STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation (NC97104).	F 000	This Plan of Correction does not constitute and admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in theis Statement of Defiiencies. This Plan of Correction is prepared solely because ist is required by state and federal law.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 164	F-164 1. Residents #66, #58 and #36 had privacy and confidentiality provided following intervention during the survey. The nurse was immediately retrained by the Director of Clinical Services on privacy and confidentiality on 11/19/2014. 2. All residents residing in the facility have the potential to be affected. 3. All nursing staff were retrained on the need to always maintain privacy and confidentiality during the provision of care and for personal information by the Director of Clinical Services on 12/16/2014. Any additional nurses will be trained on privacy and confidentiality before they are able to work. 4. The Director of Clinical Services/Assistant Director of Clinical Services/Nurse Manager will conduct Quality Improvement monitoring of no less than 3 nurses on a given monitoring day, to encompass all three shifts and to include at least one weekend date per	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed Deborah Hamilton — TITLE: ED — (X6) DATE: 12-18-14

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.

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

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F 164	Continued From page 1 facility failed to ensure that residents' personal and clinical records were kept confidential by exposing the medication administration records (MARs) containing the resident's name, diagnoses and list of medications for 3 (Residents # 66, #58 and # 36) of 3 sampled residents observed. Findings included: 1. On 11/19/14 at 7:59 AM, Nurse #5 was observed passing medications. She was observed to enter the room of Resident #66 to administer the medications. The MAR book was observed on top of the medication cart and was not in view of the nurse. The book was wide open and the resident's name, diagnoses and list of medications were exposed. Non licensed staff members were observed walking by the medication cart. On 11/19/14 at 8:13 AM, Nurse #5 was observed to enter the room of Resident #58 to administer the medications. The MAR book was observed on top of the medication cart and was not in view of the nurse. The book was wide open and the resident's name, diagnoses and list of medications were exposed. Non licensed staff members were observed walking by the medication cart. On 11/19/14 at 8:15 AM, Administrative staff #3 was interviewed. She stated that nurses were supposed to cover the resident's information on the MAR when unattended. She added that she would talk to the nurse to remind her to cover the MAR when not attended. At 8:20 AM, Administrative staff #3 was observed talking with	F 164	month .Quality Improvement will take place 5 times weekly for 2 months, then 3 times weekly or 4 weeks, then 1 time weekly for 2 months, then monthly for 2 months ensure that privacy and confidentiality is maintained. The Director of Clinical Services or Designee will immediately retrain the Nurse for any breech in privacy or confidentiality. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Assistant Director of Clinical Services/Nurse Manager to the Quality Assurance Performance Improvement Committee monthly for six months for continued substantial compliance and/or revision.	12-18-14

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

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F 164	Continued From page 2 Nurse #5. On 11/19/14 at 8:20 AM, Nurse #5 was observed in the room of Resident #36. The MAR book on top of the medication cart was observed wide open and the resident's name, diagnoses and list of medications were exposed. The medication cart was not in view of the nurse. Non licensed staff members were observed walking by the medication cart. At 8:21 AM, Nurse #5 went to the nurse's station to get blood pressure cuff and went back to the resident's room to check the blood pressure. After checking the blood pressure, she went back to the nurse's station to return the blood pressure cuff. On 11/19/14 at 8:23 AM, Nurse #5 was interviewed. She stated that she tried to close the MAR or cover the information when she left the medication cart but she forgot. She further stated that she worked night shift with fewer distraction than day shift.	F 164		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278	F-278 1. Resident #39 was evaluated by Physical Therapy on 11/20/14. Physical Therapy began treating Resident #39 on 11/20/2014 and plans to continue physical therapy times 30 days or as long as necessary. 2. All residents residing in the facility have a potential to be affected. 3. Minimum Data Set Nurse was retrained on accuracy of coding minimum data sets by the Regional Director of Nursing of	12-18-14

