	-	ID HUMAN SERVICES				M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	COMF	E SURVEY PLETED
		345186	B. WING			C /21/2020
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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	survey was conducte	vas found in compliance with 483.73, Emergency ID # DCJS11	F 000			
	was conducted from	nd COVID19 focused survey 4-15-20 through 4-21-20. 1 ions were not substantiated.				
	Immediate Jeopardy CFR 483.80 at tag F J.	was identified at 880 at a scope and severity				
F 880 SS=J	removed on 4-17-20.		F 880			4/21/20
	infection prevention a designed to provide a comfortable environm	blish and maintain an nd control program safe, sanitary and nent and to help prevent the nsmission of communicable				
	program. The facility must esta	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:				
		em for preventing, identifying, g, and controlling infections				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					05/01/2020

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.

PRINTED: 05/21/2020

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/21/2020 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345186	B. WING		_		C 21/2020
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
FIVE OAK	S MANOR			13 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 CORREC CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	staff, volunteers, visite providing services un- arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how iscor resident; including bu (A) The type and dura- depending upon the in involved, and (B) A requirement that least restrictive possile circumstances. (v) The circumstances must prohibit employed disease or infected sk contact will transmit th (vi)The hand hygiene by staff involved in dir	seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify de diseases or can spread to other in possible incidents of se or infections should be asmission-based precautions ent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable cin lesions from direct or their food, if direct ne disease; and procedures to be followed rect resident contact.	F 880				

If continuation sheet Page 2 of 13

							0.0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY	
			A. BUILDI	NG				
		345186	B. WING			C		
		545186			TREET ADDRESS, CITY, STATE, ZIP CODE	04/	21/2020	
NAME OF PI	ROVIDER OR SUPPLIER							
FIVE OAK	S MANOR							
					ONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 880	Continued From pag	e 2	F٤	380				
	6400.00(s) Lines							
	§483.80(e) Linens.	dle store process and						
		dle, store, process, and						
	infection.	s to prevent the spread of						
	§483.80(f) Annual re	view.						
		uct an annual review of its						
		ir program, as necessary.						
	This REQUIREMEN	T is not met as evidenced						
	by:							
		on, review of the "Outbreak of			Nurse#1 was educated on 4/17/2020 b			
		ases" and "Suspected			the SDC on vigilance of donning gloves	in		
		recautions Guidelines"			every resident room and removal of			
	-	ws and physician interviews,			gloves before exiting rooms and			
		revent an infection control (1) nursing staff wore			performing hand hygiene, then using	th		
		equipment (PPE) when			sanitizer once he/she enters hallway witzero tolerance.	un		
		ent rooms (Resident #1,			C.N.A.#1 was educated on 4/17/2020 b	M		
		nt #3 and Resident #4) with			the SDC on vigilance of wearing	у		
		(2) nursing staff perform			facemask at all times while in the center	r.		
		xiting 2 of 2 resident rooms			unless eating/drinking in assigned breal			
		sident #3) with droplet			area and when using the bathroom.			
		facility failed to ensure (3)			He/she was further educated on vigiland	ce		
	nursing staff perform	ed hand hygiene after exiting			of donning gloves in all Covid + rooms,			
		s (Resident #3) with droplet			then performing hand hygiene when the			
		n exiting the designated hall			gloves are removed, and to sanitize har			
		ts. These system failures			once out of the room before touching ic	e		
		COVID19 pandemic and had			cart or other equipment with zero			
		ct all residents residing in the			tolerance.			
	facility.				C.N.A. #2 was educated on 4/17/2020 c	n		
	Immediate leonardu	began on 4-15-20 when			vigilance of donning gloves in every resident room before touching anything			
		ade on the halls designated			and removal of gloves before exiting			
		o had positive test results for			rooms and performing hand hygiene, th	en		
		halls 300 and 400). The			using sanitizer once he/she enters hally			
		d nursing staff not wearing			with zero tolerance.	,		
		ning hand hygiene when			Ice chest was sanitized on 4/16/2020 by	y		
			1				1	

