DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345186	B. WING _			11/	15/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY	, STATE, ZIP CODE		
FIVE OAK	S MANOR			413 WINECOFF SCHOO CONCORD, NC 2802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		EO	00			
	conducted on 11/12/1 facility was found in c requirement CFR 483 Preparedness. Even	8.73, Emergency t ID #492711.					
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)		F 5	50			12/13/19
	self-determination, ar access to persons an	Rights. ght to a dignified existence, nd communication with and d services inside and cluding those specified in					
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and					
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.					
	rights as a resident or or resident of the Uni	right to exercise his or her f the facility and as a citizen					
	DIRECTOR'S OR PROVIDER/S cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TIT	ΓLΕ		(X6) DATE 12/02/2019
	carry orgined						12/02/2013

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.

		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345186	B. WING _		11/15/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
FIVE OAK	S MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETI THE APPROPRIATE DATE
F 550	Continued From page	e 1	F	550	
	resident can exercise	his or her rights without n, discrimination, or reprisal			
	free of interference, or reprisal from the facil rights and to be supp exercise of his or her subpart.	sident has the right to be coercion, discrimination, and ity in exercising his or her orted by the facility in the rights as required under this is not met as evidenced			
	resident and staff inter treat residents in a di by failing to provide in requested to Resider to participate in Phys from urination, missin Resident Council mere embarrassed. The fa the dignity of resident meal tray on an open a minimum of 20 min with eating on 2 of 3 failing to address Res difficulty sleeping cau banging from another	n, record review, and erview, the facility failed to gnified manner as evidenced noontinence care when at #64 resulting in her having ical Therapy with pants wet bg 30 minutes of the annual eting, and causing her to feel acility also failed to promote ts by leaving Resident #110's aired tray cart in the hall for utes before assisting her meal observations and sident #12's complaints of used by noises of yelling and r resident. This failure to 2's complaints made him		F550: Resident Rights/Ex Rights Resident #64 was provided incontinent care and was a the Resident Council meeti #110 allegedly waited on he more than 15 minutes to be meal is served beyond 15 m the time the tray arrives on will reheat the food before a resident. Resident #12 has to another room per residen All incontinent residents ha for the alleged deficient pra dependent diners who choo meals in their rooms have to alleged deficient practice.	d with ible to attend ing. Resident er meal for e served. If minutes from the hall staff serving the s been moved nt request. ave the potential actice. Any ose to have the potential for
	feel like no one was listening to his concerns. This was for 3 of 3 residents reviewed for dignity. The findings included:			have the potential for the a practice regarding grievand Development Coordinator p education on 11/29/19 on p incontinence care, timely d	Illeged deficient ces. Staff provided provision of elivery of
	7/25/18 with diagnose	admitted to the facility on es that included bilateral arthritis of knee, left and right nd neuropathy.		resident meal trays for dire which include; certified nurs licensed nursing staff, reston nurse managers, kitchen st Guardian Angel team this e	sing assistants, orative staff, taff, and

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			A 44 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4			<u>NO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		345186	B. WING		1	1/15/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
FIVE OAK	S MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 550	Continued From page	e 2	F 55	50		
	The quarterly Minimu			continue through 12/12/19.	Staff	
		)/2/19 indicated Resident		Development Coordinator pr		
		ntact. She had no behaviors		education on 11/29/ on facili		
		are. Resident #64 was		procedures for facility staff th		
	-	ore for assistance with		will continue through 12/12/		
	transfers and toileting	g and dependent on 1 for		An audit will be completed D	irector of	
	assistance with bed r	mobility and personal		Nursing or licensed nurse by		
		ed the extensive assistance		regarding residents with inco		
		had functional limitations		signs of incontinence. An au		
		on both sides of her lower		completed Director of Nursir	-	
	extremities, and she			nurse by 12/11/19 on all dep		
	and bowel.	ways incontinent of bladder		who eat in their rooms to de		
	and bower.			many meals are being serve minutes from the time the tra	-	
	The active care plan	for Resident #64 was		the hall. Beginning 11/27/19	-	
	-	and it included the focus		completed by Social Worker		
		r all Activities of Daily Living		all interviewable residents of		
		as initiated on 7/11/19 and		with current roommate assig		
		intervention of assistance		residents stated a desire to		
	with ADLs as needed			assignments.	-	
				Education was provided to d	lirect care	
	A nursing note dated	11/14/19 at 10:37 AM		staff on 11/29/19 by Staff De		
		64 returned to the facility		Coordinator (SDC) regarding		
	from an appointment			incontinent care, with empha		
				ensuring residents with visib		
	An annual Resident (			incontinence are changed in	•	
		the recertification survey on The Activity Director		this education will continue t 12/12/19. Education was pro	-	
		nt #64 would be late for the		direct care staff on 11/29/19		
		"waiting to be changed".		Development Coordinator (S	•	
				regarding timely delivery of r		
	At 2:55 PM on 11/14/	19 Resident #64 entered the		reheating meals if the tray si		
		ncil meeting 25 minutes		carts for more than 15 minut		
	after the meeting beg	-		education will continue throu	ıgh 12/12/19.	
				Education provided to facility		
		PM following the annual		11/29/19 by SDC on Grievar		
		eting an interview was		procedures, with emphasis of		
		lent #64. Resident #64		all grievances to social servi		
	stated that she was la	ate for the meeting because		education will continue throu	iah 12/12/10	

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED
		345186	B. WING		11/15/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
FIVE OAK	S MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 550	she was waiting to re she returned from an	ceive incontinent care since appointment this morning	F 55	50 Beginning 11/23/2019 auc completed by Risk Manag monitor timely tray distribu	er (RM) to
	around 11:00 AM. The resident indicated that she knew what time it was because she had a digital clock on her phone that had the time on it. She reported that she told her assigned Nursing Assistant (NA), NA #5, that she needed to be changed several times and she said, "I know I will get to you". She went on to explain that she participated in Physical Therapy (PT) in her room that afternoon and the therapist saw that her			alternating halls and altern include weekends) three to Staff Development Coordi complete audits 3x per we alternating halls to ask if no receiving incontinence can Social Worker to complete interviews per week on alternation	nating meals (to imes weekly. nator to eek on esidents are re when needed. e 10 resident ernating halls to
	this interaction with the arriving to the Reside made her embarrasse that she knew that all	th urine. Resident #64 said that h the therapist as well as ident Council meeting late assed. She further explained all the residents in the meeting he was late because she		ask if residents if they kno grievances and or if they h unresolved grievances. The audits will be present monthly QAPI by Risk Ma Worker and Staff Develop Coordinator for 3 months substantial compliance is	nave any ed to the nager, Social ment or until
	An interview was conducted wit physical therapist on 11/15/19 a therapist confirmed that she wo Resident #64 in her room on the 11/14/19 around 1:30 PM. She observed Resident #64's pants with urine when she stood up fr during the PT session. She rep was with Resident #64 for at lead during that session.	11/15/19 at 8:35 AM. The nat she worked with oom on the afternoon of PM. She stated that she 64's pants to be visibly wet stood up from her wheelchair n. She reported that she			
	NA #5 stated that she #64 on 11/14/19 from reported that Resider with incontinence car staff know when she was asked if Residen assistance with incon	ed on 11/15/19 at 10:43 AM. e was assigned to Resident 11:00 AM to 3:00 PM. She at #64 required assistance e and she was able to let the needed to be changed. She t #64 had requested tinence care during her shift on 11/14/19 and she			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 12/17/2019 1 APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	
		345186	B. WING		_	   11/ <sup>.</sup>	15/2019
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, ST	IATE, ZIP CODE		
FIVE OAK	S MANOR			413 WINECOFF SCHOOL F CONCORD, NC 28027	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	said the resident had assistance until about asked if she had chec to 2:00 PM to provide revealed that she had resident prior to 2:00 explained that someti #64 if she needed to 1 she just waited for the further explained that her wheelchair throug was frequently outsid where the resident was check to see if she ne stated that when she the afternoon of 11/14 were wet with urine al changing her pants. An interview was com Nursing (DON) on 11/ DON reported that sh be treated with dignity reported that she exp provide routine incont who required assistar 2. Resident #110 was 6/26/15 and most rec with diagnoses that in A physician's order da Resident #110 was to by staff. The significant chang assessment dated 10 #110's cognition was	not asked her for t 2:00 PM. NA #5 was sked on Resident #64 prior incontinence care and she not checked on the PM on 11/14/19. She mes she asked Resident be changed and sometimes a resident to tell her. She Resident #64 self-propelled hout the facility and she e so if she had not known as at then she wouldn't eeded changed. NA #5 changed Resident #64 on 4/19 the resident's pants and she had to assist her with ducted with the Director of f15/19 at 1:25 PM. The e expected all residents to y and respect. She further ected nursing staff to inence care to residents nce.	F 550				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/17/2019 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE	
		345186	B. WING			11/	15/2019
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
FIVE OAK	S MANOR			13 WINECOFF SCHOOL I CONCORD, NC 28027	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page and she had significan A Registered Dieticiar indicated Resident #1 pounds with 3.7% we weight loss x 90 days She required extensive eating. The active care plan f reviewed on 11/12/19 area of nutritional risk interventions included during meals. An observation was c on 11/12/19 at 12:00 f eyes closed, and diffice was not interviewable A continuous observa 100 hall during the lur beginning at 12:20 PM tray was observed with an open-air cart on th the cart, with the excer were served to the res- timeframe. Resident on the open-air cart u after the meal tray wa At 12:49 PM Nursing the meal tray to Resident with eating. A second meal observen 100 hall during the dir	<ul> <li>a 5</li> <li>ht weight loss.</li> <li>h (RD) note dated 11/12/19</li> <li>10's current weight was 140</li> <li>ight loss x 30 days, 13.6 %</li> <li>and 14.6% x 180 days.</li> <li>re assistance from staff with</li> <li>or Resident #110 was</li> <li>and it included the focus</li> <li>(initiated on 9/17/19). The</li> <li>in part, provide assistance</li> </ul> onducted of Resident #110 PM. She was in her room, cult to rouse. Resident #110 PM. She was in her room, cult to rouse. Resident #110 PM. She was in her room, cult to rouse. Resident #110 PM. She was in her room, cult to rouse. Resident #110 Sident #110's meal h a lid covering the plate on e 100 hall. All meal trays on eption of Resident #110's, sidents within a 10-minute #110's meal tray remained ntil 12:49 PM, 29 minutes s first observed on the hall. Assistant (NA) # 2 served lent #110 and assisted her vation was conducted of the ner meal on 11/12/19 at	F 550				
	the open-air cart and	110's meal tray arrived on was served to her within 10 istance provided for eating.					

