STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204 SS=B	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide sufficient preparation to ensure a safe and orderly transfer or discharge from the facility for three (3) of three sampled residents (Resident # 80, Resident #83, & Resident #160). Findings included: 1. Resident #80 was admitted to the facility 7/02/2011. Diagnoses included: Seizure, cerebral palsy, generalized edema, hypertension, osteoarthritis, osteoporosis, anxiety and dysphagia. The Admission Minimum Data Set (MDS) dated 7/9/11 indicated resident was alert and cognitively intact. It was documented that Resident #80's overall goal established during the assessment process was to be discharged to the community (per resident). There was an active discharge plan in place. A review of Resident #80's care plan dated 8/23/2011 did not document that discharge planning had been done. A nursing note dated 8/29/2011 indicated resident was discharged to (name) skilled nursing facility at 4:15 PM.	F 204	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law 1. .Corrective Action: Residents #80, #83, #160 had all been previously discharged. 2. Others with Potential to be Affected: All active short-term patient records will be reviewed by the Social Services Director to ensure the initial admission meetings, care plans and/or discharge planning meetings have occurred and/or been scheduled . The social services director and/or receptionist will schedule those meetings that have not been conducted or scheduled. The Social Services Director will check the medical record to ensure a social services note has been entered documenting the content of these meetings by 12/15/11.	12/15/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/02/11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 1 A review of the resident's medical record revealed no documentation regarding the resident/family being informed of Resident #80's transfer to another skilled nursing facility or any discharge planning that had occurred prior to resident's discharge. On 11/15/11 at 3:45 PM, the Director of Health Services stated there is a discharge planning meeting held with Social Services Director, Nursing, Therapy, Responsible Party (RP) and/or resident prior to discharge (seven to fourteen days prior to discharge) unless family/ RP/ resident requests discharge or insurance denial. This information is recorded in the care plan section of the chart and would be documented as a discharge care plan meeting. The documentation would be completed by the Social Services Director. On 11/17/11 at 11:42 AM, the Social Services Director stated the documentation for any discharge planning would have been in her social services notes but she could not find any social services documentation in the record. 2. Resident # 83 was admitted to the facility 5/27/11 and was discharged home on 9/7/11. Diagnoses included: encephalopathy with acute mental status changes of unclear etiology, secondary worsening dementia, acute on chronic renal failure, ataxia and gait instability. The Care Plan conference dated 8/16/11 indicated family member was present. Additional comments indicated resident had progressed well	F 204	3. Measure/Systemic Change The Social Services Director will ensure that all initial admission meetings, care plan and/or discharge planning meetings are documented on a social services note in the medical record by verifying the note and recording it on a log maintained in the social services director office. 4. Monitoring: The Administrator and/or Director of Health Services will audit 5 short-term patient charts weekly for the first 4 weeks and monthly for the next 4 months to ensure compliance. The audit will be recorded on an audit tool that will be maintained in the administrator's office. Results of this audit will be reviewed in monthly PI Committee Meeting for follow-up or recommendations. The Administrator is responsible to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 2 with therapy PT(Physical Therapy)/OT (Occupational Therapy). Plans were for Resident # 83 to return home with his wife. A home evaluation was done 8/30/11 by the physical therapist. Recommendations included: walker and home health. A physician's order dated 9/2/2011 indicated Home Health Physical therapy/ Occupational therapy/ Nursing/ Aide; safe strides program at (name) Home Health Agency. Also, facility should provide information related to sitter services (name of sitter services agency). On 11/15/11 at 3:45 PM, the Director of Health Services stated there is a discharge planning meeting held with Social Services Director, Nursing, Therapy, Responsible Party (RP) and/or resident prior to discharge (seven to fourteen days prior to discharge) unless family/ RP/ resident requests discharge or insurance denial. This information is recorded in the care plan section of the chart and would be documented as a discharge care plan meeting. The documentation would be completed by the Social Services Director. On 11/17/11 at 12:15 PM, the Social Services Director indicated that she would notify the Home Health Agency after she had received the home evaluation and recommendations. She stated she did not document exactly when she notified the agency and did not have documentation of discharge planning for Resident #83. On 11/17/11 at 2:40 PM, the Social Services Director stated the family had decided not to	F 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 3	F 204		

receive sitter services but she had not documented that she had given the family any information regarding the sitter services and had not documented that the family had declined those services.

