 - Infection Control: Based on record review and staff interviews, the facility failed to develop a policy and procedure to address residents with positive tuberculosis testing for	prominent place accessible to residents and visitors and reflecte accuracy of staffing by the Director of Clinical Services. Moving forwa an accurate daily staffing sheet whe posted daily in a prominent location by the Director of Clinical Services or Designee Monday through Friday and by the weeker nurse manager or designee on Saturday and Sunday. The dally staffing sheet will be additionally checked Monday through Friday by the human resource professional and the Clinical liaison on Saturday and Sunday for accuracy and prominent placement. F – 441 Resident #54 did not have adverse effect from receiving the Tuberculin skin test and the reside chart has been updated with an allergy to Aplisol. All resident chart were reviewed and updated for allergies and documentation of allergies as well as PPD skin test at the proper documentation. The interdisciplinary Team and the licensed nursing staff have been retrained on proper documentation of PPD skin test by the Director of Clinical Services on 12/1/2014. 4. On 11/19/2014 retraining of the Interdisciplinary Team on the Quality Assurance Committee meeting was completed by the Executive Director and the Region Director of Clinical Services. Additional training was completed by the Regional Director of Clinical Services on Quality Assurance	or red all some sent sent sent sent sent sent sent sen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLEJED		
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NAME OF PROVIDER OR SUPPLIER FORREST OAKES HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 620 HEATHWOOD DRIVE ALBEMARLE, NC 28001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	,BE	(X6) COMPLETION DATE	
F 520	one of one resident During a recertifica was cited for F441 signs on room door precautions. Administrative Staff at 10:13 and stated pattern of repeat de facility had a quality met quarterly at a n #6 indicated that sh repeat deficiencies nursing department effectively communicated		F 520	monitoring and improvement with the Interdisciplinary Team on 12/5/2014. The Quality Assurance Committee will have a scheduled meeting monthly to report and correct identified quality deficiencies. This meeting will be conducted by the Executive Director and will include the interdisciplinary Team and will be overseen by a member of the Regional Corporate team monthly times 6 months for continued substantial compliance and/or revision.			
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						12-18-14	