	-	D HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/17/2019 RM APPROVED IO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DA	E SURVEY IPLETED
		345186	B. WING			1	1/15/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					413 WINECOFF SCHOOL ROAD		
FIVE OAK	5 MANUR				CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR( DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 550	Continued From page	6	F	550	D		
	100 hall during the dir 5:10 PM. Resident # observed with a lid co open-air cart on the 1 the cart, with the exce were served to the res- timeframe. Resident on the open-air cart u after the meal tray wa At 5:30 PM an NA ser assisted Resident #11 An interview was cont 11/14/19 at 11:00 AM working at the facility frequently assigned to recalled working with and acknowledged the minutes for her meal 10 She revealed that this for Resident #110's m open-air cart for great being served to her. assignment for the se Resident #110 resider short hall on the 100-1 more residents than s assignments. She sta was why it took so lor tray to be served and eating. When NA #2 #110's food was still v she said, "probably no	vering the plate on an 00 hall. All meal trays on eption of Resident #110's, sidents within a 10-minute #110's meal tray remained ntil 5:30 PM, 20 minutes s first observed on the hall. ved the meal tray and 10 with eating. ducted with NA #2 on . She stated that she began in June and she was o Resident #110. NA #2 Resident #110 on 11/12/19 at it took close to 30 tray to be served to her. was a normal occurrence leal tray to sit on the er than 20 minutes prior to She explained that the NA ction of the facility where d included a long hall and hall unit and encompassed ome of the other ated that she believed this of for Resident #110's meal for her to be assisted with was asked if Resident varm when served to her					
	warm enough. NA #2	explained that since the waited so long to get her					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/17/2019 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE	
		345186	B. WING		_	11/ <sup>.</sup>	15/2019
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
FIVE OAK	SMANOR		4	413 WINECOFF SCHOOL F	ROAD		
				CONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page food that she hadn't w longer for her to go re	anted her to have to wait	F 550				
	The Dietary Manager 11/14/19 at 1:41 PM. working as the DM ab observations of Resid on the open-air cart for served during lunch of minutes during lunch of minutes during lunch of minutes during lunch of minutes during lunch of acceptable for a meal tray cart for that long of to being served to the they had some closed facility, and he was in coverings for the open the meals warm for a An interview was come Nursing (DON) on 11/ DON reported that sh regardless of their cog in a dignified manner. Resident #110's meal cart for 29 minutes pri lunch on 11/12/19 and dinner on 11/13/19 we She indicated that if a resident's meal tray h open-air tray cart for a prior to being served to reheat the food prior to resident. The DON s facility had an increas who required assistant have contributed to the	(DM) was interviewed on He reported he began yout 5 weeks ago. The lent #110's meal tray sitting or 29 minutes prior to be n 11/12/19 and for 20 on 11/13/19 were reviewed I stated that it was not tray to sit on the open-air without being reheated prior resident. He explained that I metal tray carts at the the process of ordering n-air tray carts to help keep longer period of time. ducted with the Director of (15/19 at 1:25 PM. The e expected all residents, gnitive status, to be treated The observations of tray sitting on the open-air ior to be served during d for 20 minutes during ere reviewed with the DON. cognitively impaired					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/17/2019 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345186	B. WING			11/	15/2019
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				4	13 WINECOFF SCHOOL ROAD		
FIVE OAK	S MANOR			С	CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From page	8	F	550			
	<ol> <li>Resident #12 was 7/31/19 with diagnosi accident.</li> </ol>	admitted to the facility on s of cerebral vascular					
		/1/19 documented goals and ac disease and assistance living.					
	revealed Resident #1 The resident required activities of daily living always continent. Th	Data Set documentation 2 had an intact cognition. assistance of 1 staff for g and the resident was e active diagnoses were ident, muscle weakness, rmalities of gait.					
	On 11/12/19 at 12:17 interviewed who state #25) informed him "I I asked the roommate sleeping hours). The he did not like his roo resident complained t sleeping in his wheel all day and up at nigh every hour. The room light but called out for the night. The reside awake and not getting roommate also yelled bathroom door while bathroom (did not wa finished), and the resi resident commented staff of his concerns a room each night in re yelling and they were	pm Resident #12 was ed his roommate (Resident hate you" when the resident to be quiet at night (during resident commented that mmate ' s response. The hat the resident was chair at the nurses station t getting up to the bathroom mate had not used the call staff, yelling in the middle of ent stated he was kept g enough sleep. The and banged on the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			F	ITED: 12/17/2019 ORM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) [	DATE SURVEY OMPLETED
		345186	B. WING			11/15/2019
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, Z	ZIP CODE	
FIVE OAK	S MANOR			I3 WINECOFF SCHOOL ROAD ONCORD, NC 28027		
		ATEMENT OF DEFICIENCIES	<b>I</b>	•		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETION DATE
F 550	Continued From page	<u>, 0</u>	F 550			
1 000	and no one has done		F 550			
	11/12/19 at 12:17 am his blinking eyes, yaw	sident #12 during interview revealed he looked tired by ning, and facial expression. nmented he was tired.				
	who stated she was fa Nurse #1 indicated sh resident and night sta	ewed on 11/13/19 at 9:30 am amiliar with Resident #12. he was informed by the ff "regularly" that the f (Resident #25) had kept				
	roommate in his whee	one of Resident #12 ' s el chair at the nurses' station nterview (11/13/19 at 9:30				
	during interview on 11 resident shared that h another room so he (t night. The resident 's language and stated '	. The resident commented				
	interview on 11/13/19	n of Resident #12 during revealed he continued to nking eyes, yawning, and				
	pm of Nursing Assista regularly assigned to was aware that Resid roommate kept him u	ducted on 11/13/19 at 12:20 ant #1 (NA) who was the resident and stated she ent #12 complained his p at night, banged on the billered aggressively. NA #1				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 12/17/2019 APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		345186	B. WING			_	11/	15/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
FIVE OAK	S MANOR				13 WINECOFF SCHOOL R ONCORD, NC 28027	OAD		
					-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	9 10	F	550				
	months. NA #1 stated	going on for a quiet a while, d that the roommate slept						
		as provided activities in the joing back to bed to keep						
		day. NA #1 stated that she						
	had informed the assi more than one occasi	gned nurse (Nurse #1) on on.						
	On 11/13/19 at 2:50 p	m an interview was						
	conducted with Social	I Work (SW) #1 and #2 who						
	-	were not aware or been t #12 was unable to sleep						
		ig, behavior and verbal						
	aggression from the r							
	•	ware of the roommate ' s oom door and yelling when						
	the resident was using	g the bathroom and						
		hate you" and use of curse she was not informed by						
		that there was a request for						
	room change. SW #2							
	-	e resident had concerns ates yelling and was offered						
		s not by the window. The						
		be placed on the waiting list						
		the bed by the window. nursing had not informed						
		s and a grievance was not						
		#12 ' s SW notes since the (7/31/19) revealed they were						
		11/13/19 and documented						
		y to sleep. A room change						
		d was declined; request was a waiting list for a room						
	with a bed by the wind	-						

Facility ID: 953488

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				FOR	D: 12/17/2019 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	345186	B. WING		11	/15/2019
NAME OF PROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP	•	
FIVE OAKS MANOR		4	13 WINECOFF SCHOOL ROAD		
THE CARS MANOR		C	CONCORD, NC 28027		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
<ul> <li>conducted with Nurre Resident #12 compone occasion that hinight and the residered sleep). Nurse #1 standtress the roomminisomnia (last monti did not inform SW confer/consider writinis resident did not asked.</li> <li>The Director of Nurres on 11/14/19 at 2:49 Resident #12 's consider writinisom the something signification with nurse grievance when the something signification.</li> <li>On 11/15/19 at 12:00 conducted with the with and responsible physician stated that resident has have the resi</li></ul>	pm an interview was se #1 who stated that lained to her on more than is roommate was yelling at ent was up at night (not able to ated she asked psychiatry to ate 's yelling at night due to h). Nurse #1 indicated she of the resident's complaints or g a grievance because the for one. sing (DON) was interviewed pm who was not aware of mplaints. The DON stated ent complaints to be reported bugh with the grievance commented she would start ing staff to complete a resident complains of	F 550			

Facility ID: 953488

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
		345186	B. WING		1	1/15/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR			13 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	Continued From page	e 12	F 550			
	bathroom) where there was a concern.					
F 585	Grievances		F 585			12/13/19
SS=D	CFR(s): 483.10(j)(1)-	(4)				
	§483.10(j) Grievance	S.				
		ident has the right to voice				
		ility or other agency or entity				
	-	s without discrimination or ear of discrimination or				
	•	nces include those with				
		eatment which has been				
		hat which has not been				
		or of staff and of other concerns regarding their LTC				
	facility stay.					
		ident has the right to and the				
		ompt efforts by the facility to resident may have, in				
	accordance with this	•				
		ility must make information				
	on how to file a grieva to the resident.	ance or complaint available				
	§483.10(j)(4) The fac grievance policy to en	ility must establish a nsure the prompt resolution				
		arding the residents' rights				
		graph. Upon request, the				
	to the resident. The g	copy of the grievance policy				
	include:					
		ndividually or through				
	postings in prominent facility of the right to the right	t locations throughout the				
		in writing; the right to file				
		usly; the contact information				
	of the grievance offic	ial with whom a grievance				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	): 12/17/2019 APPROVED ). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		345186	B. WING			_	11/	15/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
FIVE OAK				4	13 WINECOFF SCHOOL R	OAD		
FIVE OAK	5 MANUR			С	ONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 585	Continued From page can be filed, that is, hi address (mailing and number; a reasonable completing the review to obtain a written dec grievance; and the co- independent entities v be filed, that is, the pe Quality Improvement Agency and State Lor program or protection (ii) Identifying a Griev responsible for overse receiving and tracking conclusions; leading a by the facility; maintai information associated example, the identity of grievances submitted written grievance deci coordinating with state necessary in light of s (iii) As necessary, tak prevent further potent right while the alleged investigated; (iv) Consistent with §4 reporting all alleged v abuse, including injuri	<ul> <li>13</li> <li>s or her name, business email) and business phone</li> <li>expected time frame for</li> <li>of the grievance; the right</li> <li>bision regarding his or her</li> <li>ntact information of</li> <li>with whom grievances may</li> <li>ertinent State agency,</li> <li>Organization, State Survey</li> <li>ng-Term Care Ombudsman</li> <li>and advocacy system;</li> <li>ance Official who is</li> <li>being the grievance process,</li> <li>grievances through to their</li> <li>any necessary investigations</li> <li>ning the confidentiality of all</li> <li>d with grievances, for</li> <li>of the resident for those</li> <li>anonymously, issuing</li> <li>sions to the resident; and</li> <li>and federal agencies as</li> <li>pecific allegations;</li> <li>ing immediate action to</li> <li>ial violations of any resident</li> <li>violation is being</li> <li>483.12(c)(1), immediately</li> <li>iolations involving neglect,</li> <li>es of unknown source,</li> <li>on of resident property, by</li> </ul>		585			TE	DATE
	provider, to the admin as required by State Ia (v) Ensuring that all w include the date the g summary statement o the steps taken to inve	istrator of the provider; and						

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	-	D HUMAN SERVICES				FORM	D: 12/17/2019 M APPROVED
STATEMENT C	5 FOR MEDICARE & I of Deficiencies CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		345186	B. WING			11/	/15/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				41	13 WINECOFF SCHOOL ROAD		
FIVE OAK	5 MANUR			С	ONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	as to whether the grie confirmed, any correct taken by the facility as and the date the writte (vi) Taking appropriate accordance with State of the residents' rights or if an outside entity the State Survey Ager Organization, or local confirms a violation for rights within its area of (vii) Maintaining evide result of all grievance: 3 years from the issue decision. This REQUIREMENT by: Based on record revi- interview of the reside facility failed to follow 1 sampled resident (F included: The facility Grievance and Investigating politic documented that "All filed with the facility w corrective actions will grievance(s). Upon re- complaint report, the fa-	t's concerns(s), a statement vance was confirmed or not tive action taken or to be a result of the grievance, en decision was issued; e corrective action in a law if the alleged violation a is confirmed by the facility having jurisdiction, such as ncy, Quality Improvement law enforcement agency or any of these residents' of responsibility; and ence demonstrating the s for a period of no less than ance of the grievance is not met as evidenced ew, observation and ent, staff and Physician, the the grievance policy for 1 of Resident #12). Findings s/Complaints, Recording cy dated 4/2017 grievances and complaints ill be investigated and be taken to resolve the acceiving a greivance and Grievance Officer will begin ne allegations."	F	585	EFICIENCY) F585: Grievances Resident #12 has been moved to any room per resident request. All residents have the potential for the alleged deficient practice regarding grievances. The Staff Development Coordinator conducted education on 11/29/19 and facility grievance procedures for facilist staff, with emphasis on reporting all resident concerns or grievances to the supervisor or the social worker to en- follow up this education will continue through 12/12/19. All new hires will receive education un- hire during orientation. An audit was completed by Social W on 11/27/19 for all interviewable resident	e d on ty eir sure pon prker	
		/1/19 documented goals and			on 11/27/19 for all interviewable resid on satisfaction with current roommat assignment. No other residents had		