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
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F 278	Continued From page 3 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately assess range of motion for 1 of 1 sampled resident (Resident # 39). The findings included: Resident # 39 was admitted on 1/9/09 and readmitted on 7/1/14. Cumulative diagnoses included flaccid hemiplegia dominant side, dementia and cerebral vascular accident. Review of the Physical Therapy (PT) evaluation dated 6/24/14 revealed that Resident #'s 39's right knee extension was - 45 and her left knee extension was also -45. Physical Therapist #1 reviewed this document on 11/19/14 at 2:23 PM and interview with PT #1 at this time revealed an extension of -45 meant the resident's knee was contracted and would need to extend a further 45	F 278	Clinical Services on 12/16/2014. All nursing staff have been retrained by Director of Clinical Services on reporting changes in range of motion and filling out referrals on 12/16/2014. A review for Range of Motion of all residents residing in the facility was completed by the Unit Manager and a staff nurse on 12/17/2014. Any resident with a noted change or deficits in range of motion was referred to therapy on 12/17/2014 by the Unit Manage. Additionally, the range of motion audit was compared to the Minimal Data Sets and Resident's Care Plan by the Unit Manager and Minimum Data Set Nurse and any corrections needed were completed on 12/18/2014 by the Unit Manager and Minimum Data Sheet Nurse. 4. The Director of Clinical Services/Assistant Director of Clinical Services will conduct Quality Improvement monitoring on 3 Minimum Data Sets and Care Plans per week to	12-18-14

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

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F 278	Continued From page 4 degrees to have full range of motion (with full range of motion the knee extension would equal 0). The Annual Minimum Data Set (MDS) Assessment dated 7/8/14 revealed Resident #39 was cognitively impaired, had not rejected care and had an upper extremity range of motion impairment on one side and a lower extremity range of motion impairment on 1 side. During interview with Nurse #2 on 11/20/14 at 1:40 PM she acknowledged that the 6/24/14 Physical Therapy Evaluation indicated Resident # 39 had bilateral lower extremity contractures and therefore decreased range of motion. She indicated that based on this information the 7/8/14 MDS was inaccurately coded for range of motion.	F 278	ensure accuracy for 1 month, then 1 Minimum Data Set and Care Plan per week for 3 months, then 1 Minimum Data Sheet and Care Plan for two months. The results of the Quality Improvement monitoring will be reported by Director of Clinical Services/Assistant Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly for six months for continued substantial compliance and/or revision.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279	F-279 1. Resident #52 longer resides in the facility. Residents #51 and #16 Care Plans and Minimum Data Sets have been reviewed for accuracy of interventions and medications for behaviors by the Social Worker and the Unit Manager on 12/17/2014 any needed corrections were made by the Social Worker and Unit Manager on 12/17/14. 2. All residents residing in the facility with behaviors and/or receiving psychoactive medications have the potential to be affected.	12-18-14

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

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F 279	Continued From page 5 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to address the behavior in the care plan for 3 of 5 sampled residents receiving psychotropic medications (Resident #52, #51 and #16). Findings included: The facility's policy and procedure on the use of psychotropic medications dated 2/20/2014 (last review date) was reviewed. The procedure included " plans of care will be reviewed quarterly with the inter disciplinary team and updated as indicated for management of medications, behavior and interventions using individualized and measurable goals for behavior management and psychotropic medication usage and or reduction. " 1. Resident #52 was admitted to the facility on 11/9/11 with multiple diagnoses including dementia with behaviors. The annual Minimum Data Set (MDS) assessment dated 9/11/14 indicated that Resident #52 had memory and decision making problems and was on antipsychotic medication. The care plan dated 9/11/14 was reviewed. There was no care plan problem, goal and interventions for behavior management.	F 279	3. The Interdisciplinary Departmental Team was retrained on the need to individually plan for behavioral interventions and for the use of any psychoactive medications by the Director of Clinical Services on 12/16/2014. The Interdisciplinary Departmental Team will meet weekly to review residents residing in the facility who have behaviors and/or psychoactive medications to ensure that Minimum Data Sets and Care Plans are accurate. 4. The Director of Clinical Services/Assistant Director of Clinical Services will audit 3 affected residents for accuracy of Minimum Data Sets and Care Plans weekly for 1 month, then 1 affected resident weekly for 2 months, then 1 affected resident monthly for 3 months. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Assistant of Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	12-18-14