Facility ID: 953488

GENTER	5 FUR MEDICARE &	MEDICAID SERVICES			<u>ON</u>	<u>IB NO. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		3) DATE SURVEY COMPLETED
		345186	B. WING			C 04/21/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
FIVE OAK	S MANOR			413 WINECOFF SCHO CONCORD, NC 280		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 880	Continued From page	e 3	F 88	30		
	precautions which ca serious injury, serious Jeopardy was remove	used or is likely to cause s harm or death. Immediate ed 4-21-20 when the facility ented acceptable creditable			e sanitized daily and as sing staff and	
	allegation of Immedia facility remains out of scope and severity of	ate Jeopardy removal. The compliance at a lower f "E" that is not Immediate		affected by the	ave the potential to be alleged deficient practice.	
	place are effective.	nonitoring systems put in		Covid Unit.	f are scheduled on the	
	Findings included:				s on the facility has ut two residents identified	
	of Communicable Dis	nd procedure for "Outbreak seases" dated 8-2014 was		group. The two	ve to the 300-400 halls as a o Covid positive resident⊡s	a
	should practice good	ed in part; all employees hygiene and handwashing te isolation precautions as		remain in their	s on the short 100-hall will private rooms on Droplet cheduling on the Covid Unit	+
	necessary.	le isolation precautions as			n consistent staff	L
	Review of the facility	s Isolation policy and			Residents that were tested	
)18 was reviewed and			vere negative were placed	
	revealed in part the fo	•			00 hall as a group. All high	
		gloves, gowns and goggles entering a resident room.			, including but not limited to nd rails, medication carts,)
		rentening a resident room.			oards will be sanitized	
	1. Resident #3 was a	74-year-old woman who			nfectant daily and as	
		or COVID19 on 4-12-20 and		-	housekeeping and nursing	
	placed on droplet pre			-	to the downstairs unit,	
		imonia, dementia and			Wing was initiated	
	malnutrition.				2020. Staff entering Covid will be limited to nursing,	
	An observation was o	conducted on 4-15-20 at		· ·	, housekeeping, activities	
		istant (NA) #2 was observed			sician, technicians to	
	leaving Resident #2's	room and entering Resident		perform medica	al diagnostic testing and	
		not perform hand hygiene dent #3's room and was			d. Starting on 4/15/2020 on to 4/17/2020, the Staff	
		n but she was not wearing a			Nurse and Director of	
		se and mouth and was not			ed reeducation/competency	y I
		NA was noted to carry out a			nonstration to all	
	small table from the r	esident's room, place it in		departments w	hich includes but was not	

Facility ID: 953488

If continuation sheet Page 4 of 13

		MEDICAID SERVICES	0			MB NO. 093		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(2	X3) DATE SURVE COMPLETED		
			A. BUILDING					
		345186	B. WING			С		
		345186	B. WING			04/21/2020		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CI				
FIVE OAK	S MANOR			413 WINECOFF SCH				
	1			CONCORD, NC 28	027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIAT DEFICIENCY)	COMF	(X5) PLETIO ATE	
F 880	Continued From pag	e 4	F 88					
		alking towards the nursing			tion control, basic hand			
		orming hand hygiene, NA #2			Covid-19 is transmitted,			
	-	door marked "employees			t precautions, use of			
		chest and stated she was			ective equipment (PPE),			
	•	or ice and proceeded to			offing PPE and continued			
	leave the COVID19 ι	unit without performing hand		wear of facem	ask and the zero tolerance	e		
	hygiene.			directive for fa	ilure to comply. Staff will			
					instructed on centers zero	D		
		vith NA #2 on 4-15-20 at			ce with non-compliance			
		she was "just getting the			ndemic following			
		ving her room." She also		progressive di	sciplinary action.			
		ot" to use the hand sanitizer			47 0000 1 10 1			
	-	nt #2's room and before			17, 2020 no staff member			
	-	's room. NA #2 said she had zer or washed her hands			begin their shift until this been complete and			
		nt #3's room or prior to			cknowledged by the traine	r		
		st and exiting the unit. NA #2			nce to CDC and CMS			
		ind any residents I am just			ng, all remaining staff who	,		
	getting ice". She als				duled to work between			
		n droplet precautions, hand		4/15/2020- 4/1	7/2020 will receive			
	hygiene, how COVID	19 was spread and the use		reeducation, c	ompetency with Staff			
	of wearing PPE.			Development	Nurse or Director of Nursir	ng		
				on infection co	ontrol, basic hand hygiene,			
	-	Director was interviewed on			is transmitted, what is			
		he Medical Director stated			itions, use of personal			
		od of infecting other staff			ipment (PPE), donning an	d		
		nts if they did not use proper		-	nd continued wear of			
	hand hygiene and PF				ore the start of their next also be made aware of			
	The Administrator an	d Director of Nursing (DON)			during this pandemic			
		4-15-20 at 7:00pm. Both the			ressive disciplinary action.			
		DN stated they were unaware						
		PPE when entering resident		All Covid posit	ive staff will also receive			
		Iroplet precautions and said			ompetency with return			
		COVID19 units periodically			by the Staff Development	:		
		ut that there was no specific			tor of Nurses on infection			
		oring of the staff using their			hand hygiene, how			
		tor and DON stated the staff			ansmitted, what is droplet			
	on the COVID19 unit	s (300 and 400 hallways)		nrecautions u	se of personal protective			