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	S FOR MEDICARE & OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(¥2) MULT	PLE CONSTRUCTION	OMB NO. 0 (X3) DATE SU	
	CORRECTION	IDENTIFICATION NUMBER:	` '	G	(X3) DATE SUI COMPLET	
		345186	B. WING		11/15/	/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
FIVE OAK	S MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027	)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEE	N OF CORRECTION E ACTION SHOULD BE C TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 585	Continued From page	e 15	F 5	85		
	interventions for cardi with activities of daily The 14-day Minimum revealed the resident The resident required activities of daily living always continent. Th cerebral vascular acc and unspecified abno On 11/12/19 at 12:17 interviewed who state #25) informed him "I I asked the roommate sleeping hours). The he did not like his roo resident complained t sleeping in his wheel all day and up at nigh every hour. The room light but called out for the night. The reside awake and not getting roommate also yelled bathroom (did not wa finished), and the resi resident commented staff of his concerns a room each night in re yelling and they were	iac disease and assistance living. Data Set documentation had an intact cognition. Assistance of 1 staff for g and the resident was e active diagnose were ident, muscle weakness, ormalities of gait. pm Resident #12 was ed his roommate (Resident hate you" when the resident to be quiet at night (during resident commented that ormate 's response. The that the resident was chair at the nurses station it getting up to the bathroom mate had not used the call staff, yelling in the middle of ent stated he was kept g enough sleep. The I and banged on the the resident used the it until the resident was ident did not like this. The that he had informed the and the staff would enter his sponse to the roommate 's aware. The resident stated ehavior) keeps happening		complaints about currer wanted a room change Social Worker will com resident interviews per alternating halls to ask know how to report grid they have any unresold starting 11/27/19. The audits will be pres monthly QAPI by the S months or until substar achieved.	e. plete 10 random week on residents if they evances and or if ved grievances ented to the ocial Worker for 3	
	who stated she was fa	ewed on 11/13/19 at 9:30 am amiliar with Resident #12. he was informed by the				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/17/2019 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345186	B. WING			11/	15/2019
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
FIVE OAK				4	413 WINECOFF SCHOOL ROAD		
	5 MANOR			0	CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 585	him up at night. Resident #12 had add during interview on 11 resident shared that h another room so he (t night. The resident 's language and stated ' resident does not like "it happened again las An interview was comp m Nursing Assistant assigned to the reside aware that Resident # roommate kept him up bathroom door and ho stated this had been g months. NA #1 stated assigned nurse (Nurs occasion. On 11/13/19 at 2:50 p conducted with Social both stated that they w informed that resident because of loud yellin aggression from the m They were also not aw banging on the bathro	(Resident #25) had kept ditional information to add /13/19 at 10:25 am. The is wife had asked staff for he resident) can sleep at a roommate had used foul 'I hate you" which the . The resident commented at night." ducted on 11/13/19 at 12:20 #1 (NA) who was regularly ent and stated she was #12 complained his to at night, banged on the billered aggressively. NA #1 going on for a quiet a while, d that she had informed the e #1) on more than one m an interview was I Work (SW) #1 and #2 who were not aware or been at #12 was unable to sleep g, behavior and verbal esident ' s roommate. ware of the roommate ' s bom door and yelling when	F	585			
	words. SW #1 stated the resident's spouse room change. SW #2 informed today that the regarding his roomma	hate you" and use of curse she was not informed by that there was a request for					

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						FORM	: 12/17/2019 I APPROVED
STATEMENT (	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			(X3) DATE	
		345186	B. WING		_	   11/ <sup>.</sup>	15/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
FIVE OAK	S MANOR			413 WINECOFF SCHOOL CONCORD, NC 28027	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	for another room with Both SWs stated that them of the complaint initiated. (SW are the A review of Resident a resident's admission ( notified by nursing on the resident's concerr behaviors and inability was offered today and made to be placed on with a bed by the wind On 11/14/19 at 2:30 p conducted with Nurse Resident #12 complai one occasion that his night and the resident sleep). Nurse #1 stat to address the roomm insomnia (last month) did not inform SW of to offer/consider writing resident did not ask for The Director of Nursir on 11/14/19 at 2:49 pt Resident #12 's comp she expected residen to SW for follow throu process. The DON co education with nursing grievance when the re something significant On 11/15/19 at 12:05	be placed on the waiting list the bed by the window. nursing had not informed is and a grievance was not Grievance Officers). #12 's SW notes since the (7/31/19) revealed they were 11/13/19 and documented nof his roommate 's y to sleep. A room change d was declined; request was a waiting list for a room dow. om an interview was e #1 who stated that ined to her on more than roommate was yelling at t was up at night (not able to ted she asked for psychiatry hate 's yelling at night due to . Nurse #1 indicated she the resident's complaints or a grievance because the or one. ng (DON) was interviewed m who was not aware of plaints. The DON stated t complaints to be reported ugh with the grievance ommented she would start g staff to complete a esident complains of to them.	F 58	5			

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		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/17/2019 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345186	B. WING		11	/15/2019
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR			13 WINECOFF SCHOOL ROAD ONCORD, NC 28027		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT		(¥5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 585	Continued From page		F 585			
		for Resident #12. The				
		ne had been informed of the behavior escalation and that				
		behaviors for a long time.				
		ented he was informed bout mid October, that there				
	was an altercation be	tween residents, Resident				
		e, where the roommate was oom door and yelling. The				
		ed that the resident was				
		ncident. The Physician expect staff to bring to the				
	team (DON) resident					
		anging on the bathroom				
	bathroom) where ther	the roommate was in the e was a concern.				
F 637 SS=D	Comprehensive Asse CFR(s): 483.20(b)(2)(	ssment After Signifcant Chg ii)	F 637			12/13/19
	determines, or should there has been a sign	in 14 days after the facility have determined, that ificant change in the mental condition. (For				
	purpose of this section	n, a "significant change"				
		e or improvement in the will not normally resolve				
		itervention by staff or by				
		d disease-related clinical an impact on more than				
		ent's health status, and				
		ary review or revision of the				
	care plan, or both.) This REQUIREMENT	is not met as evidenced				
	by: Based on observation	a report roviou and staff		E627: Comprohensive Assessment	at offer	
	interviews, the facility	n, record review and staff failed to complete a		F637: Comprehensive Assessmer Significant Change	it alter	
	significant change in s	status Minimum Data Set			in	
	(IVIDO) IOI a resident V	vith two or more areas of		Resident #114 Significant Change		

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						<u>10. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
		345186	B. WING		1	1/15/2019
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
FIVE OAK	S MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 637	Continued From page	e 19	F 63	7		
		Daily Living, continence and		Status Assessment (SCSA	) completed	
		of 3 sampled residents		and transmitted on 11/27/2		
	,	e ulcers (Resident #114).		Coordinator.	-	
	The findings included	1:		MDS Coordinator reset ass		
	Desident #114 was a			for Resident #114 upon dis	•	
		riginally admitted to the hais to the help a		significant change and com assessment for Resident #	•	
		ompression fracture of the		assessment reference date		
		abetes and heart failure.		completed on 11/26/2019 a		
	,,			on 11/27/2019.		
	The Admission MDS	assessment dated 6/18/19		An audit of current resident	ts with prior	
		114 was cognitively intact		Omnibus Budget Reconcilia		
		sion for eating, limited		(OBRA) assessment comp		
	assistance for bed m	-		acute care admission the la	-	
		essistance with toileting and bendent on staff for bathing.		reviewed for SCSA by MDS with no other SCSA identifi		
		her indicated Resident #114		On 12/2/2019 MDS Coordin		
		el and bladder and had no		weekly audit of all residents	•	
	pressure ulcers.			therapy, new skin issues or		
				significant changes identifie		
		#114 was discharged to the		capture of SCSA for all resi		
		dmitted on 8/13/19 with a		12/2/2019 MDS coordinato	• •	
		eumonia and deep tissue t great toe and right heel.		interdisciplinary team, inclu		
		t great toe and right heel.		limited to; MDS Coordinato Nursing and/or Unit Coordi		
	A review of the Wour	nd Evaluation and		Worker, Dietician and/or Di		
		ary dated 8/21/19 revealed		License Therapist, review of		
		nstageable Deep Tissue		schedule which entails ider		
	Injury to his right hee	l and left big toe for a		significant change for resid		
	duration of 9 days.			prior to assessment referer	•	
	Bovious of the Marine	t Evaluation and		weeks prior to assessment		
	Review of the Wound	ary dated 8/28/19 revealed		week prior to assessment of of residents readmitted to f		
		ry to Resident #114's right		following clinical meeting.	admity at the	
	heel was resolved.	,		Education provided to Care	e Plan Team by	
				Regional Minimum Data Se		
	A review of the Wour			on 11/22/2019 related to th		
	Management Summa	ary dated 10/2/19 revealed		Assessment Instrument (R	AI)Guidelines	