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F 279	Continued From page 6 The physician's orders for November, 2014 revealed that Resident #52 was on Zyprexa 5 milligrams (mgs) daily for dementia with behaviors and depakote 250 mgs twice a day for psychosis. On 11/19/14 at 3:47 PM, Nurse #2 was interviewed. She stated that the social worker was responsible for developing the care plan for behaviors. On 11/19/14 at 4:18 PM, administrative staff #1 was interviewed. She stated that her expectation was that residents on medications for behaviors should have a care plan developed to address behavior management. On 11/19/14 at 5:29 PM, administrative staff #4 was interviewed. She acknowledged that she was responsible for developing the care plan for behavior management. She indicated that she could not find the behavior care plan for Resident #52. 2. Resident #51 was admitted to the facility on 6/25/13 with multiple diagnoses including dementia with behaviors. The quarterly MDS assessment dated 9/10/14 indicated that Resident #51 had memory and decision making problems and was on antipsychotic and antianxiety drugs.	F 279		12-18-14

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F 279	Continued From page 7 The care plan dated 9/10/14 was reviewed. There was no care plan problem, goal and interventions for behavior management. The physician's orders for November, 2014 revealed that Resident #51 was on Seroquel 25 mgs at bedtime for dementia with behaviors, Ativan 1 mgs at bedtime and 0.5 mgs twice a day for anxiety and depakote 500 mgs at bedtime for dementia with behaviors . On 11/19/14 at 3:47 PM, Nurse #2 was interviewed. She stated that the social worker was responsible for developing the care plan for behaviors. On 11/19/14 at 4:18 PM, administrative staff #1 was interviewed. She stated that her expectation was that residents on medications for behaviors should have a care plan developed to address behavior management. On 11/19/14 at 5:29 PM, administrative staff #4 was interviewed. She acknowledged that she was responsible for developing the care plan for behavior management. She indicated that she could not find the behavior care plan for Resident #51. 3. Resident #16 was admitted to the facility 7/9/2004 with last readmission to the facility 8/22/2008. Cumulative diagnoses included anxiety and organic brain syndrome. A Quarterly Minimum Data Set (MDS) dated	F 279		12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 8 9/19/14 indicated Resident #16 had short term and long term memory impairment and was severely impaired in decision-making. Inattention, disorganized thinking and altered level of consciousness was noted as behavior continuously present. Medications administered during the assessment period included antipsychotic, anxiety and antidepressant medication. A care plan dated 2/10/14 and last reviewed on 9/19/14 was reviewed. There was no care plan problem, goal and interventions for behavior management. The physician orders for November 2014 revealed that Resident #16 was on Lexapro (antidepressant medication) 10 mg. (milligrams) daily for depression, Seroquel (antipsychotic medication) 12.5 mg. at 2:00PM daily and 25 mg. two tablets (50 mg) daily at 8:00PM and Xanax (anxiety medication) 0.25 mg. at bedtime. On 11/19/14 at 3:47 PM, Nurse #2 was interviewed. She stated that the social worker was responsible for developing the care plan for behaviors. On 11/19/14 at 4:18 PM, administrative staff #1 was interviewed. She stated that her expectation was that residents on medications for behaviors should have a care plan developed to address behavior management. On 11/19/14 at 5:29 PM, administrative staff #4 was interviewed. She acknowledged that she was responsible for developing the care plan for	F 279		12-18-14

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

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F 279	Continued From page 9 behavior management. She indicated that she could not find the behavior care plan for Resident #16.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, record reviews and observations, the facility failed to monitor fluid intake for one of one sampled resident (Resident # 50) on dialysis with fluid restriction. Findings Included: Resident #50 was admitted to the facility on 9/26/14 with multiple diagnoses including end stage renal disease, renal dialysis and diabetes mellitus. A review of the Minimum Data Set dated 10/3/14 revealed the resident was assessed as being cognitively intact. The resident was assessed as receiving dialysis as part of her medical treatment. A review of the Plan of Care dated 10/3/14 indicated the resident was dependent on hemodialysis to sustain life due to end stage renal disease.	F 309	F-309 1. The Fluid Restriction for resident #50 was discontinued on 11/19/2014 by the physician. 2. No other residents residing in the facility are on fluid restrictions. 3. Nursing Staff were retrained on the need for accurate Intake and Output monitoring, as ordered by the physician, as well as documentation when a fluid restriction is prescribed on 12/16/2014 by the Director of Clinical Services. 4. If an order is received for a fluid restriction for a resident residing or admitted in the facility, the Director of Clinical Services/Assistant Director of Clinical Services will monitor for proper documentation and ensure resident is not receiving additional free fluids 5 times weekly for 1 month, then 3 times weekly for 1 month, then 1 time weekly for 2 months, then 1 time monthly for 2 months while the resident remains on fluid restrictions. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Assistant of Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	12-18-14

