STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	**413 WINECOFF SCHOOL ROAD CONCORD, NC 28027**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 05/08/17 through 05/10/17. Past-noncompliance was identified at: CFR 483.25 at tag F323 at a scope and severity (J) The tags F323 J constituted Substandard Quality of Care. Past-noncompliance began on 04/15/17. The facility came back in compliance effective 04/18/17. A Partial extended survey was conducted.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		6/2/17

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

Electronically Signed | 05/31/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete an accurate assessment of Resident #1 for one of three sampled residents. The findings included: Resident #1 was admitted to the facility on 5/22/15 with diagnoses of Alzheimer ' s dementia, brain lesion, anxiety and depression. Review of a social worker ' s note dated 4/3/17 revealed Resident #1 was alert with confusion, had impaired short term memory and denied feeling depressed. She had a diagnosis of anxiety with no noted moods/behaviors in the look back period. Review of the nurse ' s note dated 4/5/17 indicated the resident continued with exit seeking behavior. The nurse ' s note dated 4/7/17 indicated she was yelling at staff, attempted to hit staff and hit another resident. The most recent Minimum Data Set (MDS), an	F 278	1. Corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice; A. Resident #1 Minimum Data Set (MDS) was corrected (modified) on 5/25/17 to accurately reflect residents moods and behaviors. 2. Corrective action will be accomplished for those residents having potential to be affected by the same alleged deficient practice; A. Facility will complete 100% audit of all residents most current MDS to verify accuracy and compliance with state/federal regulations. Any identified non compliance with Minimum Data Sets will be corrected (modified) immediately. Audits will be completed on or before June 2, 2017. Audits will be completed by IDT team. Outcome of audits will be documented on MDS audit tool. Facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 annual, dated 4/7/17 indicated Resident #1 had both short and long term memory problems. There were no mood or behaviors documented for this assessment. She required extensive assistance of one staff member for bed mobility, transfers, was non-ambulatory and required one person assist for locomotion in her wheelchair and required total assistance of one staff member for personal hygiene and toileting. Interview with the social worker and the Director of Nursing on 5/10/17 at 3:50 PM revealed the social worker had not reviewed the medical record for the dates after her note of 4/3/17. She was not aware she had to review information from the assessment reference date of 4/7/17. The Director of Nursing explained the assessment should include any information from 4/7/17 and looking back and the social note was completed early. The social worker and Director of Nursing explained the annual MDS was not accurate.	F 278	will complete random audits post completion of 100% audit (10 per week times 4 weeks) then (10 per month times 2 months) to verify accuracy and compliance with state/federal regulations. Any identified non compliance with Minimum Data Sets will be corrected (modified) immediately. 3. Measures/systemic changes put in place to ensure that the deficient practice does not recur; A. Facility will complete random audits (10 per week times 4 weeks) then (10 per month times 2 months) to verify accuracy and compliance with state/federal regulations. Any identified non compliance with Minimum Data Sets will be corrected (modified) immediately. B. Interdisciplinary Team who complete Minimum Data Sets have received additional training on completion of assessments/accuracy of MDS. Training was completed on 5-29-17 by facility Director of Nursing. Any new hires to Interdisciplinary Team will receive training from Director of Nursing on completion of Assessments/Accuracy of MDS during orientation. 4. Monitoring of corrective action to ensure the alleged deficient practice will not recur; A. Reports of audit findings will be reported to the Quality Assurance committee monthly times three to review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 3	F 278	for continued intervention of plan or amendment of plan. In the event corrections are needed a plan will be developed, implemented and evaluated for its effectiveness.	
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and physician interview the facility failed to provide supervision of a resident with dementia from	F 323	Past noncompliance: no plan of correction required.	5/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4	F 323		

exiting the facility on 4/15/17, failed to respond to a door alarm connected to a wanderguard system, failed to stay with a resident outside the facility and prevent the resident from crossing a two lane highway. Resident #1 left the facility in a wheelchair, crossed the parking lot and a two lane highway unsupervised. There were no injuries sustained and she was returned to the facility by a staff member approximately 15 to 20 minutes after she was last observed in the building. This was one of one sampled residents found outside the facility. (Resident #1)

The findings included:

Resident #1 was admitted to the facility on 5/22/15 with diagnoses of Alzheimer ' s dementia, brain lesion, anxiety and depression.

Review of the nurse ' s notes dated 4/5/17 indicated the resident continued with exit seeking behavior. The nurse ' s notes dated 4/7/17 indicated she was yelling at staff, attempted to hit staff and hit another resident.

The most recent Minimum Data Set, an annual, dated 4/7/17 indicated Resident #1 had both short and long term memory problems. There were no mood or behaviors documented for this assessment and she had no wandering behaviors. She required extensive assistance of one staff member for bed mobility, transfers, was non-ambulatory and required one person assist for locomotion in her wheelchair and required total assistance of one staff member for personal hygiene and toileting.