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							O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	1 Y /	E SURVEY IPLETED
		345186	B. WING			1	1/15/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR		413 WINECOFF SCHOOL ROAD CONCORD, NC 28027				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 637	Continued From page	e 20	F 63	37			
	the left big toe was a (sores that have brok top two layers of the s below). A quarterly MDS asse revealed Resident #1 intact. He required ex mobility, transfers, dr hygiene and was dep for bathing. The asse Resident #114 was a and bladder and had On 11/12/19 at 11:15 interviewed. He state assistance with bed r dressing prior to his h 2019, but after his ho readmitted with press and left big toe, had to and required more ass personal care tasks. An interview occurred 11/14/19 at 2:20pm. #114 went to the hos to limited assistance Daily Living (ADL's) a and bladder. When h in August 2019, he ha required more assista incontinence care. On 11/14/19 at 4:20p	Stage 3 pressure ulcer en completely through the skin and into the fatty tissue essment dated 10/22/19 14 remained cognitively tensive assistance with bed essing, toileting, personal endent on a staff member ssment also indicated lways incontinent of bowel a stage 3 pressure ulcer. am Resident #114 was d he required very little nobility, transfers and nospitalization in August spitalization he was sure areas to his right heel become more incontinent esistance from staff for d with Nurse Aide #4 (NA) on She stated before Resident pital he required supervision with most of his Activities of and was continent of bowel e returned from the hospital ad a sore on his foot, ance with ADL's as well as m MDS Nurse #1 was		57	for SCSA requirements when a resider condition changes from his/her baselin as indicated by comparison of the resident's current status to the most recent comprehensive assessment ar any subsequent quarterly assessment New hires responsible for scheduling setting assessment reference dates w be trained by Regional MDS Nurse du orientation period. Interdisciplinary te including but not limited to; MDS Coordinator, Director of Nursing and/o Unit Coordinator, Social Worker, Dieti and/or Dietary Manager, License Therapist, will review resident with readmission or change in status for a significant change for either major improvement or decline during the standard clinical meeting, decision to proceed with SCSA will be determined to 14 days and SCSA completed withi days after decision of SCSA. The MDS Coordinator or Licensed Nu will complete a weekly audit of up to 5 residents with observations of SCSA a SCSA scheduled for 3 months. The MDS Coordinator will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review recommendations. The findings will b reported to QAPI for 3 months. Trends be noted, and the plan of correction w modified as needed based on trend.	he hd ts. and fill uring am or cian or cian d up n 14 rse and t and e s will	
	complete a significan the increased need for	ed it was an oversight not to t change assessment due to or assistance with bed d dressing, the change with					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345186	B. WING		11/15/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FIVE OAK	S MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIC
F 637	Continued From page	21	F 63	7	
		new area of a pressure rly MDS was completed on			
	11/15/19 at 1:30pm si expectation for the M significant change in a required in the regula	he Director of Nursing on he indicated it was her DS Nurse to complete a status MDS assessment as tion, 14 days after 2 or more areas were determined.			
F 641 SS=D	Accuracy of Assessm		F 64	1	12/13/19
	resident's status.	of Assessments. t accurately reflect the is not met as evidenced			
	facility failed to code to (MDS) assessment and expectancy and active	ew and staff interview, the the Minimum Data Set ccurately in the areas of life e diagnoses for 1 of 1 r hospice care (Resident		F641: Accuracy of Assessments Resident #110 assessment was corri on 11/14/2019 to reflect the end of lif active diagnosis by MDS Coordinato transmitted and accepted on 11/19/2 All residents receiving hospice servic have the potential to be affected. An	re and r and 019. ces
	The findings included	:		was conducted on 11/27/2019 by the Director of Nursing for each hospice	
	6/26/15 and most rec	admitted to the facility on ently readmitted on 9/9/19 icluded dementia, failure to r fracture.		resident to determine if their assessr were accurate and no inaccuracies v discovered. MDS nurses were educated by the	
	was admitted to hosp	rd indicated Resident #110 ice services on 10/10/19.		Regional MDS Nurse on 11/22/19 regarding proper coding of life expect and active diagnosis on the MDS. Ne hires responsible for scheduling and	ew
	assessment dated 10	e Minimum Data Set (MDS) /19/19 indicated Resident severely impaired. She was		setting assessment reference dates be trained by Regional MDS Nurse of orientation period.	

Facility ID: 953488

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						IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	· · · · · · · · · · · · · · · · · · ·	E SURVEY IPLETED
		345186	B. WING		–   1 <sup>,</sup>	1/15/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
FIVE OAK	S MANOR			413 WINECOFF SCHOOL R CONCORD, NC 28027	ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
		ervices but was not coded	F 64	DON/License Nurse	e will conduct MDS	
	<ul> <li>coded with hospice services but was not coded with a life expectancy of less than 6 months.</li> <li>An interview was conducted with MDS Nurse #1 on 11/14/19 at 10:10 AM. The 10/19/19 MDS for Resident #110 that indicated she was receiving hospice services but did not have a life expectancy of less than 6 months was reviewed with MDS Nurse #1. MDS Nurse #1 confirmed she coded the sections of this MDS assessment related to hospice services and life expectancy for Resident #110. She revealed she was unaware of the Resident Assessment Instrument (RAI) instructions that indicated a life expectancy of less than 6 months was to be coded if the resident was receiving hospice services.</li> <li>During an interview with the Director of Nursing on 11/15/19 at 1:25 PM she stated she expected</li> </ul>			audits to hospice services and validate life expectancy and up to 5 residents of active diagnosis are coded in the MDS weekly. Director of Nursing will present audits to the Quality Assurance Performance Improvement monthly times 3 months for review. Trends will be noted, and the plan of correction will be modified as needed based on trend.		
	the MDS to be coded 1b. A Nurse Practitior indicated Resident #1 fracture.	ner note dated 10/7/19				
	assessment dated 10 #110's cognition was	e Minimum Data Set (MDS) /19/9 indicated Resident severely impaired. Resident was not included as an				
	on 11/14/19 at 10:10 Resident #110 that had diagnosis of a femur f MDS Nurse #1. MDS coded the active diag	ducted with MDS Nurse #1 AM. The 10/19/19 MDS for ad not included an active fracture was reviewed with S Nurse #1 confirmed she noses section of this MDS dent #110. She revealed this				

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 12/17/2019 RM APPROVED NO. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345186	B. WING		1	1/15/2019
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
FIVE OAK	S MANOR					
				CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From page	e 23	F 641			
	was an error and that the active diagnoses on this 10/19/19 MDS should have included Resident #110's femur fracture as an active diagnosis.					
		as an active diagnosis.				
	•	vith the Director of Nursing PM she stated she expected				
F 656	Develop/Implement C	Comprehensive Care Plan	F 656			12/13/19
SS=D	CFR(s): 483.21(b)(1)					
	implement a compret care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The cor describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the re- under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAB	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's d mental and psychosocial fied in the comprehensive mprehensive care plan must g- are to be furnished to attain ent's highest practicable l psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). ervices or specialized s the nursing facility will PASARR a facility disagrees with the RR, it must indicate its				

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PRINTED: 12/17/2019

		D HUMAN SERVICES MEDICAID SERVICES			FORM	): 12/17/2019 MAPPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
		345186	B. WING		11/	15/2019
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK			41	13 WINECOFF SCHOOL ROAD		
			С	ONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page (A) The resident's goat desired outcomes. (B) The resident's pre- future discharge. Faci whether the resident's community was asses local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, in requirements set forth section. This REQUIREMENT by: Based on observation record review, the fac comprehensive care pr antipsychotic medicat of an anticoagulant (R long-term antibiotic us facility also failed to in nutrition (Resident #1 sampled residents. Th 1. Resident #79 was cumulative diagnoses Brain Injury (TBI). Review of Resident # Data Set (MDS) dated moderate cognitive im no behaviors. He was	<ul> <li>24</li> <li>als for admission and</li> <li>ference and potential for lities must document</li> <li>a desire to return to the seed and any referrals to a and/or other appropriate</li> <li>se.</li> <li>an the comprehensive care</li> <li>n accordance with the</li> <li>in paragraph (c) of this</li> <li>is not met as evidenced</li> <li>ns, staff interviews and</li> <li>lity failed to develop a</li> <li>olan for the use of an</li> <li>ions (Resident #79), the use</li> <li>Resident #125) and</li> <li>se (Resident #17). The</li> <li>nplement the care plan for</li> <li>10). This was for 4 of 28</li> <li>he findings included:</li> <li>admitted on 7/6/15 with</li> <li>of Dementia and Traumatic</li> <li>79's quarterly Minimum</li> <li>10/8/19 indicated</li> <li>pairment and he exhibited</li> </ul>	F 656		e ADS with al	
	Review of Resident # Physician orders read 37.5 milligrams (mg) e	Seroquel (antipsychotic)		the Director of Nursing and License N to verify comprehensive care plans ar place for residents receiving antipsycl medications, anticoagulants, long-terr	urse e in notic	

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		MEDICAID SERVICES				3 NO. 0938-03		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	. ,	DATE SURVEY COMPLETED		
		345186	B. WING			11/15/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	· · · ·		
FIVE OAK	S MANOR			413 WINECOFF SCHOOL RO. CONCORD, NC 28027	AD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE		
F 656	Continued From page	e 25	F 65	56				
		79's November 2019		antibiotics as well as	nutritional			
		ation Record (MAR) read he		supplements. This a				
		uel nightly as ordered.		residents on antibioti				
				were updated by 11/				
		79's comprehensive care		residents on antipsyc				
		11/12/19 did not include a		had up to date care p				
	care plan for the use medication.	of an antipsychotic		MDS nurses and Reg	-			
medication.			Nurse on 11/22/19 re					
	In an interview on 11/14/19 at 10:10 AM, MDS Nurse #1 stated she started at the facility one			developing/implemer	• •			
				care plans. Dietary S	÷ .			
	year ago and for 8 m	onths, she was the only		supplements on the t	tray educated on tray			
		and care plans. MDS Nurse		card system and acc				
	-	hired MDS Nurse #2 in		11/26/2019. New hire				
	August 2019.			scheduling and settin	-			
	In another interview o	on 11/14 at 4:25 PM, MDS		reference dates will t Regional MDS Nurse				
		thought she completed a		period. Monthly revie	0			
	care plan for Resider	•		medication orders wi				
		ently she did not. She stated		Facility Pharmacy Co				
	it was an oversight ar	nd should be care planned.		residents with these	orders and will			
					lity within 72 hours of			
		/15/19 at 1:20 PM, the		completion.				
		DON) stated it was her		DON or License Nurs				
	medication be care p	ident #79's antipsychotic		audits to validate cor plans are in place for	•			
	medication be care p	lamed.			itions, anticoagulants,			
				long-term antibiotics	•			
	2. Resident #125 was	s admitted on 10/23/19 a		supplements weekly.				
	diagnosis of a right fe	emur fracture.		of supplements provi				
		· · · · · · · - ·			k Manager beginning			
		ay admission Minimum Data		-	or 3 months. Facility			
		27/19 indicated moderate		Pharmacy Consultan				
	cognitive impairment	oded for having received his		findings to QAPI mor update all comprehe				
		ation 4 of the 7 look back		accuracy based on re				
	days.			Director of Nursing a				
	,			comprehensive care				
	Review of Resident #	t125c November 2010		presented to Quality				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					MAPPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345186	B. WING			11/15/2019	
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				41	3 WINECOFF SCHOOL ROAD		
FIVE OAK	5 MANUR			C	ONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page	e 26	F	556			
1 000		d Enoxaparin (anticoagulant)		550	Performance Improvement monthly ti	mos	
		ubcutaneously every day with			3 months for review. Trends will be noted		
	a start date of 10/23/				and the plan of correction will be mod		
					as needed based on trend.		
		#125's November 2019					
		ation Record (MAR) read he oxaparin injection daily as					
	ordered.						
		#125's comprehensive care					
	care plan for the use medication.	11/08/19 did not include a of an anticoagulant					
		114/10 at 10:10 AM MDS					
		/14/19 at 10:10 AM, MDS started at the facility one					
		onths, she was the only					
		and care plans. MDS Nurse					
	#1 stated the facility August 2019.	hired MDS Nurse #2 in					
		on 11/14 at 4:25 PM, MDS					
		thought she completed a					
	•	nt #125's anticoagulant rently she did not. She stated					
		nd should be care planned.					
	In an interview on 11	/15/19 at 1:20 PM, the					
		DON) stated it was her					
	expectation that Res	ident #125's anticoagulant					
	medication be care p	lanned.					
		admitted to the facility on s that included dementia.					
	orthin with diagnose	ש וומנ וווטוטעכע עלווולוונום.					
		or Resident #17 dated thenamine Hippurate					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/17/2019 MAPPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			1 Y Z	E SURVEY PLETED
		345186	B. WING			11	/15/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR				113 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	Urinary Tract Infection was no stop date for the A hard copy print out of dated 8/2/19 between Coordinator (SDC) and the state's infection co- program indicated the Hippurate for UTI projection was reviewed. The A she believed Methena fall under the purview stewardship program used to prevent or co- growth of bacteria but infections. The 8/9/19 significant (MDS) assessment in cognition was severed an antibiotic on 7 of 7 infections. Resident #34's active reviewed on 11/13/19 physician's order for N remained an active or A review of Resident for care plan on 11/13/19 related to the long-ter antibiotic. An interview was cont 11/13/19 at 3:30 PM. responsible for the fac program and monitori	<ul> <li>1 gram (gm) daily for n (UTI) prophylaxis. There this order.</li> <li>of email correspondence n the Staff Development nd the Associate Director for ontrol and epidemiology e usage of Methenamine phylaxis for Resident #17 Associate Director wrote that amine Hippurate would not of the facility's antibiotic as this medication was ntrol UTIs and stop the t was not used to treat active</li> <li>change Minimum Data Set idicated Resident #17's ly impaired. She received days and had no active</li> <li>physician's orders were and revealed the 7/30/19 Methenamine Hippurate rder.</li> <li>#17's active comprehensive o revealed no information rm use of a prophylactic</li> </ul>	F	656			