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F 309	Continued From page 10 A review of the Physician's Orders revealed an order dated 10/28/14 which stated " 1400 cubic centimeters per day fluid restriction due to hemodialysis. " A review of the Physician's Orders revealed an order dated 11/17/14 which stated " Clarify 1400 cubic centimeters fluid restriction: 300 cubic centimeters nursing (150 days/150 evenings)/1100 cubic centimeters dietary (620 cubic centimeters breakfast/240 cubic centimeters lunch/240 dinner). " A review of the Medication Administration Record (MAR) dated October 2014 revealed an entry dated 10/28/14 which stated " For Your Information: 1400 fluid restriction per day. " There was no documentation of the amount of fluid consumed by the resident recorded on the MAR dated October 2014. A review of the MAR dated November 2014 revealed an entry which stated " For Your Information: 1400 fluid restriction 300 cubic centimeters (cc) = nursing 150 cc days/150 cc evenings/ 620 cc = breakfast + 240 = lunch 240 = dinner. " There was no documentation of the amount of fluid consumed by the resident recorded on the MAR dated November 2014. A review of the Nurses Notes from 10/28/14 until 11/19/14 was conducted. A note dated 10/28/14 stated " Order for 1400 cc fluid restriction today. " A note dated 10/29/14 stated " Resident is on 1400 cc fluid restrictions. Able to voice needs. " A note dated 11/17/14 stated " Clarify 1400 cc	F 309		12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 11 fluid restriction and made notation. " No documentation regarding the amount of fluid consumed by the resident was observed. No documentation of the resident being non compliant with the fluid restriction was observed. No documentation of the resident receiving education regarding the risks associated with being non complaint with the fluid restriction was observed. A review of the Interdisciplinary Progress Notes was conducted. A dietary note dated 11/17/14 stated " Will clarify fluid restriction to 1400 cc: 300 cc nursing (150 day/150 evening) and 1100 cc dietary (620 breakfast/240 dinner/240 lunch). " An interview was conducted with Nurse #3 on 11/19/14 at 10:53 AM. Nurse #3 stated the resident was on fluid restrictions. She stated that fluids were provided on the resident's meal trays and additional fluids were to be measured by the nursing staff before being offered to the resident. Nurse #3 observed an ice pitcher on the resident's bedside table and stated that the ice pitcher should not have been in the resident's room. She stated the resident was given ice upon request only. She stated the resident was cognitively intact and was capable of drinking from an ice pitcher without assistance from the staff. Nurse #3 stated the resident was not compliant with the fluid restriction. An interview was conducted with Nursing Assistant (NA) #1 on 11/19/14 at 11:01 AM. NA #1 stated the resident was restricted to 1400 cc of fluids per day. She stated 1100 cc of fluids came on her meal trays and the nursing staff gave her an additional 300 cc with medication	F 309		12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 309	Continued From page 12 administration. NA #1 stated if the resident requested additional fluid, the nursing assistants were expected to inform the nurse to ensure the resident did not exceed her daily amount. She stated the nursing assistants fill the resident's ice pitcher three times a day with water and ice. NA #1 picked up the ice pitcher located on the resident's bedside table and stated the pitcher was approximately a little less than half full. An interview was conducted with Administrative Staff #3 on 11/19/14 at 12:31 PM. She stated intake and output was not being documented on the resident because the resident had the right to drink water. An interview was conducted with Administrative Staff #1 on 11/19/14 on 2:11 PM. She stated the nursing staff was offering approximately 120 cc of fluid with each administration of medication. She stated the nursing staff was aware they were only to give the resident 150 cc during the day, 150 cc during the evening and that no fluids were to be given at night. Administrative Staff #1 stated the amount of fluids consumed by the resident was not being documented. She stated the resident was cognitively intact and aware she was on a fluid restriction. She stated the resident was not compliant with the fluid restriction. She further stated the nursing staff was expected to educate the resident regarding the need for the fluid restriction. An interview was conducted with Resident #50 on 11/19/14 at 3:48 PM. The resident stated she was aware her fluid intake was supposed to be restricted. She stated she had requested to have her ice pitcher filled and the staff was filling the	F 309		12-18-14