#3. Resident #160 was admitted to the facility on 9/12/2011 and was discharged home on 9/26/2011. Diagnoses included: diverticulitis, anemia, hypertension, gout and generalized weakness.

A Social Services progress note dated 9/12/2011 indicated Resident #160 was anticipated to be a short term stay at the facility.

A review of Resident #160's medical record revealed a purple sheet that was titled "Orders Needed from the Social Services Director". The sheet stated Resident #160 was scheduled for discharge to home with Home Health on 9/24/2011 with twenty-four (24) hour care and supervision. Discharge orders needed included Home Health Physical therapy, Home Health Occupational therapy, Home Health Nursing; equipment needed was a lightweight wheelchair. The form also stated Resident #160 was going to be discharged home secondary to insurance stopping payment as of 9/23/2011 and the family would be informed regarding the appeal process.

On 11/16/2011 at 9:01 AM, the Social Services Director stated the Interdisciplinary Team (Social Service Director, the therapist, nurse, MDS (Minimum Data Set) coordinators and Administrator) met weekly. During the meeting,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 4 they discussed the anticipated discharge date. The Social Service Director said she called the family a week or two in advance of the discharge for a meeting which could be held in person or over the phone. The resident's therapy progress would be reviewed and a home evaluation done by one of the facility therapy staff may be scheduled with the family. The therapy staff would perform the home evaluation and any recommendations are given to the Social Services Director. She stated she transferred all that information to a purple sheet which details equipment needed, services needed, if the resident required twenty-four (24) hour care or supervision and a Home Health referral. She would call the Home Health Agency of family choice. The equipment that was needed would be delivered to the facility so the family would have the equipment when the resident was discharged. The Social Services Director reviewed the chart and noted there was no documentation regarding discharge planning or a meeting with the resident/family prior to discharge. She said she did not know why she didn't document the information on Resident #160's chart.	F 204		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	F 226	1. Corrective Action: On 11/16/11 the Administrator completed the report of unknown injury to resident #63. The administrator sent the report by facsimile to the North Carolina Health Care Personnel Registry at 6:03 PM on 11/16/11.	12/15/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 5 facility failed to report an injury of unknown source to the State agency within 24 hours for one (1) of one (1) residents (Resident # 63). Findings included: According to North Carolina Administrative Code: 10A NCAC 13o .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL " The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). In addition, according to North Carolina General Statute G.S. 131E-256(g): facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in process. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. " Review of the facility policy titled " Abuse Reporting: Healthcare Centers, Home Health Agencies, Hospice (UHS-Pruitt) issued December 2001 and last revised 7/09 (page 4 of 8) revealed, in part, " if an agency staff member suspects that a healthcare center or assisted living patient/resident has been involved in alleged mistreatment, neglect, or abuse, including injuries of unknown source or misappropriation of patient/resident property, the occurrence will be	F 226	2. Other with Potential to be Affected: The Administrator and Director of Health Services will review all active resident records for injuries of unknown origin by 12/15/11. Findings of unknown injury will be reported immediately by facsimile to the North Carolina Health Care Personnel Registry. A statutory investigation will be completed and final report will be submitted within 5 days by the Administrator or Director of Health services by facsimile to the North Carolina Health Care Personnel Registry 3. Measure/Systemic Change: Administrator and/or Director of Health Services will report status of all abuse, neglect, misappropriation of funds and injury of unknown origin investigations at the morning meeting. This will include confirmation that the 24 and 5 day reports were completed and submitted per facility policy and procedure. If an allegation of abuse, neglect, misappropriation of funds or an injury of unknown origin occurs on the weekend, it will be reported by telephone to the Administrator and Director of Health Services. The Administrator or Director of Health Services will report the allegation within 24 hours by facsimile to the North Carolina Health Care Personnel Registry. The Administrator or Director of Health Services will report the status of investigation as well as confirmation that the 24 and 5 day reports were sent at the next scheduled morning meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 6 immediately reported to the center/agency Administrator, as well as the center/agency Administrator. ' Immediate reporting ' should not exceed 24 hours after the occurrence. " " Following the initial reporting of the incident, the healthcare center/agency Administrator will implement their protocol for investigation and reporting of suspected abuse and/or neglect, assuring that the appropriate state agencies, legal representative and/or family members, and Corporate Services are notified of the incident and pending investigation. " Resident #63 was admitted on 9/19/11 and had cumulative diagnoses including: dementia, presumptive Alzheimer ' s disease, history of hip fractures, status post left posterior 4th rib fracture, multiple falls and history of multiple fractures related to osteoporosis. Review of the Minimum Data Set admission assessment dated 9/26/11 the resident was severely cognitively impaired but under the communication heading Resident #63 was coded as usually understood and usually understands. Review of the Change of Condition Nurses Notes dated 11/13/11 at 9:05 PM revealed " This nurse went to give ativan 1 mg (milligram) IM (intramuscular) to resident d/t (due to) behaviors. This resident was sitting on top of bed at the foot of bed. This nurse asked 300 hall NA (Nursing assistant) to help put resident up in bed. When this Nurse & NA went to pull resident up; resident started yelling & stated ' my arm is broken, don ' t touch it. ' This nurse asked resident what happened & resident stated ' I fell on my face & that girl picked me up and put me in the bed '	F 226	4. Monitoring: The Director of Health Services will maintain a log tracking all investigations to include confirmation that 24 hour report was sent by facsimile per policy and procedure to the North Carolina Health Care Personnel Registry. A copy of the facsimile confirmation page will be included with the investigation documentation. Administrator or Director of Health Services will report monthly for 4 months to the PI meeting for tracking and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 7 (pointing to NA). This NA had not been in resident ' s room. X-ray of Lt (left) shoulder ordered at this time. " The Change of Condition Nurses Notes dated 11/13/11 at 11:15 PM revealed, in part, " X-ray results received. There is a fx (fracture) of the humoral neck (with) moderate medial displacement. " An incident report and investigation for the resident ' s injury incident was requested on 11/16/11 at 10:00 Am. On 11/16/11 at 4:00 PM interview with the Director of Nursing (DON) revealed that due to corporate policy incident reports cannot be provided to surveyors, however surveyors can view the investigation with a staff member present. The DON also stated that Resident #63 ' s injury incident, which occurred on 11/13/11, was not a fall. The DON reported that, although Resident #63 had stated she fell and that the NA (Nursing Assistant) had put her back on the bed; that NA had not been in the room and was just helping the nurse while the assigned NA was elsewhere. The DON indicated she was still investigating the incident and was trying to reach another NA from an incident that occurred a week previously, where the resident had hit a staff member. She stated that it was possible Resident #63 had hurt her arm at that time, but the description of the incident had not specified which arm the resident used. However, the DON noted that Resident #63 had not complained of pain in her arm the week preceding the injury incident on 11/13/11. The DON further indicated that she had not yet interviewed, or set up	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 8	F 226		