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	SURVEY	
AND FLAN OF CORRECTION IDENTIFICATION NOMBER. A. BUILDING	(X3) DATE SURVEY COMPLETED	
345186 B. WING 11/15/.	5/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAKS MANOR 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE       C         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       C	(X5) COMPLETION DATE	
F 656       Continued From page 28       F 656         Hippurate for Resident #17 was reviewed with the SDC. She confirmed she initiated this correspondence with the Associate Director of the state's infection control and epidemiology program to ensure this medication's usage was in accordance with the facility's antibiotic stewardship program.         During an interview with MDS Nurse #1 on 11/1/4/19 at 10:10 AM the use of a long-term prophylactic antibiotic or Resident #17 was reviewed. The care plan for Resident #17 that included no information related to the use of a long-term prophylactic antibiotic antibiotic antibiotic usage. She reported that she thought there was a care plan in place in the past, but the facility was in the process of switching to a new care plan for Resident #17's prophylactic antibiotic usage. She reported that she thought there was a care plan in place in the past, but the facility was in the process of switching to a new care plan for Resident #17 was created.         An interview was conducted with the Director of Nursing on 11/16/19 at 1:25 PM. She stated that she expected a care plan to be in place to address the long-term use of a prophylactic antibiotic antibiotic or Resident #17.         4. Resident #110 was admitted to the facility on 6/25/15 and most recently readmitted on 9/9/19 with diagnoses that included dementia.         A physician's order dated 9/24/19 indicated mighty shake (nutritional supplement) twice daily with thuch and dinner for Resident #110 related		

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	2: 12/17/2019 1 APPROVED 2: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345186	B. WING			11/15/2019		
NAME OF PI	ROVIDER OR SUPPLIER	•	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
	S MANOR			4	413 WINECOFF SCHOOL ROAD			
FIVE OAK	5 MANOR			0	CONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	E	(X5) COMPLETION DATE
F 656	Continued From page 29		F	656				
	assessment dated 10 #110's cognition was required the extensive and she had significal The active care plan f reviewed on 11/12/19 area of nutritional risk of the interventions for provision of nutritional This intervention spect twice daily was one of nutritional supplement A meal observation w #110 at lunch on 11/1 #110 was in her room #2 served her meal tr assistance with eating viewed, and it indicate included on the tray. observed on Resident A meal observation w 5:30 PM. Resident # #3 served her meal tr assistance with eating	for Resident #110 was and it included the focus (initiated on 9/17/19). One or this focus area was the I supplements as ordered. cified that mighty shake f Resident #110's ordered ts. as conducted of Resident 2/19 at 12:49 PM. Resident and Nursing Assistant (NA) ay and began to provide her g. The dietary tray card was ed a mighty shake was to be There was no mighty shake						
	included on the tray. observed on Residen NA #3 was interviewe She confirmed Reside on her dietary tray ca her tray. She indicate	There was no mighty shake t #110's meal tray. ed on 11/13/19 at 5:33 PM. ent #110 had a mighty shake rd, but no mighty shake on ed that she had not noticed s missing, but she would go						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/17/2019 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345186	B. WING		11/	15/2019	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR				13 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page 30		F	656			
	working at the facility frequently assigned to recalled working with and assisting her with confirmed the mighty #110's meal tray for lu had not obtained the kitchen. She admitted that the mighty shake meal tray. NA #2 rev wanted to get anyone reported this issue to The Dietary Manager 11/14/19 at 1:41 PM. working as the DM at observation of Reside being served on her r on 11/12/19 and the of were reviewed with the there were multiple net kitchen and he believe occurred.	<ul> <li>She stated that she began in June and she was o Resident #110. NA #2 Resident #110 on 11/12/19 n eating her lunch. She shake was not on Resident unch on 11/12/19 and she mighty shake from the d that it happened frequently was not on Resident #110's ealed that she had not e in trouble, so she hadn't anyone.</li> <li>(DM) was interviewed on He reported he began bout 5 weeks ago. The ent #110's mighty shake not neal tray for the lunch meal dinner meal on 11/13/19 he DM. The DM stated that ew staff working in the ed this was why this error</li> </ul>					
F 675 SS=D	Nursing on 11/15/19 a she expected care pla consistently implement supplements to be pro-	nted and for nutritional	F	675			12/13/19
		e damental principle that d services provided to facility					

Facility ID: 953488

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						10. 0938-039		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED		
		345186	B. WING		1	11/15/2019		
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD				
FIVE OAK	S MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE		
F 675	Continued From page	e 31	F 67	5				
	-	dent must receive and the	_	-				
	facility must provide t							
		services to attain or maintain						
	<b>.</b>	le physical, mental, and						
		ing, consistent with the nsive assessment and plan						
	of care.	isive assessment and plan						
		is not met as evidenced						
	by:							
	Based on record rev	iew, observation and		F675: Quality of Life				
		ent, staff and Physician, the		Resident #12 has been move	d to another			
	facility failed to provid	de an environment that		room per resident request.				
		nt ' s quality of life for 1 of 5		All residents have the potentia				
		esident #12). Findings		alleged deficient practice rega	irding			
	included:			grievances.				
	Posidont #12 was ad	mitted to the facility on		Staff Development Coordinate	•			
		mitted to the facility on nosis of cerebral vascular		facility grievance procedures				
	accident.			staff.	or lacinty			
				On 11/27/19 an audit was con	npleted by			
	His active care plan of	lated 8/1/19 documented		Social Worker for all interview	able			
	-	ns for cardiac disease and		residents on satisfaction with				
	assistance with activi	ties of daily living.		roommate assignment. No oth				
	The 11 day Minimum	Data Cat de suma station		had complaints about current	roommates			
		Data Set documentation 2 had an intact cognition.		or wanted a room change. Staff Development Coordinate	or provided			
		assistance of 1 staff for		education on 11/29/19 on faci				
	-	g and the resident was		grievance procedures for facil	•			
		e active diagnoses were		education will continue throug	•			
		cident, muscle weakness,		12/12/19.All new hires will rec				
	and unspecified abno	ormalities of gait.		education upon hire during or				
				regarding reporting resident re	oommate			
		pm Resident #12 was		complaints.	0			
		ed his roommate (Resident		Social Services will conduct 1				
	-	hate you" when the resident		audits weekly, interviewing re-				
		to be quiet at night (during resident commented that		determine roommate satisfact 11/27/19.	ion starting			
		mmate 's response. The		Audits will be presented by the	e Social			
			1		5 500iui	1		

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		MEDICAID SERVICES				<u>). 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		345186	B. WING		11	/15/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	(S MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 675	sleeping in his wheel all day and up at nigh every hour. The room light but called out for the night. The reside awake and not getting roommate also yelled bathroom door while bathroom (did not wa finished), and the res resident commented staff of his concerns a room each night in re yelling and they were "this (roommate ' s be and no one has done Nurse #1 was intervie who stated she was f Nurse #1 indicated sh resident and night sta resident ' s roommate him up at night. Resident #12 had add during interview on 12 resident shared that h another room so he (f night. The resident 's language and stated resident does not like "it happened again la An interview was con pm with Nursing Assis regularly assigned to was aware that Resident	chair at the nurses station it getting up to the bathroom inmate had not used the call staff, yelling in the middle of ent stated he was kept g enough sleep. The and banged on the the resident used the it until the resident was ident did not like this. The that he had informed the and the staff would enter his sponse to the roommate 's aware. The resident stated ehavior) keeps happening anything." ewed on 11/13/19 at 9:30 am amiliar with Resident #12. he was informed by the aff "regularly" that the e (Resident #25) had kept ditional information to add 1/13/19 at 10:25 am. The his wife had asked staff for the resident) could sleep at s roommate had used foul "I hate you" which the e. The resident commented	F 675		ly times	

Facility ID: 953488

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		D HUMAN SERVICES				FORM	D: 12/17/2019
STATEMENT O	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345186	B. WING			11/15/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
FIVE OAK				41	13 WINECOFF SCHOOL ROAD		
FIVE OAK	5 WANOK			С	ONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 675	bathroom door and he #1 stated this had bee while, months. NA #1 informed the assigned than one occasion. On 11/13/19 at 2:50 p conducted with Social both stated that they with informed that resident because of loud yelling aggression from the re- They were also not aw banging on the bathroot the resident was using statements such as "I words. SW #1 stated the resident's spouse room change. SW #2 informed today that the regarding his roomma another room that was resident requested to for another room with Both SWs stated that them of the complaint initiated. A review of Resident a resident's admission ( notified by nursing on the resident's concerr behaviors and inability was offered today and	mmate banging on the ollering and intervened. NA en going on for a quiet a commented that she had d nurse (Nurse #1) on more man interview was Work (SW) #1 and #2 who were not aware or been t #12 was unable to sleep g, behavior and verbal esident 's roommate's bom door and yelling when g the bathroom and hate you" and use of curse she was not informed by that there was a request for e stated that she was he resident had concerns ates yelling and was offered s not by the window. The be placed on the waiting list the bed by the window. The be placed on the waiting list the bed by the window. The s and a grievance was not #12 's SW notes since the (7/31/19) revealed they were 11/13/19 and documented n of his roommate 's y to sleep. A room change d was declined; request was a waiting list for a room dow.	F	675			