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
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

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F 309	Continued From page 13 pitcher at least twice a day.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to continue interventions to prevent a further decline in range of motion for 1 of 1 sampled resident (Resident # 39). The findings included: Resident # 39 was admitted on 1/9/09 and readmitted on 7/1/14. Cumulative diagnoses included flaccid hemiplegia dominant side, dementia and cerebral vascular accident. The Annual Minimum Data Set (MDS) Assessment dated 7/8/14 revealed Resident #39 was cognitively impaired, had not rejected care and had an upper extremity range of motion impairment on one side and a lower extremity range of motion impairment on 1 side. Review of the Care Plan dated 7/16/14 revealed Resident #39 required assistance with self-care, toileting, transferring and mobility. Review of the Physical Therapy (PT) Discharge	F 318	F-318 1. Resident #39 was evaluated by Physical Therapy on 11/20/14. Physical Therapy began treating Resident #39 on 11/20/2014 and plans to continue physical therapy times 30 days or as long as necessary. 2. All residents residing in the facility have a potential to be affected. 3. All nursing staff have been retained by the Director of Clinical Services on 12/16/2014 on reporting changes in range of motion and filling out therapy referrals. A review for Range of Motion of all residents residing in the facility was completed by the Unit Manager and a staff nurse on 12/17/2014. Any resident with a noted change or deficit in range of motion was referred to therapy on 12/17/2014 by Unit Manager and/or staff nurse. Restorative nurse, Restorative Aid and Director of Therapy have been retrained on 12/17/2014 by the Director of Clinical Services on training the Restorative Aid for residents released from therapy to restorative to maintain the	12-18-14

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
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

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F 318	Continued From page 14 Summary dated 7/5/13 (2013) revealed that Resident # 39's right knee extension was -5 and her left knee extension was also -5. Physical Therapist #1 reviewed this document on 11/19/14 at 2:20 PM and interview at with PT #1 at this time revealed an extension of -5 meant the resident's knee had a slight contraction and would need to extend a further 5 degrees to have full range of motion (with full range of motion the knee extension would equal 0). Further review of the Physical Therapy Discharge Summary dated 7/5/13 revealed the resident was discharged from PT services to the Restorative Nursing Program for maintenance. Review of a Restorative Report for the dates 1/1/14 - 2/16/14 on 11/19/14 at 5:15 PM revealed Passive and Active Range of Motion Services were last provided to the resident on 1/12/14 and that Restorative services for splinting were last provided on 1/10/14. Administrative Staff #7 reviewed this Restorative Report on 11/19/14 at 5:15 PM and interview at this time revealed that Resident # 39 did not receive Restorative Nursing Services after 1/12/14 and that the facility did not maintain any record of restorative services provided prior to 1/1/14. Review of the Physical Therapy evaluation dated 6/24/14 revealed that Resident #'s 39's right knee extension was - 45 and her left knee extension was also -45. Physical Therapist #1 reviewed this document on 11/19/14 at 2:23 PM and interview with PT #1 at this time revealed an extension of -45 meant the resident ' s knee was contracted and would need to extend a further 45 degrees to have full range of motion (with full range of motion the knee extension would equal	F 318	resident's optimal activities of daily living. The restorative nurse will continue to assess residents on restorative nursing weekly with the assist of the restorative aid, this will include the need to continue on restorative nursing/refer back to therapy or to discharge from restorative nursing for a continued functional maintenance/decrease or increase in the resident's functional status or activities of daily living. 4. The Director of Clinical Services/Assistant Director of Clinical Services/Unit Manager will conduct Quality Improvement monitoring of 3 Range of Motion Assessments per week for 2 months to ensure therapy has received a referral and completed a "hands on" screen (resident permitting), then 2 Range of Motion Assessments per week for 2 months to ensure therapy has received a referral and completed a "hands on" screen (resident permitting), then 1 Range of Motion Assessments per week for 2 months to ensure therapy has received a referral and completed a "hands on" screen (resident permitting). The results of the Quality	12-18-14

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
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