Record review revealed the nurse practitioner visited the resident on 4/7/17 and added the medication Depakote Sprinkles (for mood/behaviors) 125 milligrams (mg) twice a day. She recently had a gradual dose reduction and then discontinuation of an antianxiety medication, Clorazepate 3.75mg, half a tab twice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5	F 323		

a day for 5 days and then every day for 5 cays, then discontinue. The GDR (gradual dose reduction) began on 3/24/17 and continued until April 2nd. The note indicated the resident had increased agitation, exit seeking behaviors and combativeness.
There were no documented behaviors or agitation recorded in the nurse ' s notes from 4/7/17 to 4/15/17.
Review of the assessment for risk for elopement, dated 4/7/17 indicated the resident remained at risk for elopement, but had not attempted to elope during the assessment timeframe.
Review of an incident report form dated 4/15/17 at 9:15 AM revealed the resident had left the facility unsupervised. The report indicated the location of the incident was "across the street."
Review of an interdisciplinary team note dated 4/17/17 revealed the incident was reviewed and revealed Resident #1 had encouraged another resident (Resident #4), who also had dementia with long term memory problems, to let her out the door at the back of the facility. The resident was returned to the facility when a house keeper alerted another staff member Resident #1 was outside the facility. Resident #1 had no injuries noted after a head to toe assessment was completed. The alarm system for wanderguards was working properly and Resident #1 had a functioning wanderguard on her ankle. Staff were immediately inserviced on "code silver." Code silver was their code for a missing resident. A mock code silver was conducted with staff responding appropriately.
Review of the care plan dated 4/18/17 indicated Resident #1 had dementia with behaviors of exit seeking. The goal included the resident would be safe in facility with intervention from staff. The approaches included placement of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6	F 323		

wanderguard, staff to check function and placement of wanderguard as ordered, redirect resident as able, check exit doors as ordered and encourage land assist her to out of room activities.
The physical layout of the building where Resident #1 resided included: Resident #1 resided on the 100 "short hall" with the sunroom 72 feet from her room. The sunroom door was connected to the wanderguard system and would lock down when a resident with a wanderguard approached the door. An alarm would sound and would not stop until a code was entered into the keypad. The door led to a sunroom with exit doors opening to a parking lot. The sunroom door was 172 feet from the main nurses ' desk. The 100 hall (long hall) and 300 hall were spokes like a wheel out from the nurse ' s desk.
Resident #4 was not an elopement risk, and had access to the sunroom. She was ambulatory and had no wanderguard on her person. Review of the MDS dated 3/31/17, for Resident #4, revealed she had long term memory impairment. The MDS indicated Resident #4 had a BIMS (brief interview for mental status) of 9. Diagnosis for Resident #4 included dementia with behaviors.
The wanderguard system was checked using a wanderguard bracelet on 5/9/17 with the Director of Nursing (DON) at the sunroom door. As we approached the door, approximately 5 feet, the alarm sounded and the door locked. The DON held the door for the surveyor open, with the surveyor further back from the door. The alarm sounded after going through the door with the wanderguard bracelet held at waist level. The door locked after the door closed and the alarm continued to sound until a code was entered on the keypad.
Interview with housekeeper #2, who alerted the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

staff a resident was outside the building, was conducted on 5/8/17 at 3:15 PM. She explained she was a new employee (second day working) and was not sure the person in the wheelchair was a resident. She was on the front porch on break and saw someone in a wheelchair in the parking lot. She came inside the facility and saw housekeeper #2 and gave him a verbal report she thought a resident was outside in the parking lot. She did not go to the resident or attempt to return her to the facility. A follow up interview was conducted on 5/9/17 at revealed her break time was from 9:00 am to 9:15 AM.
Interview on 5/8/17 at 1:30 PM with nurse #3 who was the manager on duty for the weekend revealed she had already checked Resident #1 ' s wander guard bracelet, and it was functioning correctly. The doors had been checked and they were functioning correctly. After the resident was returned inside the facility, she rechecked her wanderguard and it functioned correctly. She had called the administrator to inform him of the incident. She began an inservice of staff on code silver (missing resident) and the wanderguards per the administrator ' s instructions.
Interview with housekeeper #1 on 5/8/17 at 1:40 PM revealed he was coming down the hall adjacent to the sunroom, when he was notified by housekeeper #2 a resident was outside the facility. He was coming down the hall by the dining room. Housekeeper #2 approached him in the hallway and informed him a resident might be outside in the parking lot. He instructed her to tell the nurse and he went outside immediately to look for the resident. He found the resident across the street and returned her to the facility. He was not sure of the time, but thought it may have been around 10:00 AM. Resident #1 told him she wanted to go home. The weather that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8	F 323		