Facility ID: 953488

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				FORM	: 12/17/2019 APPROVED
	. ,			(X3) DATE COMPI	SURVEY
345186	B. WING		_	11/15/2019	
	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	4	13 WINECOFF SCHOOL R	OAD		
	C	CONCORD, NC 28027			
AUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
<ul> <li>I who stated that</li> <li>ed to her on more than commate was yelling at</li> <li>vas up at night (not able to d she asked psychiatry to ' s yelling at night due to Nurse #1 indicated she e resident's complaints or grievance because the one.</li> <li>(DON) was interviewed who was not aware of aints. The DON stated complaints to be reported in with the grievance mented she would start staff to complete a ident complained of o them.</li> <li>m an interview was sician who was familiar r Resident #12. The e had been informed of the shavior escalation and that ehavior sfor a long time.</li> <li>ted he was informed out mid October, that there veen residents, Resident where the roommate was m door and yelling. The d that the resident was cident. The Physician pect staff to bring to the resident interaction nging on the bathroom he roommate was in the</li> </ul>	F 675				
		EDICAID SERVICES         (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING         345186       B. WING         345186       B. WING         C       ID PREFIX         AUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)       ID PREFIX TAG         344       F 675         44       F 675         454       F 675         464       F 675         471 who stated that ed to her on more than pommate was yelling at vas up at night (not able to d she asked psychiatry to 's yelling at night due to Nurse #1 indicated she e resident's complaints or grievance because the one.         (DON) was interviewed who was not aware of aints. The DON stated complaints to be reported n with the grievance nmented she would start staff to complete a ident complained of o them.         m an interview was sician who was familiar r Resident #12. The e had been informed out mid October, that there veen residents, Resident where the roommate was m door and yelling. The d that the resident was cident. The Physician pect staff to bring to the resident interaction nging on the bathroom he roommate was in the	EDICAID SERVICES         (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         345186       B. WING         345186       B. WING         EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DENTIFYING INFORMATION)       ID PREFIX (EACH CORREC CROSS-REFERENCE CROS-REFERENCE CROSS-REFERENCENCE CROSS-REFERENCENCENCE CROSS-REFEREN	HUMAN SERVICES EDICAID SERVICES EDICAID SERVICES () PROVIDENSUPPLEXICLA )DENTIFICATION NUMBER:	HUMAN SERVICES     FOOME NO       EDICAID SERVICES     OMB NO       i) DENTIFICATION NUMBER:     (2) MULTIPLE CONSTRUCTION     (2) OMULTIPLE CONSTRUCTION       345186     b. WING     (2) MULTIPLE CONSTRUCTION     (2) OMULTIPLE CONSTRUCTION       345186     b. WING     11/   STREET ADDRESS, CITY, STATE, ZIP CODE        413 WINECOFF SCHOOL ROAD CONCORD, NC 28027   EMENT OF DEFICIENCIES UBENTIFICATION NUMBER: TAG CONCORD, NC 28027  EMENT OF DEFICIENCIES UDENTIFICATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG CONCORD, NC 28027  EMENT OF DEFICIENCE TO THE APPROPRIATE DEFICIENCY TAG CONCORD, NC 28027  EMENT OF DEFICIENCE TAG STREET ADDRESS, CITY, STATE, ZIP CODE 413 WINECOFF SCHOOL ROAD CONCORD, NC 28027  EMENT OF DEFICIENCIES TO THE APPROPRIATE DEFICIENCY TAG CONCORD, NC 28027  EMENT OF DEFICIENCY TAG FF 675  H 44 TAG FF 675  H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF 675 H 45 TAG FF

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 12/17/2019 FORM APPROVED OMB NO. 0938-0391	)		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	]		
		345186	B. WING			11/15/2019			
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
FIVE OAK	S MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED					
F 692 SS=D			F 692	2		12/13/19			
	(Includes naso-gastric both percutaneous en percutaneous endosc enteral fluids). Based comprehensive asses ensure that a resident	ssment, the facility must t-							
	of nutritional status, s desirable body weight balance, unless the re	ins acceptable parameters uch as usual body weight or t range and electrolyte esident's clinical condition s is not possible or resident otherwise;							
	§483.25(g)(2) Is offer maintain proper hydra	ed sufficient fluid intake to ation and health;							
	there is a nutritional p provider orders a ther	is not met as evidenced			on Status				
	interviews with staff a facility failed to provid ordered on 2 of 3 dini	nd Registered Dietician, the e nutritional supplements as ng observations for 1 of 7 r nutrition (Resident #110).		F692: Nutrition/Hydrati Maintenance Resident #110 tray card 11/26/2019 to move nut supplements from prefer physician nourishment	d was updated or tritional erences to	n			
	The findings included			All residents receiving r supplements have the p	nutritional potential for the				
		dmitted to the facility on ently readmitted on 9/9/19 icluded dementia.		alleged deficient practic conducted by the Regis 11/26/19 tray cards for nutritional supplements	stered Dietician c residents receivi	ng			
		ated 9/24/19 indicated nal supplement) twice daily		updated to show nutrition under the supplement s	onal supplements	s			

Facility ID: 953488

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DA	<u>10. 0938-039</u> TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		co	MPLETED
		345186	B. WING			1	1/15/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR				13 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 692	<ul> <li>with lunch and dinner for Resident #110 related to poor appetite.</li> <li>The significant change Minimum Data Set (MDS) assessment dated 10/19/19 indicated Resident #110's cognition was severely impaired, she required the extensive assistance of 1 for eating, and she had significant weight loss.</li> <li>A Registered Dietician (RD) note dated 11/12/19 indicated Resident #110's current weight was 140 pounds with 3.7% weight loss x 30 days, 13.6% weight loss x 90 days, and 14.6% x 180 days. She required extensive assistance from staff with eating and her nutritional supplements included mighty shakes twice daily.</li> <li>The active care plan for Resident #110 was reviewed on 11/12/19 and it included the focus area of nutritional risk (initiated on 9/17/19). One of the interventions for this focus area was the provision of nutritional supplements as ordered. This intervention specified that mighty shake twice daily was one of Resident #110's ordered</li> </ul>		F 6	692 card. All supplement orders were and tray cards now reflect supp nourishment section. The Registered Dietician update card system on 11/26/19 and ea the Certified Dietary Manager (0 regarding entering nutritional su under physician orders in the tra- system on 11/26/19. All residen cards were reviewed by the CD updated as needed. Nursing sta educated by Registered Dieticia beginning 11/26/19 on reading of tickets to ensure the supplement nursing hires will receive educa hire during orientation regarding of meal tickets to ensure supple included on meal tray as ordered The Registered Dietician and on will all audit new admissions we random resident tray cards on a include weekends, who receive		blement in ted the tray educated by (CDM) upplements ray card ht tray DM and taff will be an the tray nt was otify the t. All new ation upon g reading ements are ed. or the CDM eekly and all meals to	
	#110 at lunch on 11/1 #110 was in her room #2 served her meal tr assistance with eating viewed, and it indicate included on the tray. observed on Residen A second meal obser Resident #110 at the	vas conducted of Resident (2/19 at 12:49 PM. Resident in and Nursing Assistant (NA) ray and began to provide her g. The dietary tray card was ed a mighty shake was to be There was no mighty shake it #110's meal tray. vation was conducted of dinner meal on 11/12/19 at 110 was in her room and her			supplements 3 times per week. Audits be presented to Quality Assurance Performance Improvement by the Registered Dietician monthly times 3 months or until substantial compliance achieved.		

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 12/17/2019 APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE	
		345186	B. WING			_	11/	15/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				4	413 WINECOFF SCHOOL F	ROAD		
FIVE OAK	5 MANUR				CONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	e 37	F	692	2			
	11/13/19 at 5:30 PM. room and NA #3 serve to provide her assista tray card was viewed, shake was to be inclu no mighty shake obse meal tray. NA #3 was interviewe She confirmed Reside on her dietary tray can her tray. She indicate the mighty shake was and obtain one from t An interview was con- 11/14/19 at 11:00 AM working at the facility frequently assigned to recalled working with and assisting her with confirmed the mighty #110's meal tray for lu had not obtained the kitchen. She admitted that the mighty shake meal tray as ordered. had not wanted to get hadn't reported this is that Resident #110 se and she had the best cream and the mighty it. NA #2 reported that received her ice creat tray and she ate most	ducted with NA #2 on . She stated that she began in June and she was o Resident #110. NA #2 Resident #110 on 11/12/19 n eating her lunch. She shake was not on Resident unch on 11/12/19 and she mighty shake from the d that it happened frequently was not on Resident #110's NA #2 revealed that she t anyone in trouble, so she sue to anyone. She stated eemed to prefer sweet foods intake of items such as ice y shake when she received at Resident #110 had m on 11/12/19 on her lunch t of the ice cream.						
		(DM) was interviewed on						

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	-	D HUMAN SERVICES				FORM	D: 12/17/2019 MAPPROVED
STATEMENT (	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		345186	B. WING _			11/	15/2019
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	S MANOR			41	13 WINECOFF SCHOOL ROAD		
FIVE OAK	5 MANOR			С	ONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 692 F 756 SS=E	11/14/19 at 1:41 PM. working as the DM ab observation of Reside being served on her m on 11/12/19 and the d were reviewed with the there were multiple net kitchen and he believe occurred. During an interview w 1:43 PM she stated th supplements to be pro- the nutritional needs of An interview was come Nursing on 11/15/19 as she expected nutrition consistently provided Drug Regimen Review CFR(s): 483.45(c)(1)( §483.45(c) Drug Regi §483.45(c)(1) The dru- must be reviewed at b licensed pharmacist. §483.45(c)(2) This rev- of the resident's medi §483.45(c)(4) The pha- irregularities to the att facility's medical direc- and these reports mu- (i) Irregularities includ drug that meets the ca- (d) of this section for a	He reported he began yout 5 weeks ago. The ent #110's mighty shake not meal tray for the lunch meal linner meal on 11/13/19 we DM. The DM stated that ew staff working in the ed this was why this error with the RD on 11/14/19 at hat she expected nutritional poided as ordered to support of the residents. ducted with the Director of at 1:25 PM. She stated that hal supplements to be as ordered. w, Report Irregular, Act On 2)(4)(5) men Review. Ig regimen of each resident east once a month by a view must include a review cal chart. armacist must report any rending physician and the stor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph		756			12/13/19

Facility ID: 953488

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 12/17/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345186	B. WING		11/15/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FIVE OAKS MANOR			413 WINECOFF SCHOOL ROAD	
THE CARS MANOR			CONCORD, NC 28027	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
<ul> <li>separate, written repattending physician a director and director minimum, the resider and the irregularity th (iii) The attending phyresident's medical representation has been take be no change in the resident's medical \$483.45(c)(5) The fact maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action This REQUIREMENT by:</li> <li>Based on record rev and Pharmacy Const to identify and addres involuntary movemer for 2 of 3 sampled remedication (Resident included:</li> <li>1. Resident #25 was 12/1/17 with diagnost schizoaffective disord Documentation of the assessment for the remedication of the a</li></ul>	<ul> <li>ast be documented on a port that is sent to the ind the facility's medical of nursing and lists, at a at's name, the relevant drug, e pharmacist identified.</li> <li>ysician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in a record.</li> <li>cility must develop and procedures for the monthly that include, but are not s for the different steps in s the pharmacist must take ifies an irregularity that in to protect the resident.</li> <li>T is not met as evidenced</li> <li>iew and interview of the staff ultant, the Pharmacist failed as the need for an abnormal at scale (AIMS) assessment sidents on antipsychotic is #25 and #34). Findings</li> </ul>	F 7	56 F756: Drug Regimen Review, Re Irregular, Act on Residents #25 and #34 were imm assessed on November 14th, 201 Abnormal Involuntary Movement 5 (AIMS) completed and added to th charts during survey. There were abnormal findings. 100% audit of residents on antips medications completed on Novem 14th, 2019 during survey by Unit Managers. There were no abnorm findings. On this day, all residents assessed, AIMS were updated accordingly, and placed in their ch Effective November 14th, 2019,	nediately 19 with Scale, heir no ychotic nber nal s were