Facility ID: 953488

If continuation sheet Page 5 of 13

	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION		<u>D. 0938-03</u> E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· · ·	PLETED	
			A. BUILDING	<u> </u>			С	
		345186	B. WING			04/21/2020		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			1 04	121/2020	
					3 WINECOFF SCHOOL ROAD			
FIVE OAK	S MANOR			СС	ONCORD, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE	
F 880	Continued From page	5	Гос	00				
F 000			F 88	80	an inverse (DDE), deparing and deffine			
		taff to these units, but they work other units the same			equipment (PPE), donning and doffing PPE and continued wear of facemask			
		hey had done "a lot" of			before meeting Health Department			
	training regarding CC				requirements to return to work prior to			
		shing, sanitizing and the use			start of work. Staff will be instructed or	า		
		back" and perform further			centers zero tolerance stance with			
	education.	-			non-compliance during this pandemic			
					following progressive disciplinary actio	n.		
		79-year-old female who had						
	-	0VID19 on 4-12-20 and			On April 17, 2020 visual posters/tools			
	placed on droplet pre				provided by the CDC/CMS local health			
	diagnoses were in pa	irt hypertension and			department will be strategically placed			
	dementia.				throughout Covid unit and in employee restrooms. On April 16, 2020 the Direct			
	During an observation	n on 4-15-20 at 4:00pm,			of Nursing and or designee will begin	,101		
	-	() #2 was noted to walk into			conducting enhanced surveillance			
		with a paper gown on but no			observation every shift for compliance	to		
		ose and mouth and no			all infection control practices; observin			
	gloves. The NA was o	observed picking up the			for facemasks in place, hand hygiene	•		
	remote for the bed co	ontrols, lowering the			before entering room, gloves worn in			
		icking up a blanket and			rooms and randomly asking staff abou			
		lent's chair. When the NA			droplet precautions. These observation	ns		
		was noted to place her hand			will be conducted on every shift and	u		
		hall as she walked down the resident's room without			documented for a period of three mont Zero tolerance for compliance will be	ins.		
		ene before touching the			adhered too. The Director of Nurses a	nd		
	handrail.	che belore todoning the			or designee will immediately educate a			
					correct any staff member found to be			
	NA #2 was interviewe	ed on 4-15-20 at 4:03pm. NA			deficient in practice.			
		st walked in there for a						
		her bed was down and put a			All education and observation			
		She said she did not think			documentation will be reviewed month	-		
		sk on her gloves since she			by the Quality Assurance Performance			
		performing resident care.			Improvement (QAPI) committee for thr	ee		
		did not realize she had			months to evaluate improvement and			
	she had attended in-s	in the hall. The NA stated			consistency. After three months the Q committee will determine if further			
		sching, how COVID19 was			monitoring is necessary in accordance	•		
	spread and the use o				with this plan of correction.			

Facility ID: 953488

If continuation sheet Page 6 of 13

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/21/2020 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMF	SURVEY LETED
		345186	B. WING			_		C 21/2020
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
FIVE OAK	S MANOR				13 WINECOFF SCHOOL R CONCORD, NC 28027	ROAD		
(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 B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	6	F	880				
	4-15-20 at 5:16pm. The staff had the likelihood members and residen hand hygiene and PP The Administrator and were interviewed on 4 Administrator and DO of staff not using the F rooms that were on da they would enter the 0 throughout the day bu surveillance or monito PPE. The Administrat on the COVID19 units were not dedicated st "try" not to have staff day. They also said the training regarding CO precautions, hand wa	Director of Nursing (DON) 1-15-20 at 7:00pm. Both the N stated they were unaware PPE when entering resident roplet precautions and said COVID19 units periodically at that there was no specific oring of the staff using their or and DON stated the staff s (300 and 400 hallways) aff to these units but they work other units the same ney had done "a lot" of						
	tested positive for CO placed on droplet pre-	nic obstructive pulmonary						
	nursing assistant (NA Resident #4's room w did not wash her hand the resident's wheelch resident out of the do	n on 4-15-20 at 4:15pm, A) #3 was noted to enter ithout wearing gloves and ds, she placed her hand on hair handle and rolled the prway. The NA was noted to er gloves on and began nt's room.						