day was warm, sunny with good visibility. The road was a two lane road and was usually high traffic on the road. The resident was found at the edge of the two lane road, on a secondary road with housing on each side of the road. He was able to return her to the facility without incident or refusals from the resident. He could not remember the time frame exact.
Interview with aide #1 on 5/8/17 at 3:00 PM revealed she was assigned to Resident #1 on 4/15/17. She had provided care to Resident #1. Aide #1 had assisted Resident #1 in getting dressed and she was up in her wheelchair at 7:00 AM. She last observed Resident #1 at the nurse ' s station at 9:00 AM. She continued with her assignment and providing care to other residents on the 100 short hall. When she was providing care to her third resident she heard someone say Resident #1 was outside the building, but she could not remember the time it occurred. She did not go to Resident #1, but continued with her assignment. Upon return to the facility, Resident #1 was asked to stay at the nurse ' s station.
Aide #1 explained Resident #1 had mental and memory problems, but it varied. The resident was in a "good mood" that morning, did not say anything regarding wanting to leave, go home, or alert her in any way she might attempt to leave the facility. Follow up interview on 5/9/17 at 11:18 AM for clarification revealed she could not remember if the sunroom door alarm had been sounding. She explained residents wander to the door and set it off frequently. She was providing care to a resident and did not leave the resident to check the door.
Interview with the Administrator on 5/9/17 at 10:20 PM revealed he was informed of the incident approximately 9:15 AM on 4/15/17. The manager on duty had notified him of the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

The resident was last observed at 9:00 AM. Interventions of inservicing staff began on that date by the manager on duty. A reenactment with the resident in the wheelchair revealed she propelled 176 feet in 3.5 minutes. The distance from the sunroom exit door to across the road was checked by maintenance with a laser and measured 176 feet. A sign had been posted on the exit doors on Monday 5/8/17 to remind visitors to not allow residents out the door without management being aware. Resident #4 had a wanderguard placed on her person after the incident so she could not open the door for other residents.

Interview with aide #2 on 5/9/17 at 10:50 AM revealed she was collecting breakfast trays on 100 hall on 4/15/17 around 9:00 am to 9:30 AM. She explained she did not hear the door alarm while at the e100 hall. As she approached the nurse ' s station she heard the alarm. She went down the "short hall" (hall where the alarm was sounding) a courier for the laboratory was trying to exit the sunroom door. He could not go out the door since it was alarming, it was also locked down. She put the code in to silence the alarm, and unlock the door. There were no residents in the hallway or in the sunroom outside the locked door. His van blocked the windows to the sunroom, and she could not visualize the parking lot. She did not go outside to look for a resident. She further explained residents with wanderguards set off the alarm frequently, and then leave the area when it locks. She thought a resident had "set it off" and had gone back down the hall.

Interview on 5/9/17 at 11:08 AM with nurse #1, who was the charge nurse for Resident #1, revealed she was passing morning medications and was informed the Resident #1 had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

outside the facility. At the time she was informed, the resident was back in the facility. She could not remember what time she was informed. She did not hear the alarm sounding as she was on 300 hall which was not near the sunroom. She began the investigation, obtained staff interviews and completed the incident report form. She had not seen Resident #1 to give her morning medications until she returned inside the facility.
Interview with nurse #2 on 5/9/17 at 11:22 AM revealed she was on 100 hall giving medications. She had not heard the alarm. The alarm could be heard at the nurse ' s desk, but she was at the end of 100 hall (long hall) which is away from the nurse ' s desk. The housekeeper #1 had been in her car taking a break when she saw the person in a wheelchair and reported her out of the facility. Housekeeper #1 had reported the incident to nurse #2.
Interview with the DON on 5/9/17 at 11:46 AM revealed she was called around 9:30 AM and informed of the incident on 4/15/17. She gave instructions to continue the inservices, place a wanderguard on Resident #4 and for staff to keep Resident #1 at the nurse ' s desk to be monitored. Further interview revealed, after the IDT meeting on 4/17/17 residents were audited for elopement risks, care plans were updated as needed, and monitoring of residents for wanderguard functioning.
Interview with the Nurse Practitioner (NP) on 5/9/17 at 1:30 PM revealed she added the medication on 4/7/17 due to her increased wandering in the facility. The resident had gone out with family prior to 4/7/17 and on return she was asking where her daughter was, if she was coming and where her car was located. The NP explained that was a change from her usual behavior and thus the Depakote was added.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11	F 323		

Interview with Resident #4 on 5/9/17 at 2:30 PM revealed she did not remember if she opened the door for a resident. She explained, "If they asked me, I probably did hold the door."
Review of the corrective actions revealed on 4/15/17:
- Resident #1 was brought inside the facility, assessed for injuries and none found. The wanderguard for Resident #1 was checked and the facility wanderguard system was checked and functioned properly.
- all residents with wanderguards were checked for placement and function.
- Inservice was provided to all staff on duty on 4/15/17 regarding checking inside/outside the facility when the wanderguard door alarms.
- A wanderguard bracelet was applied to Resident #4 to prevent her from assisting other residents from exiting the facility.
On 4/17/17:
- audits of elopement risk assessments to verify no other residents were at risk were completed.
- audits of all residents with wanderguards were completed to verify accuracy of the care plan and assessment.
- Signage posted on exit doors requesting visitors to not assist residents outside without speaking to management.
- Quality Assurance meeting held with additional education to staff provided and "code silver" (missing residents) was completed.
Review of the audits for wanderguard placement after 4/17/18 revealed Resident #4 had not been added to their audit until 4/18/17.
A compliance date of 4/18/17 was determined with the immediate jeopardy removed.