interviews, for the two NAs that had contact with the resident on second shift 11/13/11, when the resident ' s injury incident occurred, but that the investigation was underway. The DON then provided the statement of the Nurse who worked with the resident that evening, for review in her presence, but indicated that due to corporate policy making a copy would not be possible. When the DON was asked if a 24 hour report had been completed, given that this injury was not considered to be the result of a fall and the cause was unknown, she stated she would need to have the Administrator answer that question. She also indicated that their corporate policy had changed and although she had done the 24 hour reports for years, the Administrator was now responsible for them; however this was a very recent change for them.

Review of the statement (date unknown) of the nurse who worked with Resident #63 when the injury incident occurred on 11/13/11, revealed the statement was similar to what she had written in the Change of Condition Nursing Notes on 11/13/11 at 9:05 PM (see above).

On Wednesday 11/16/11 at 4:50 PM, interview with the Administrator revealed that in the Monday morning meeting at 9:00 AM he had been notified of the Resident #63 ' s injury incident and had asked if the cause was known. He also reported that since he was told the cause was unknown, he had commented in the meeting that it was an injury of unknown origin. He further stated that he had wanted to get more information before doing the 24 hour report. He stated that following the Monday morning meeting he had a conference call and then at about 10:45 the State

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 9	F 226		

surveyors entered the building and he forgot to complete the 24 hour report, but he would do it immediately.