Facility ID: 953488

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## PRINTED: 12/17/2019

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUITIPI		CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	· ,				IPLETED	
		345186	B. WING			11/15/2019		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
FIVE OAK	S MANOR				3 WINECOFF SCHOOL ROAD DNCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 756	Continued From page	e 40	F 75	66				
	XR 400 milligrams tw	vice a day dated 3/22/18.			Pharmacy consultant added AIMS			
	<b>T</b> I I I I I I I I				monitoring to his antipsychotic			
The care plan dated 6/17/19 had goals and interventions for antipsychotic medication				medications report that will be reviewer monthly during QAPI meeting. On	u			
	documented. A review of the resident 's quarterly Minimum				November 15th, 2019, education was			
					provided by the Director of Nursing (Do	,		
		ent 's quarterly Minimum ed 9/2/19 revealed clear			to all Unit Managers, clinical superviso and Pharmacy Consultant on facility po			
	. ,	ood, and understands. The			regarding quarterly antipsychotic	лсу		
		y cognitively impaired. The			medication monitoring and			
	resident required extended ext	ensive assistance of one			documentation. Effective December 1st, 2019, Risk			
	-	onal hygiene. Transfer,			Manager (RM) or Director of Nursing			
	standing and turning	required supervision. The			(DON) will conduct monthly audits for a	all		
	active diagnoses wer	-			residents receiving antipsychotic	1		
		re 7 days of antipsychotic, depressant medication			medication to ensure AIMS is complete quarterly.	a		
	administered.				Effective December 1st, 2019, audit			
					results will be brought to QAPI by the			
	On 11/14/19 at 5:00 p	pm an interview was Director of Nursing (DON)			Director of Nurses x 3 months, with further monitoring to be decided by the			
		evaluation was scheduled			QAPI committee if thresholds are not n			
		S by the Unit Coordinator.						
		sment for the resident						
	The DON indicated s	edical record was 3/16/18.						
		rmed her that he had not						
		evaluation with psychotropic						
	medication administr	ation.						
	The Pharmacy Cons	ultant was interviewed in						
	person on 11/14/19 a	at 5:10 pm who stated he had						
		assessment during his						
		eview, which should be done s, but had not informed staff						
	when one was not ide	entified in the resident's						
	medical record.							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/17/2019 M APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345186	B. WING			11/	/15/2019
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR				413 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	and 400 (Resident #2 11/15/19 at 1:00 pm r assessment schedule psychotropic medicati that she scheduled th quarterly MDS and the responsible to comple She commented the <i>A</i> been scheduled for st would be corrected. 2. Resident #34 was a 8/6/15 with diagnoses anxiety, and psychotic An Abnormal Involunt assessment was com Resident #34 with a s movements identified A physician's order fo 3/13/19 indicated ABH Ativan (antianxiety me (mg)/Benadryl (antihis mg/Haldol (antipsycho contents of 1 milliliter day. The quarterly Minimut assessment dated 9/5 #34's cognition was s received antipsychotic medication on 7 of 7 of back period. A review of Resident a orders on 11/14/19 in ABH gel twice daily ref	<ul> <li>25) was interviewed on regarding the AIMS</li> <li>a for residents who received ion. Unit Manager #1 stated is assessment with the e assigned nurse was ete the AIMS assessment. AIMS assessment had not taff to complete and this</li> <li>admitted to the facility on a that included dementia, c disorder.</li> <li>arry Movement Scale (AIMS) upleted for 12/26/18 for score of 0 (no involuntary ).</li> <li>arr Resident #34 dated H gel, a combination gel of edication) 0.5 milligrams stamine medication) 25 otic medication) 1 mg, apply (ml) syringe to skin twice a</li> </ul>	F	756			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/17/2019 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>			(X3) DATE	
		345186	B. WING			11/	15/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR				413 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 756	an AIMS assessment movement assessment for Resident #34 since There was no evidence record of the Pharman and addressing that a other involuntary move been completed for R During an interview w (DON) on 11/14/19 at facility's normal proce assessments quarter antipsychotic medicat assessments were do annual MDS assessment DON reported that the completed by hand an copy medical record. Coordinators were res AIMS assessments we An interview with MDS 5:25 PM revealed cor AIMS assessment or any other involuntat completed for Reside stated she reviewed t medical record for Res Unit Coordinator (UC) 11/15/19 at 8:46 AM. facility's normal proce assessments were co timeframes coordinate	through 11/14/19 revealed or any other involuntary in had not been completed e 12/26/18. The in Resident #34's medical cy Consultant identifying in AIMS assessment or any ement assessment or any for residents on ion. She indicated the AIMS one when the quarterly and nents were completed. The e AIMS assessments were ind were placed in the hard She indicated the Unit sponsible for ensuring the ere completed. S Nurse #2 on 11/14/19 at offirmation that there was no any movement assessment int #34 since 12/26/18. She he hard copy and electronic isident #34. ) #2 was interviewed on She stated that the ess was for AIMS impleted quarterly, and the ed with the MDS	F	756	3		

Facility ID: 953488

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	: 12/17/2019 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION			SURVEY
		345186	B. WING				11/1	5/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
FIVE OAK	S MANOR				13 WINECOFF SCHOOL ROAD CONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE		(X5) COMPLETION DATE
F 756	or by one of the floor her unit who were on Resident #34's medic AIMS assessment wa Resident #34 from 12 was reviewed with UC was an oversight and assessments should H 3 months for Residen gel which included the Haldol. An interview was cont Consultant on 11/14/1 that his expectation for assessments was on medication and every Pharmacy Consultant important to complete for antipsychotic med side effects of the me most recent AIMS cor reviewed with the Pha Resident #34's physic ABH gel had been in reviewed with the Pha revealed he had not ic assessment was not of for Resident #34. He he had not routinely c assessments during h reviews. The Pharma acknowledged that his been for an AIMS ass	<ul> <li><i>x</i> 3 months either by herself nurses for all residents on antipsychotic medication.</li> <li>al record that revealed an s not completed for /27/18 through 11/14/19</li> <li><i>x</i> 22. She revealed that this that routine AIMS have been completed every t #34 due to her use of ABH e antipsychotic medication</li> <li><i>ducted with the Pharmacy</i> 9 at 5:15 PM. He stated or the completion of AIMS initiation of an antipsychotic 6 months thereafter. The explained that it was routine AIMS assessments ication due to the potential dications. Resident #34's mpleted on 12/26/18 was armacy Consultant.</li> <li><i>c</i> and <i>y</i> 2/26/18 was armacy Consultant. He dentified that an AIMS completed since 12/26/18 additionally revealed that hecked for AIMS his monthly drug regimen toy Consultant</li> <li><i>s</i> expectation would have essment to be completed a nonths for Resident #34 due which included the</li> </ul>	F7	/56				

Facility ID: 953488

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/17/2019 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE	
		345186	B. WING				11/	15/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATI	E, ZIP CODE		
FIVE OAK	S MANOR				13 WINECOFF SCHOOL ROA	AD		
				د د	ONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	2 44	F	756				
F 758 SS=E	11/15/19 at 1:25 PM s the Pharmacy Consul AIMS assessments for medication during his reviews and to compli- recommendation for a assessment was due. Free from Unnec Psy CFR(s): 483.45(c)(3)( §483.45(e) Psychotro §483.45(c)(3) A psych affects brain activities processes and behav- but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe- resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication specific condition as o in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventio	an updated AIMS if an chotropic Meds/PRN Use (e)(1)-(5) ppic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following ensive assessment of a nust ensure that nts who have not used re not given these drugs n is necessary to treat a diagnosed and documented nts who use psychotropic I dose reductions, and	F	758				12/13/19
	resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication specific condition as o in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventio contraindicated, in an	nust ensure that nts who have not used re not given these drugs n is necessary to treat a diagnosed and documented nts who use psychotropic I dose reductions, and ns, unless clinically						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 12/17/2019 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		345186	B. WING				11/	15/2019
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				4	13 WINECOFF SCHOOL ROAD			
FIVE OAK	5 MANUK			С	ONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 758	Continued From page §483.45(e)(3) Reside psychotropic drugs pu unless that medication diagnosed specific co in the clinical record; a §483.45(e)(4) PRN or are limited to 14 days §483.45(e)(5), if the a prescribing practitione appropriate for the PF beyond 14 days, he o rationale in the reside indicate the duration f §483.45(e)(5) PRN or drugs are limited to 14 renewed unless the a prescribing practitione the appropriateness of This REQUIREMENT by: Based on record revi and Pharmacy Consu complete the abnorma scale (AIMS) assess residents on antipsyc #25 and #34). Finding	e 45 Ints do not receive ursuant to a PRN order in is necessary to treat a indition that is documented and ders for psychotropic drugs . Except as provided in ttending physician or er believes that it is RN order to be extended r she should document their nt's medical record and for the PRN order. ders for anti-psychotic 4 days and cannot be ttending physician or er evaluates the resident for of that medication. is not met as evidenced ew and interview with staff ltant, the facility failed to al involuntary movement nent for 2 of 3 sampled hotic medication (Residents gs included: admitted to the facility on es of insomnia and er.		758	F758: Free from Unnecessary Psychotropic Meds/PRN use Residents #25 and #34 were i assessed on November 14th, AIMS completed and added to during survey. There were no findings. 100% audit of residents on an medications completed on No 14th, 2019 during survey by U Managers. There were no abn findings. On this day, all reside	/ mmediate 2019 with their cha abnorma tipsychot vember nit iormal ents were	ely n arts al ic	
	Resident #25 had a p	hysician order for Seroquel ice a day dated 3/22/18.			assessed, AIMS were updated accordingly, and placed in the Effective November 14th, 2019 Pharmacy consultant added A monitoring to his antipsychotic	ir charts. 9, IMS		

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	O. 0938-039
AND PLAN OI	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	;	CON	1PLETED
		345186	B. WING		1 <sup>.</sup>	1/15/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
FIVE OAK	(S MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	The care plan dated 6 interventions for antip A review of the reside Data Set (MDS) dates speech, was understo resident was severely resident required exter staff for dressing and assistance with perso standing and turning active diagnoses wer- insomnia. There wer- antianxiety, and antid administered. On 11/14/19 at 5:00 p conducted with the D who stated the AIMS with the quarterly MD The last AIMS for the medical record was 3 she checked with the her that he had not che evaluation with psych administration. The Pharmacy Consu- person on 11/14/19 at looked for the AIMS at be done about every informed staff when co- resident's medical reco- pharmacy review.	6/17/19 had goals and osychotic medication. ent ' s quarterly Minimum d 9/2/19 revealed clear bod, and understands. The y cognitively impaired. The ensive assistance of one toileting and limited onal hygiene. Transfer, required supervision. The e schizophrenia and e 7 days of antipsychotic, lepressant medication of Nursing (DON) evaluation was scheduled VS by the Unit Coordinator. resident documented in the V16/18. The DON indicated Pharmacist who informed hecked for an AIMS notropic medication	F 75	8 medications report that will be monthly during QAPI meeting November 15th, 2019, educat provided by the Director of Nu to all Unit Managers, clinical s and Pharmacy Consultant on regarding quarterly antipsyche medication monitoring and documentation. All new nurse hires will receiv upon hire during orientation re AIMS. Effective December 1st, 2019 Manager (RM) or Director of N (DON) will conduct monthly a residents receiving antipsyche medication to ensure AIMS is quarterly. Effective December 1st, 2019 results will be brought to QAP Director of Nurses x 3 months further monitoring to be decid QAPI committee if thresholds	. On cion was ursing (DON) supervisors, facility policy otic e education egarding , Risk Nursing udits for all otic completed , audit I by the s, with ed by the	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/17/2019 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345186	B. WING			1	1/15/2019
NAME OF P	ROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR				413 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 758	that she scheduled th quarterly MDS and th responsible to complet She commented the <i>A</i> been scheduled for st would be corrected. 2. Resident #34 was a 8/6/15 with diagnoses anxiety, and psychotic An Abnormal Involunt assessment was com Resident #34 with a s movements identified A physician's order fo 3/13/19 indicated ABH Ativan (antianxiety me (mg)/Benadryl (antihis mg/Haldol (antipsycho contents of 1 milliliter day. The quarterly Minimul assessment dated 9/8 #34's cognition was s received antipsychotic medication on 7 of 7 of back period. A review of Resident 1 orders on 11/14/19 in ABH gel twice daily re A review of the hard of record from 12/27/18	ion. Unit Manager #1 stated e assessment with the e assigned nurse was ete the AIMS assessment. AIMS assessment had not taff to complete and this admitted to the facility on a that included dementia, c disorder. Tary Movement Scale (AIMS) pleted for 12/26/18 for score of 0 (no involuntary ). r Resident #34 dated H gel, a combination gel of edication) 0.5 milligrams stamine medication) 25 otic medication) 1 mg, apply (ml) syringe to skin twice a	F	758			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/17/2019 APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345186	B. WING			11/	15/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR						
				C	CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page movement assessme for Resident #34 since	nt had not been completed	F	758			
	(DON) on 11/14/19 at facility's normal proce assessments quarterl antipsychotic medicat assessments were do annual MDS assessm DON reported that the completed by hand ar copy medical record. Coordinators were res AIMS assessments w An interview with MDS	tion. She indicated the AIMS one when the quarterly and nents were completed. The e AIMS assessments were nd were placed in the hard She indicated the Unit sponsible for ensuring the					
	completed for Reside stated she reviewed t medical record for Re	ary movement assessment nt #34 since 12/26/18. She he hard copy and electronic sident #34. ) #2 was interviewed on					
	11/15/19 at 8:46 AM. facility's normal proce assessments to be co timeframes coordinate assessments. She re responsible for ensuri were completed every or by one of the floor her unit who were on Resident #34's medic AIMS assessment wa Resident #34 from 12	She stated that the ess was for AIMS ompleted quarterly, and the ed with the MDS eported that she was ing the AIMS assessments y 3 months either by herself nurses for all residents on antipsychotic medication. eal record that revealed an as not completed for 2/27/18 through 11/14/19 C #2. She revealed that this					