Facility ID: 953488

If continuation sheet Page 7 of 13

		D HUMAN SERVICES MEDICAID SERVICES				RINTED: 05/21/2020 FORM APPROVED MB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		3) DATE SURVEY COMPLETED
		345186	B. WING			C 04/21/2020
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP C	CODE	
FIVE OAK			4	13 WINECOFF SCHOOL ROAD		
FIVE OAK	SWANOR		C	ONCORD, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	Continued From page	7	F 880			
	 #3 stated "I have then put them on yet. I was resident out of the dod door to perform reside she had been in-servi hand hygiene and the The facility's Medical 4-15-20 at 5:16pm. Th staff had the likelihood members and residen hand hygiene and PP The Administrator and were interviewed on 4 Administrator and DO of staff not using the F rooms that were on du they would enter the 0 throughout the day bu surveillance or monito PPE. The Administrato on the COVID19 units were not dedicated st "try" not to have staff day. They also said th training regarding CO precautions, hand wa of PPE but would "go education. 4. Resident #1 was an 	brway so I could shut the ent care." She also stated ced on droplet precautions, use of wearing PPE. Director was interviewed on the Medical Director stated d of infecting other staff ts if they did not use proper E protection. Director of Nursing (DON) 1-15-20 at 7:00pm. Both the N stated they were unaware PPE when entering resident roplet precautions and said COVID19 units periodically at that there was no specific oring of the staff using their or and DON stated the staff is (300 and 400 hallways) aff to these units but they work other units the same hey had done "a lot" of VID19, isolation shing, sanitizing and the use back" and perform further				
		rt dementia and coronary				

Facility ID: 953488

If continuation sheet Page 8 of 13

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES	1			FORM OMB NO): 05/21/2020 APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			SURVEY LETED
		345186	B. WING		_		21/2020
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
FIVE OAK	S MANOR			13 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-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	nurse #1 was noted to with a gown and mask mouth. She was observed e and using hand saniti nurse was observed e and using hand saniti nursing station. Nurse #1 was intervie The nurse stated she room to check on her needed to wear glove be performing care. S attended in-services of proper hand hygiene The facility's Medical 4-15-20 at 5:16pm. Th staff had the likelihood members and resider hand hygiene and PP The Administrator and were interviewed on 4 Administrator and DC of staff not using the F rooms that were on d they would enter the 0 throughout the day bu surveillance or monito PPE. The Administrato on the COVID19 units were not dedicated st "try" not to have staff day. They also said th training regarding CO precautions, hand wa	n on 4-15-20 at 3:55pm, b be in Resident #1's room k that covered her nose and rved touching the resident's hout wearing gloves. The exiting the resident's room zer before approaching the wed on 4-15-20 at 4:00pm. had entered Resident #1's and did not think she s since she was not going to the also stated she had on isolation precautions, and the use of PPE. Director was interviewed on he Medical Director stated d of infecting other staff its if they did not use proper E protection. d Director of Nursing (DON) I-15-20 at 7:00pm. Both the VN stated they were unaware PPE when entering resident roplet precautions and said COVID19 units periodically at that there was no specific oring of the staff using their or and DON stated the staff is (300 and 400 hallways) aff to these units but they work other units the same hey had done "a lot" of	F 880				

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/21/2020 APPROVED 0. 0938-0391
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		345186	B. WING				C 21/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				413 WINECOFF SCHOOL	ROAD		
FIVE OAK	S MANOR			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	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page education.	9	F 88	30			
	received COVID19 tra 3-17-20. Further revie						
	the Immediate jeopar	d the DON were notified of dy on 4-17-20 at 2:34pm. In the facility provided the gation of Immediate					
		pipients who have suffered, a serious adverse outcome compliance; and					
	the alleged deficient p scheduled on the Cov Nurse#1 was educate on vigilance of donnir room and removal of and performing hand	ed on 4/17/2020 by the SDC ng gloves in every resident gloves before exiting rooms					
	C.N.A.#1 was educate on vigilance of wearin while in the center, ur assigned break area a bathroom. He/she wa vigilance of donning g then performing hand are removed, and to s the room before touch equipment with zero t	s further educated on loves in all Covid + rooms, hygiene when the gloves sanitize hands once out of hing ice cart or other					