Review of the 24 hour report regarding Resident #63 ' s injury of unknown source on 11/13/11 revealed it was dated 11/16/11 and the facsimile transmittal page associated with it indicated it was faxed on 11/16/11 at 18:03 (6:03 PM) to the North Carolina Health Care Personnel Registry. The allegation description read " Patient was sitting up on side of bed and was approached by staff to assist her back to bed and resident stated ' my arm is broken, don ' t touch it. ' Resident feels she has fallen and was helped up but no fall was witnessed. " There were no staff members listed as potentially being involved in the incident.

Interview with NA # 1 on 11/17/11 at 9:50 AM revealed she had worked on another hall on 11/13/11 second shift but assisted Resident #63 back into bed after dinner, at the request of the nurse, because the NA on the resident ' s hall was on break. She indicated that the Resident #63 required minimal assistance for the transfer and that she just provided stand by assist and raised the resident ' s legs into the bed, without incident. After NA#1 had put resident #63 to bed she had gone to the kitchen to get something for another resident. The NA stated that when she came back from the kitchen she heard Resident #63 hollering and saw her sitting on the side of the bed. She stated that at this time the nurse told her to leave the resident as the nurse was going to give her some medication. She stated that later NA # 2 told her that Resident #63 said that someone who put her in the bed hurt her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 10 Interview with NA #2 on 11/17/11 at 10:30 AM revealed that she worked both second and third shift on 11/13/11. She stated that she had helped the resident into bed for a nap prior to dinner as she had been agitated. Awhile later she went back in the room and found Resident #63 sitting on the side of the bed; the resident had taken her personal alarm off. NA #2 stated that she got the resident up in her wheelchair for dinner at that time and awhile later was assisting in the dinning room. NA #2 said that after she was finished in the dinning room she went on break and that the resident was still up in her wheelchair at that time. She went on to say that when she returned back from break, the nurse asked her to shift Resident #63 up in the bed as the resident was sitting hunched over at the foot of the bed, facing the door. The NA reported that she said to the resident " let ' s get you higher in the bed " and the resident said " don ' t touch my arm it ' s broken. " The NA added that the nurse then came in and the resident said " I fell and she put me back in bed " and the nurse responded by explaining that NA #2 had not been there. The NA said she later asked NA #1, who put the resident back to bed while NA #2 was on break, if there had been any problems during the transfer but NA #1 reported no problems.	F 226		
F 286 SS=C	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by:	F 286	1. Corrective Action: Residents #80, 172, 123, 31 and 139 are all discharged. The Medical Records Director will place 15 months of sections A, V and Z for comprehensive assessments and sections A and Z for other assessments on the medical record for residents #123, 71, 83, 21, 70, 102, 31, 170, 134, 57, 158, 30 and 63 by 12/15/11.	12/15/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 11 Based on record review and staff interview, the facility failed to ensure that resident's MDS (Minimum Data Set) assessments were readily accessible for 16 (Residents # 30, #70, #102, #123, #71, #134, #172, #63, #139, #80, #83, #21, #31, #170, #57 & #158) of 16 sampled residents. The findings include: 1. Resident # 30 was re-admitted to the facility on 05/23/08. Review of the resident's records revealed that there were no MDS assessments found. Review of the transmitted MDS assessments to the state revealed that there were 5 assessments submitted in the last 15 months. They were the annual assessment dated 01/25/11 and the quarterly assessments dated 11/02/10, 04/19/11, 07/12/11 and 10/11/11. On 11/16/11 at 9:12 AM, the MDS coordinator was interviewed. She stated that the policy was not to print the MDS assessments. She further stated that all MDS assessments were in the computer and not all staff members have access to the MDS assessments. She indicated that if the staff members have questions about the MDS assessments, they would come to us. 2. Resident # 70 was admitted to the facility on 10/07/11. Review of the resident's records revealed that there were no MDS assessments found. Review of the transmitted MDS assessments to the state revealed an admission MDS assessment dated 10/14/11. On 11/16/11 at 9:12 AM, the MDS coordinator was interviewed. She stated that the policy was not to print the MDS assessments. She further	F 286	2. Other with Potential to be Affected: The Medical Records Director will ensure 15 months sections A, V and Z for comprehensive assessments and sections A and Z for all other assessments are on the medical record for all active residents. The Director of Clinical Services and/or Director of Health Services will in-service all licensed nurses on how to access the MDS using the company network. This in-service will include review of the assessment as well as the Care Area Assessments (CAAs) by 12/15/11. 