# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

## PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345442

## NAME OF PROVIDER OR SUPPLIER

FORREST OAKES HEALTHCARE CENTER

## STREET ADDRESS, CITY, STATE, ZIP CODE

620 HEATHWOOD DRIVE
ALBEMARLE, NC 28001

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### IDENTIFICATION NUMBER:

345442

### DATE SURVEY COMPLETED

08/12/2020

### PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

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

#### ID PREFIX TAG

**E 000 Initial Comments**

An unannounced COVID-19 Focused Survey was conducted onsite 8/11/20 and continued offsite 8/12/20. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. See Event # P5E611.

**F 000 INITIAL COMMENTS**

An unannounced COVID-19 Focused Infection Control Survey was conducted onsite 8/11/20 and continued offsite on 8/12/20. The facility was found in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. See Event # P5E611.

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**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.**