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CENTERS FOR MEDICARE & MEDICAID SERVICES			O	FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
345186	B. WING		_	11/15/2019	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
FIVE OAKS MANOR		13 WINECOFF SCHOOL R CONCORD, NC 28027	COAD		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)	) ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION E DATE	
<ul> <li>F 758 Continued From page 49 assessments should have been completed eve 3 months for Resident #34 due to her use of AE gel which contained the antipsychotic medication Haldol.</li> <li>An interview was conducted with the Pharmacy Consultant on 11/14/19 at 5:15 PM. He stated that his expectation for the completion of AIMS assessments was on initiation of an antipsycho medication and every 6 months thereafter. The Pharmacy Consultant explained that it was important to complete routine AIMS assessmen for antipsychotic medications.</li> <li>During a follow up interview with the DON on 11/15/19 at 1:25 PM she stated that she expect AIMS assessments to be completed every 3 months and for the Unit Coordinators to ensure that these assessments were in the medical record.</li> <li>F 849 SS=D</li> <li>FF(s): 483.70(o)(1)-(4)</li> <li>§483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility ma do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement wit a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an</li> </ul>	BH on / / / / / / / / / / / / / / / / / /			12/13/19	

Facility ID: 953488

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	-	ID HUMAN SERVICES				FORM	D: 12/17/2019 MAPPROVED
STATEMENT C	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			D. 0938-0391 SURVEY PLETED
1		345186	B. WING			11/	15/2019
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	·	
FIVE OAK				41:	3 WINECOFF SCHOOL ROAD		
FIVE OAK	5 MANUR			CC	ONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 849	LTC facility through an paragraph (o)(1)(i) of the LTC facility must r requirements: (i) Ensure that the hos professional standard to individuals providin to the timeliness of the (ii) Have a written agre that is signed by an au the hospice and an au the LTC facility before any resident. The wri at least the following: (A) The services the h (B) The hospice's resp the appropriate hospid in §418.112 (d) of this (C) The services the L provide based on eac (D) A communication communication will be LTC facility and the ho that the needs of the n met 24 hours per day. (E) A provision that th notifies the hospice al (1) A significant change mental, social, or emo (2) Clinical complication alter the plan of care. (3) A need to transfer for any condition. (4) The resident's deal (F) A provision stating responsibility for deter course of hospice car	n agreement as specified in this section with a hospice, meet the following spice services meet ls and principles that apply ig services in the facility, and e services. eement with the hospice uthorized representative of a hospice care is furnished to itten agreement must set out hospice will provide. ponsibilities for determining ce plan of care as specified a chapter. LTC facility will continue to the resident's plan of care. process, including how the e documented between the ospice provider, to ensure resident are addressed and ue LTC facility immediately bout the following: ge in the resident's physical, otional status. ons that suggest a need to the resident from the facility ath. g that the hospice assumes rmining the appropriate	F 8	.49	DEFICIENCY)		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 12/17/2019 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE : COMPL	SURVEY
		345186	B. WING			11/1	5/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
			4	13 WINECOFF SCHOOL RO	AD		
FIVE OAK	SMANOR		c	ONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 849	responsibility to furnis care, meet the resider nursing needs in coor representative, and en provided is appropriat resident's needs. (H) A delineation of the including but not limited direction and manage counseling (including) bereavement); social supplies, durable meet necessary for the pall associated with the te conditions; and all oth necessary for the care illness and related coor (I) A provision that wh personnel are respon- of prescribed therapies determined appropria delineated in the hosp facility personnel may where permitted by S the LTC facility. (J) A provision stating report all alleged violation mistreatment, neglect and physical abuse, in source, and misappro- by hospice personnel administrator immedia	the tit is the LTC facility's the 24-hour room and board int's personal care and dination with the hospice insure that the level of care rely based on the individual the hospice's responsibilities, ed to, providing medical ment of the patient; nursing; spiritual, dietary, and work; providing medical dical equipment, and drugs iation of pain and symptoms irminal illness and related the rhospice services that are e of the resident's terminal nditions. Then the LTC facility sible for the administration es, including those therapies to by the hospice and bice plan of care, the LTC administer the therapies tate law and as specified by g that the LTC facility must ations involving , or verbal, mental, sexual, hocluding injuries of unknown priation of patient property , to the hospice ately when the LTC facility e alleged violation. the responsibilities of the facility to provide	F 849				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 12/17/2019 1 APPROVED
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	
		345186	B. WING			11/*	15/2019
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
FIVE OAK	S MANOR			13 WINECOFF SCHOOL	ROAD		
			C	CONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 849	Continued From page	52	F 849				
	§483.70(o)(3) Each L	TC facility arranging for the					
	provision of hospice c						
	• •	gnate a member of the					
	for working with hospi	ary team who is responsible ice representatives to					
		e resident provided by the					
	LTC facility staff and h						
	interdisciplinary team	member must have a unction within their State					
	-	and have the ability to					
		r have access to someone					
		l capabilities to assess the					
	resident. The designated interd	lisciplinary team member is					
	responsible for the fol						
		hospice representatives					
		facility staff participation in					
	residents receiving the	ning process for those ese services.					
		th hospice representatives					
		providers participating in the					
	-	he terminal illness, related					
	of care for the patient	conditions, to ensure quality and family.					
	(iii) Ensuring that the	LTC facility communicates					
		ical director, the patient's					
	attending physician, a	and other practitioners ovision of care to the patient					
		ate the hospice care with the					
	medical care provided	by other physicians.					
	•	owing information from the					
	hospice: (A) The most recent l	hospice plan of care specific					
	to each patient.	isspice plan of cale specific					
	(B) Hospice election						
		ation and recertification of					
	the terminal illness sp	ecific to each patient.					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/17/201 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION					(X3) DATE SURVEY COMPLETED
		345186	B. WING		11/15/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FIVE OAK	SMANOR			413 WINECOFF SCHOOL ROAD	
				CONCORD, NC 28027	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 849	Continued From page	e 53	F 849	9	
		act information for hospice			
		hospice care of each			
	patient.				
	( )	ow to access the hospice's			
	24-hour on-call syste	em. tion information specific to			
	each patient.	ion mornation specific to			
	•	an and attending physician (if			
	any) orders specific t	•			
		LTC facility staff provides			
	•	icies and procedures of the ent rights, appropriate forms,			
		equirements, to hospice staff			
	furnishing care to LT				
	•	TC facility providing hospice			
		agreement must ensure that			
		en plan of care includes both			
	•	pice plan of care and a rvices furnished by the LTC			
	-	aintain the resident's highest			
		mental, and psychosocial			
	well-being, as require	ed at §483.24.			
		T is not met as evidenced			
	by: Based on record row	iow and staff interview, the		E840: Hooping Convision	
		view and staff interview, the n the hospice provider's plan		F849: Hospice Services Resident #110 Hospice Plan of Care	was
	-	dents reviewed for hospice		received and place in resident chart	
	care (Resident #110)	•		11/14/19.	
				All residents receiving hospice servi	
	The findings included	d:		have the potential to be affected. An	audit
	Docidont #110 was -	admitted to the facility on		was conducted on 11/26/19 by the	ob l
		admitted to the facility on cently readmitted on 9/9/19		Medical Records Coordinator for each hospice resident to determine if their	
		ncluded dementia and failure		hospice plan of care was in the char	
	to thrive.	-		residents receiving hospice services of care were on chart.	
	A physician's order d	lated 10/10/19 indicated		Care Plan Team was educated by	
		admitted to hospice services.		Regional MDS Nurse on 11/22/19	

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CENTERS FOR MEDICARE 8 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY LETED
THE FERRET CONTECTION	IDENTI IOATION NOIWIDEN.	A. BUILDING	3		
	345186	B. WING		11/	15/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
FIVE OAKS MANOR			413 WINECOFF SCHOOL ROAD CONCORD, NC 28027		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 849 Continued From page	ie 54	F 84	19		
<ul> <li>assessment dated 1 #110's cognition was was receiving hospid</li> <li>A review of the hard electronic medical re there was no plan of provider in Resident</li> <li>An interview was co Nursing (DON) on 1 reported that the fact were the designated with the hospice provider record. She stated s</li> <li>Medical Records sta</li> <li>SW #1 and SW #2 v at 10:20 AM. Both S provider normally put the hard copy medic stated that they had residents on hospice required documenta hospice providers.</li> <li>On 11/14/19 at 10:31 plan of care for Resif fax at the facility. Th certification period o</li> <li>During a follow up in 11/15/19 at 1:25 PM</li> </ul>	copy medical record and the ecord on 11/13/19 revealed care from the hospice #110's medical record. nducted with the Director of 1/14/19 at 9:47 AM. She ility Social Workers (SWs) staff who coordinated care viders. The DON reviewed dical record and confirmed 's plan of care was not in the she was going to have ff obtain this document. were interviewed on 11/14/19 SWs reported that the hospice t all of their documentation in al record themselves. They not reviewed the records of e services to ensure all tion was obtained from the 6 AM the hospice provider's dent #110 was received by his plan of care was for the f 10/10/19 through 1/7/20. terview with the DON on she stated she expected the lan of care to be in the		regarding comprehensive dou for residents receiving Hospic Hospice providers will be edu 12/11/2019 by Social Worker providing care plans to facility development and review qua needed. Social Worker will au residents within 72 hours of in Hospice Services to ensure of place. New hires responsible scheduling and setting asses reference dates will be traine Regional MDS Nurse during of period. Care plans will be rev care plan meeting per the MD with invitation extended to Ho providers. MDS Coordinator and Social conduct chart audits to valida plan of care inclusion weekly both MDS Coordinator and S will be presented to Quality A Performance Improvement m 3 months by the MDS Coordi review. Trends will be noted, of correction will be modified based on trend.	ce services. acated by related to y on rterly and as udit charts for nitiation of care plan is in e for sment d by orientation riewed during DS scheduled ospice Worker will the hospice . Audits from ocial Worker ssurance nothly times nator for and the plan	

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		ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 12/17/2019 FORM APPROVED MB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345186	B. WING		_	11/15/2019	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
FIVE OAKS MANOR		413 WINECOFF SCHOOL F	ROAD				
	1			CONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE	

Event ID: 492711

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