3. Measure/Systemic Change: Case Mix Director and/or LPN MDS Coordinator will audit 10 random charts monthly for 4 months to ensure that 15 months of sections A, V and Z for comprehensive assessments and sections A and Z for all other assessments are on the medical record. The results will be recorded on an audit tool maintained in the Case Mix Director's office. The Case Mix Director, Director of Health Services, Assistant Director of Health Services, Nurse In Charge or the LPN MDS Coordinator will ask one licensed nurse on each shift to demonstrate how to access the MDS assessment to include reviewing the CAA weekly for 4 weeks then monthly times 4 months. 4. Monitoring: The Case Mix Director or LPN MDS Coordinator will report findings monthly to the PI Committee for the next 4 months for tracking and trending. Deficient practice will result in re-education and corrective action as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 12 stated that all MDS assessments were in the computer and not all staff members have access to the MDS assessments. She indicated that if the staff members have questions about the MDS assessments, they would come to us. 3. Resident # 102 was re-admitted to the facility on 08/12/11. Review of the resident's records revealed no MDS assessments found. Review of the transmitted MDS assessments to the state revealed an admission MDS assessment dated 08/18/11. On 11/16/11 at 9:12 AM, the MDS coordinator was interviewed. She stated that the policy was not to print the MDS assessments. She further stated that all MDS assessments were in the computer and not all staff members have access to the MDS assessments. She indicated that if the staff members have questions about the MDS assessments, they would come to us. 4. Resident #123 was admitted to the facility on 2/23/11 and last readmitted on 10/5/11. No Minimum Data (MDS) assessments were found on the resident's record. Review of the transmitted MDS assessments to the state since admission revealed an admission assessment dated 3/5/11, quarterly assessments dated 5/20/11 and 8/12/11 and a significant change assessment dated 10/5/11. On 11/16/11 at 9:12 AM, the MDS coordinator was interviewed. She stated that the policy was not to print the MDS assessments. She further stated that all MDS assessments were in the computer and not all staff members have access to the MDS assessments. She indicated that if	F 286		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 13 the staff members have questions about the MDS assessments, they would come to us. 5. Resident #71 was last readmitted to the facility on 12/27/10. No Minimum Data (MDS) assessments were found on the resident's record. Review of the transmitted MDS assessments to the state since readmission revealed quarterly assessments dated 1/3/11, 3/28/11 and 9/19/11 and an annual assessment dated 6/27/11. On 11/16/11 at 9:12 AM, the MDS coordinator was interviewed. She stated that the policy was not to print the MDS assessments. She further stated that all MDS assessments were in the computer and not all staff members have access to the MDS assessments. She indicated that if the staff members have questions about the MDS assessments, they would come to us. 6. Resident #134 was admitted to the facility on 5/4/11. No Minimum Data (MDS) assessments were found on the resident's record. Review of the transmitted MDS assessments to the state since admission revealed an admission assessment dated 5/11/11. On 11/16/11 at 9:12 AM, the MDS coordinator was interviewed. She stated that the policy was not to print the MDS assessments. She further stated that all MDS assessments were in the computer and not all staff members have access to the MDS assessments. She indicated that if the staff members have questions about the MDS	F 286		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 14 assessments, they would come to us. 7. Resident # 172 was admitted to the facility on 10/19/11 and readmitted on10/28/11. Review of the resident's records revealed no MDS assessments found, however Section A, Z and V of the admission assessment were present and dated 11/1/11, the remaining sections were not present. Review of the transmitted MDS assessments to the state revealed the admission MDS was not yet present. On 11/16/11 at 9:12 AM, the MDS coordinator was interviewed. She stated that the policy was not to print the MDS assessments. She further stated that all MDS assessments were in the computer and not all staff members have access to the MDS assessments. She indicated that if the staff members have questions about the MDS assessments, they would come to us. 8. Resident # 63 was admitted to the facility on 9/19/11. Review of the resident's records revealed no MDS