Facility ID: 953488

If continuation sheet Page 10 of 13

		ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 05/21/20 FORM APPROVE MB NO. 0938-039	ED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(3) DATE SURVEY COMPLETED	-
		345186	B. WING			C 04/21/2020	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO	DE		
			4	13 WINECOFF SCHOOL ROAD			
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 PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETION DATE	N
F 880	anything and removal rooms and performing sanitizer once he/she tolerance. Ice chest was sanitize housekeeper with EP continues to be saniti- nursing staff and hous "Specify the action the process or system adverse outcome fror when the action will b The downstairs on the but two residents ider the 300-400 halls as a positive resident's in p 100-hall will remain in Droplet precautions. S will be based on cons Residents that were to negative were placed group. All high touch a limited to doorknobs, ice chest, keyboards disinfectant daily and housekeeping and nu downstairs unit, include initiated beginning 4/1 positive rooms will be services, housekeeping needed. Starting on 4	ent room before touching of gloves before exiting g hand hygiene, then using enters hallway with zero ed on 4/16/2020 by A rated sanitizer and zed daily and as needed by sekeeping. In the entity will take to alter n failure to prevent a serious n occurring or recurring, and e complete. In the entity has co-horted all nuffied as COVID positive to a group. The two Covid orivate rooms on the short to their private rooms on Scheduling on the Covid Unit istent staff assignments. ested for Covid and were on the 100-300 hall as a surfaces, including but not hand rails, medication carts, will be sanitized using EPA as needed by the rsing staff assigned to the ding Covid Wing was I/2020. Staff entering Covid limited to nursing, social ng, physician, technicians to nostic testing and EMT as /15/2020 and continuing on f Development Nurse and ovided	F 880				

Facility ID: 953488

If continuation sheet Page 11 of 13

CENTER STATEMENT (AND PLAN OF NAME OF PI	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345186	A. BUILDING	E CONSTRUCTION	— TATE, ZIP CODE	FORM OMB NO (X3) DATE COMP	LETED
FIVE OAK	S MANOR			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 CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	but was not limited to hygiene, how Covid-1 droplet precautions, u equipment (PPE), dor continued wear of fac instructed on centers non-compliance durin progressive disciplina to CDC and CMS soc staff who were not scl 4/15/2020- 4/17/2020 competency with Staf Director of Nursing or hand hygiene, how Cd is droplet precautions equipment (PPE), dor continued wear of fac their next shift. They v zero tolerance during progressive disciplina staff will also receive with return demonstra Development Nurse of infection control, basic Covid-19 is transmitte precautions, use of pe equipment (PPE), dor continued wear of fac thealth Department re prior to start of work. I centers zero tolerance non-compliance durin progressive disciplina posters/tools provided health department wil throughout Covid unit restrooms. The Direct	lepartments which includes infection control, basic hand 9 is transmitted, what is use of personal protective nning and doffing PPE and emask. Staff will be zero tolerance stance with g this pandemic following iny action. Due to adherence ial distancing, all remaining heduled to work between will receive reeducation, f Development Nurse or n infection control, basic ovid-19 is transmitted, what , use of personal protective nning and doffing PPE and emask before the start of will also be made aware of this pandemic following iny action. All Covid positive reeducation/competency ation by the Staff or Director of Nurses on c hand hygiene, how ed, what is droplet ersonal protective nning and doffing PPE and emask before meeting equirements to return to work Staff will be instructed on e stance with g this pandemic following iny action. Visual d by the CDC/CMS local I be strategically placed and in employee	F 880				

Facility ID: 953488

If continuation sheet Page 12 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							INTED: 05/21/2020 FORM APPROVED IB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345186		B. WING			C 04/21/2020		
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
FIVE OAKS MANOR				413 WINECOFF SCHOOL ROAD CONCORD, NC 28027			
			ID		PROVIDER'S PLAN OF CORRE	ECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	COMPLETION DATE
F 880	Continued From page 12		F	880			
	observation every shift for compliance to all infection control practices; observing for						
	facemasks in place, hand hygiene before entering room, gloves worn in rooms and randomly asking staff about droplet precautions. Zero tolerance for						
	compliance will be adhered too. The Director of Nurses and or designee will immediately educate						
	and correct any staff i deficient in practice. 4 jeopardy removal.	member found to be I/17/2020 of immediate					
	The facility's credible allegation for Immediate Jeopardy removal, with an Immediate Jeopardy removal date of 4-17-20. Immediate Jeopardy was validated on 4-21-20 at 12:00pm as evidenced by licensed and non-licensed staff interviews, in service record reviews and observations. The in service included information on PPE use, infection control standards, COVID19 virus to include how the virus is spread and isolation precautions to include droplet						
	revealed staff were ut resident rooms and p hygiene upon exiting.	ations of the COVID19 units ilizing PPE when entering erforming appropriate hand The observations also meals being brought to the					
	doors of the COVID19 within the unit.	9 units allowing staff to stay					

If continuation sheet Page 13 of 13