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

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A PULIDING DEPARTOR CORRECTION  ON 19 PROVIDER OR SUPPLIER 346188  SUBME OF PROWDER OR SUPPLIER FIVE OAKS MANOR  SUBMENT STATEMENT OF DEPICIENCIES (EACH) DEPICIENCY MIST DE PROCEDED BY FILL REGULATORY OR LISC DEPARTMENT ON PROCEDED BY FILL REGULATORY OR LISC DEPARTMENT OF CONTROL REGULATORY OR LISC DEPARTMENT OF CONTROL REGULATORY OR LISC DEPARTMENT OF CONTROL PROVIDED BY FILL REGULATORY OR LISC DEPARTMENT OF PROCEDED BY FILL REGULATORY OR LISC DEPARTMENT OF CONTROL PROVIDED BY FORMENT OF	CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
### SPEED ANS MANOR    Comparison of the process of	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA		ļ ·		ļ.	
STREET ADDRESS, CITY, STATE, 2PC CODE 473 WINDLOOP SUBMINARY STATEMENT OF DESCRIPTIONS  ONCORD, NC 28927  FOR SUBMINARY STATEMENT OF DESCRIPTIONS  FOR I SUBMINARY STATEMENT OF CORRECTION (CONCORD)  FOR IN STATEMENT OF	WD ADW OL COUVEDING		B. WNG		1	2012
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Summary stylement or deficiency was a present processed of infection.   Proposers and transport lines so as to prevent the spread of infection.	IAME OF PROVIDER OR SUPPLIER		41	3 WINECOFF SCHOOL ROAD		
## PROVIDENCE TO PROJUMENT OF DESIGNATIONS OF THE APPROPRIATE CONTENT OF THE APPROPRIATE CONTENT OF THE APPROPRIATE CONTENT ON THE APPROPRIATE CONTENT OF THE APPROPRIATE CONTENT ON TH	FIVE OAKS MANOR		C			(X5)
SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;  (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.  (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.  (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens  Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	PREFIX (EACH DEFICIENT	COMMIST RE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OFO RE	COMPLETION
CANDATE	F 441 SS=D  The facility must es Infection Control Presafe, sanitary and control present the of disease and infection Control The facility must exprogram under who (1) Investigates, control in the facility; (2) Decides what present the facility; (2) Decides what present does not be applied (3) Maintains a reactions related to (b) Preventing Specific (1) When the Infecter mines that a prevent the spreasionate the resident (2) The facility must communicable different contact will (3) The facility must hands after each hand washing is professional practical control in the facility must be presented i	control, prevent  tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.  If Program stablish an Infection Control ich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections.  Tread of Infection ction Control Program resident needs isolation to d of infection, the facility must not.  Lest prohibit employees with a sease or infected skin lesions cot with residents or their food, if a transmit the disease.  Lest require staff to wash their direct resident contact for which indicated by accepted ctice.	F 441	accomplished for those refound to have been affect alleged deficient practice.  1. No residents have be affected by the alleged deficient practice.  Corrective action will be accomplished for those thaving potential to be affected the same alleged deficient.  1. Facility has no document to be affected or confirmany resident nor state had a diagnosis of some successful to the same alleged deficient.  2. Nurse #1 received of Action/education for following facility purfection Control. Some successful the same alleged deficient to work with restrictions.  4. Staff will receive a training on the following Spread.	en ed ed en	10-5-1
TITLE						(X6) DATE

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.

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING		С	
		B. WNG		09/14/2012		
FIVE OAK		TATEMENT OF DEFICIENCIES	413	ET ADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD NCORD, NC 28027 PROVIDER'S PLAN OF CORRECT	FION (X6)	
(X4) ID PREFIX TAG	/CACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	)EU DE	
F 441	by: Based on observati document review the 1 staff members (Not diagnosis of scables receiving treatment.  The findings include According to the Ce Prevention (CDC) an infestation of the (Sarcoptes scable) microscopic scable) layer of the skin wh The most common intense itching and	T is not met as evidenced  on, staff interview and e facility failed to ensure 1 of urse #1) with a potential e did not return to work before  ed: enters for Disease Control and 'Human scabies is caused by e skin by the human itch mite	F 441  5. Employees identified with communicable disease will be required to provide medical clearance from physician to management before allowed return to work. Utilization of this protocol will eliminate to potential for our residents to affected by the same alleged deficient practice.  6. New hires will receive ab training during orientation. Training will be provided by SDC whom is a R.N.		will be dical an to lowed to tion of inate the ents to be lleged ive above ation.	
	Review of the document titled "CDC - Scables - Resources for Health Professionals - Institutional Settings - Single case "revealed, in part, "Maintain a high index of suspicion that scables may be the cause of undiagnosed skin rash; suspected cases should be evaluated and confirmed by skin scrapings. "In regards to when staff who had scables can return to work it read "Staff generally can return to work the day after receiving a dose of treatment with permethrin or ivermectin; however, symptomatic staff who provide hands-on care to any patient may need to use disposable gloves for several days after treatment until sure they are no longer infested."			Measures put into place or changes made to ensure that alleged deficient practice will occur;  1. Staff will receive addition training on the follow to assure understanding communicable disease responsibilities before allowed entrance to will disease.	the Il not  tional ing topics ag of e and their being ork place,	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING

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		345186	B. WNG		C 09/14/2012		
	OVIDER OR SUPPLIER	340100		4	EET ADDRESS, CITY, STATE, ZIP CODE		
FIVE OAK	S MANOR			С	ONCORD, NC 28027		
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Review of the patient dated 9/7/12 at 8:44 the Emergency Roor evaluation of an itchy she had been evaluation of an itchy she had been evaluation of an itchy she had been evaluation between Shower whole body from near then shower and lau in hot water. "Elimpermethrin.  Review of the facility Precautions dated A scabies was listed a required contact preinformation about so prevent it from spreyent were no othe procedures regarding Review of the facility 9/7/12, 9/8/12 and 9/14/12, 9/8/12 and 9/1	information for Nurse #1, AM, and given to Nurse #1 at n where she went for rash, revealed, in part, that ited for scabies and insect d treatment was "Elimite and dry, then apply cream to ck down, leave on 8 hours nder clothes and bed clothes te is a brand name for  policy for Contact ugust 2009 revealed that s one of the conditions that cautions. No other cabies, or how to treat it and ading was in the document. r facility policies or	F	441	Infection control, Preventi Spread of infection and Lin New hires will receive train during orientation. Training be provided by SDC whom R.N.  2. Employees identified we communicable disease will required to provide medical clearance from physician an analgement before allow return to work.  Performance will be monified our monthly Quality Assus Committee monthly meeting review the need for continuintervention or amendment plan.  1. Failure to adhere to facility policy will be considered violation. Violations will in disciplinary action in accordance with facility progressive disciplinary	nens. ning ng will n is a  vith a 1 be al to ed to  tored at rance ing x3 to nued at of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PRO IDEN		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A, BUILDING			С	
		345186	B. WNG		09	/14/2012	
	OVIDER OR SUPPLIER		413	TADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD NCORD, NC 28027	_		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From page her she was being to said that once she will discovered the med. She stated that she time but went into work at 3 PM that was hoping her emittreatment. Nurse # and told her the med did not request the DON did not offer to also said that she wask for, time off to further stated that she follow-up questions completed the scal precautions required She added that she following day and laundry precautions she felt it had been #1's right arm was cattered red mark improved and she itchiness.  Interview with the revealed that she the Emergency Reand would have her for scabies. She #1 did not go until DON added that the being treated for prescription cost:	LSC IDENTIFYING INFORMATION	F 441				

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		345186	B. WNG		C 09/14/2012	
NAME OF PR	OVIDER OR SUPPLIER		413 W	ADDRESS, CITY, STATE, ZIP CODI VINECOFF SCHOOL ROAD CORD, NC 28027	E	
(X4) ID PREFIX TAG	(FACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	enable her to return did not know for sur scabies, only that N However, she also a Nurse #1 told her si anything to verify the had been treated ar return to work.  Interview with the A 9/14/12 at 7 PM rev. Nurse #1 really had indicated that some make untrue claims. However, they also Nurse #1 said she obligation to protect before Nurse #1 rethat she either did completed the requiprecautions correct that they understood diagnosis was presignanting paid time focus would be on Therefore, confirm present was irreleved or was no longer processed.  On 9/21/12 at 8:15 the physician reveal that the facility had scabies among reacknowledged that have a confirmed was not done for constructions.	to work but said that she also e if Nurse #1 really had urse #1 said she had scabies. acknowledged that once he had scabies she did not do at she did not have it and/or had was therefore cleared to diministrator and DON on realed they were uncertain that I a diagnosis of scabies. They be time staff had been known to sto get time off work. I acknowledged that, given had scabies, there was an at residents by ensuring that, turned to work, they confirmed not have scabies or had sired treatment and they. They also acknowledged dot that while verifying that a sent would be a factor in off, in infection control the protecting residents. In ing that the diagnosis was want but verifying that it was not be understood they can be understood to the primary.  So AM, telephone interview with aled no negative outcomes in the occupance of scabies, as a scraping diagnosis, she should have scabies before returning to work.	F 441			

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NAME OF PR	OVIDER OR SUPPLIER  S MANOR		413	T ADDRESS, CITY, STATE, ZIP CODE WINECOFF SCHOOL ROAD NCORD, NC 28027			
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