assessments found. Review of the transmitted MDS assessments to the state revealed an admission MDS assessment dated 9/26/11. On 11/16/11 at 9:12 AM, the MDS coordinator was interviewed. She stated that the policy was not to print the MDS assessments. She further stated that all MDS assessments were in the computer and not all staff members have access to the MDS assessments. She indicated that if the staff members have questions about the MDS assessments, they would come to us. 9. Resident # 139 was re-admitted to the facility	F 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 15 on 6/22/11 and had been discharged without readmission prior to the survey. Review of the resident's records revealed no MDS assessments found, however facility computerized records revealed an admission assessment was completed on 6/10/11. Review of the transmitted MDS assessments to the state revealed resident #139 ' s name and the 6/10/11 admission MDS was not present. On 11/16/11 at 9:12 AM, the MDS coordinator was interviewed. She stated that the policy was not to print the MDS assessments. She further stated that all MDS assessments were in the computer and not all staff members have access to the MDS assessments. She indicated that if the staff members have questions about the MDS assessments, they would come to us. 10. Resident #80 was admitted to the facility on 07/02/2011. No Minimum Data Set (MDS) assessments were found on the resident's medical record. On 11/16/2011 at 9:12 AM., the MDS Coordinator was interviewed. She stated that the policy was not to print the MDS assessment. She further stated that all MDS assessments were in the computer and not all staff members had access to the MDS assessment. She indicated if staff members had questions about the MDS assessments, they would come to us (MDS staff). 11. Resident #83 was admitted to the facility 5/27/2011. No MDS assessments were found on the resident's medical record. On 11/16/2011 at 9:12 AM., the MDS Coordinator	F 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	63 00 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 16 was interviewed. She stated that the policy was not to print the MDS assessment. She further stated that all MDS assessments were in the computer and not all staff members had access to the MDS assessment. She indicated if staff members had questions about the MDS assessments, they would come to us (MDS staff). 12. Resident #21 was readmitted to the facility 06/13/2010. No Minimum Data Set (MDS) assessments were found on the resident's medical record. On 11/16/2011 at 9:12 AM., the MDS Coordinator was interviewed. She stated that the policy was not to print the MDS assessment. She further stated that all MDS assessments were in the computer and not all staff members had access to the MDS assessment. She indicated if staff members had questions about the MDS assessments, they would come to us (MDS staff). 13. Resident #31 was admitted to the facility 06/03/2011. No Minimum Data Set (MDS) assessments were found on the resident's medical record. On 11/16/2011 at 9:12 AM., the MDS Coordinator was interviewed. She stated that the policy was not to print the MDS assessment. She further stated that all MDS assessments were in the computer and not all staff members had access to the MDS assessment. She indicated if staff members had questions about the MDS assessments, they would come to us (MDS staff). 14. Resident #170 was admitted to the facility 10/19/2011. No Minimum Data Set (MDS)	F 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 17 assessments were found on the resident ' s medical record. On 11/16/2011 at 9:12 AM., the MDS Coordinator was interviewed. She stated that the policy was not to print the MDS assessment. She further stated that all MDS assessments were in the computer and not all staff members had access to the MDS assessment. She indicated if staff members had questions about the MDS assessments, they would come to us (MDS staff). 15. Resident #57 was admitted to the facility 01/30/2010. No Minimum Data Set (MDS) assessments were found on the resident's medical record. On 11/16/2011 at 9:12 AM., the MDS Coordinator was interviewed. She stated that the policy was not to print the MDS assessment. She further stated that all MDS assessments were in the computer and not all staff members had access to the MDS assessment. She indicated if staff members had questions about the MDS assessments, they would come to us (MDS staff). 16. Resident #158 was admitted to the facility 09/05/2011. No Minimum Data Set (MDS) assessments were found on the resident's medical record. On 11/16/2011 at 9:12 AM., the MDS Coordinator was interviewed. She stated that the policy was not to print the MDS assessment. She further stated that all MDS assessments were in the computer and not all staff members had access to the MDS assessment. She indicated if staff members had questions about the MDS	F 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 18 assessments, they would come to us (MDS staff).	F 286		

