**A. BUILDING**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345442

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 
B. WING 

(X3) DATE SURVEY COMPLETED: R-C 07/25/2018

**NAME OF PROVIDER OR SUPPLIER**

FORREST OAKES HEALTHCARE CENTER

(STREET ADDRESS, CITY, STATE, ZIP CODE)

620 HEATHWOOD DRIVE ALBEMARLE, NC  28001

**FORM APPROVED**

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

OMB NO. 0938-0391

PRINTED: 08/29/2018

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

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
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A revisit was conducted on 7/25/2018 and the facility was back into compliance effective 7/23/2018.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

Electronically Signed

07/30/2018