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

RECEIVED
DEC 28 2011
CONSTRUCTION SECTION

PRINTED: 12/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____ (ON BUILDING 01)	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/8/2011 at approximately 10:00 Am onward the following was noted: 1) The utility room corridor door at the main nurse station did not close latch and seal at the time of the survey. 2) The soiled linen room corridor door at the 200 Hall nurse station did not close latch and seal at the time of the survey. 42 CFR 483.70(a)	K 029	K029 1. **Corrective Action:** The utility room door at the main nurse's station is on order and will be replaced by January 22, 2012. The soiled linen room corridor door at the 200 Hall nurse station was adjusted on December 19, 2011 and now latches and seals properly. 2. **Others with Potential to be Affected:** The Maintenance Director will check all facility doors for proper latch and seal by January 9, 2012. Doors that can be adjusted will be adjusted by January 9, 2012 by the Maintenance Director. Doors that must be replaced will be ordered by January 22, 2012. 3. **Measure/Systemic Change:** The Maintenance Director will check all facility doors monthly times 4 months to ensure they properly latch and seal. The Maintenance Director will make any necessary adjustments to ensure the doors properly latch and seal. 4. **Monitoring:** The Administrator will randomly check 3 doors for proper latch and seal monthly for the next 4 months to ensure compliance. Results will be reported to the monthly PI Committee Meeting for follow-up or recommendations.	1/22/12
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/23/11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING 01 - BUILDING 01 B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/8/2011 at approximately 10:00 Am onward the following was noted: 1) At the Service Breezeway side exit the area immediately outside the door was blocked with chairs and tables impeding the means of egress around the building and at the rear of the building in the means of egress the gas meter was protruding into the sidewalk reducing the width available and not allowing for a unobstructed path to the public way. 2) The staff at the main nurse station when asked about how to release the magnetic locking devices at the exit doors where not able at the time of the survey to answer the question. 42 CFR 483.70(a)	K 038	**K038** **1. Corrective Action:** The area immediately outside the service breezeway side exit door was cleared on 12/8/2011. The sidewalk adjacent to the gas meter protruding from the building will be widened by a contractor by January 22, 2012. The Maintenance Director or a member of the leadership team will in-service facility staff on the emergency release to the magnetic locking devices at the exit doors by January 8, 2012. **2. Other with Potential to be Affected:** All exits were inspected on December 8, 2011 by the Administrator and no other exits were found to have any objects impeding the means of egress. The Maintenance Director will include education on the emergency release to the magnetic locks on the exit doors with new hire orientation. **3. Measure/Systemic Change:** The Maintenance Director will inspect all exit areas weekly times 4 weeks then monthly times 4 months to ensure all exit areas are free from obstructions that impede the means of egress. Any obstructions will be removed at that time. During the monthly fire drills the Maintenance Director will ask one random staff member to demonstrate how to release all the magnetic locks on the exit doors. Education will be provided by the Maintenance Director at that time if necessary. **4. Monitoring:** The Maintenance Director will report findings monthly to the PI meeting for tracking and trending.	1/22/12
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/8/2011 at approximately 10:00 Am onward the following was noted: 1) One of the electronically supervised tamper alarms on the check valve for the sprinkler system located at the road in the vault when checked did not provide an alarm at the Fire Alarm Control Panel (FACP) when tested.	K 061		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING 01 - BUILDING 01 B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 061	Continued From page 2 42 CFR 483.70(a)	K 061	**K061** **1. Corrective Action:** The electronically supervised tamper alarm will be repaired on January 5, 2012. **2. Other with Potential to be Affected:** On January 5, 2012 both tamper alarms will be tested after the faulty alarm has been repaired. **3. Measure/Systemic Change:** The Maintenance Director will ensure that the vendor servicing the sprinkler system checks the electronically supervised tamper alarm properly and also ensure that there is an alarm at the Fire Alarm Control Panel. **4. Monitoring:** The Maintenance Director will check the electronically supervised tamper alarm quarterly to ensure that it is functioning and that there is an alarm at the Fire Alarm Control Panel. The Maintenance Director will report quarterly to the PI meeting for tracking and trending.	1/22/12