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FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 318	Continued From page 15 0). Review of the Quarterly MDS Assessment dated 10/8/14 revealed Resident #39 was cognitively impaired, had not rejected of care and had an upper extremity impairment on one side and a lower extremity impairment on both sides. Interview with the Restorative Aide on 11/19/14 at 2:42 PM revealed that Resident #39 had been receiving Restorative Nursing services for Passive and Active Range of Motion post discharge from Physical Therapy services (July 2013). She stated that Resident #39 was discharged from Restorative Nursing Services at some point because the resident had been provided splints but was non-compliant with them, and would take them off. The Restorative Aide also said that Resident #39 had been compliant with the range of motion services but both range of motion and the splints were discontinued because the resident was discharged from Restorative. The Restorative Aide was uncertain why Resident #39 was not continued on Restorative for Passive Range of Motion, even though she was only non-compliant with the splints. She added that the Restorative Nurse made the decision to discharge the resident but was no longer working at the facility. In addition she revealed that there were no Restorative Care Plans or Progress Notes maintained in the resident's medical record or in the facility. The time spent with the resident providing Restorative Nursing services was the only information that was maintained according to the Restorative Aide. Interview with Administrative Staff # 1 on	F 318	Improvement monitoring will be reported by the Director of Clinical Services/Assistant of Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	12-18-14

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
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 318	Continued From page 16 11/19/14 at 4 PM revealed that she expected nursing staff to report identified decreases in range of motion so they could be referred to Rehabilitation Therapy. The Therapy Department was also responsible for a quarterly screen on Resident that was expected to identify residents with developing contractures. On 11/20/14 at 1 PM observation of PT #1 measuring the degree of contractures in the resident's knees at this time revealed one knee had -55 extention and the other had -75 extension. The resident was cooperative with the procedure.	F 318		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F-329 1. Resident #52 no longer resides in the facility. The Care Plans for residents #51, #16, #58 and #40 were reviewed by the Interdisciplinary Departmental Team on 12/17//2014 and non-pharmacological interventions have been care planned for each of these residents. Behavioral monitoring sheets have been implemented on each of these residents by the Assistant Director of Clinical Services and the Director of Social Services on 12/17/2014 and will be kept in the medication administration book going forward. 2. All residents residing in the facility with behaviors and/or have the potential to be affected.	12-8-14

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

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	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

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F 329	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to try and or to consider non pharmacological intervention before administering an antipsychotic medication (Resident # 40) and failed to monitor the behaviors of residents receiving psychotropic medications for 5 (Residents # 52, 51, 16, 58 and 40) of 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident #40 was originally admitted to the facility on 10/18/11 with multiple diagnoses including psychosis and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 10/23/14 indicated that Resident #40 had memory and decision making problems and had received antianxiety and antidepressant medications. The care plan dated 10/23/14 was reviewed. One of the care plan problems was the use of the psychotropic drugs. The approaches included to monitor behavioral symptoms and side effects. The doctor's orders were reviewed. On 3/27/14, there was an order for zyprexa 2.5 mgs 1 tablet by mouth daily as needed (PRN) for psychosis. On 10/28/14, there was an order to discontinue	F 329	3. On 12/1/2014 the Interdisciplinary Departmental Team was retrained on monitoring behaviors, psychoactive medications, non-pharmacological interventions and Behavioral Monitoring sheets. All nurses have were educated on the Behavioral Monitoring sheets by the Director of Clinical Services on 12/10/2014 and no nurses have worked prior to education on Behaviors/Psychoactive Medications/non-pharmacological interventions/Behavioral Monitoring sheets. On 12/17/2014, the Interdisciplinary Departmental Team met and reviewed all resident care plans for behaviors and/or psychoactive medications. All residents residing in the facility were reviewed and the care plans were updated by the Social Worker, Unit Manager or Minimum Safety Data Sheet Nurse to reflect the need for psychoactive medications and/or non-pharmacological interventions as indicated by the Interdisciplinary Departmental Team. In addition on	12-18-14

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
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

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F 329	Continued From page 18 the zyprexa 2.5 mgs PRN and to start zyprexa 2.5 mgs by mouth every evening. The current physician's orders (November, 2014) revealed that Resident #40 was on on zyprexa (antipsychotic drug) 2.5 mgs in the evening, ativan 0.5 mgs twice a day for anxiety, Zoloft 100 mgs daily for depression and desyrel 50 mgs at bedtime for depression. The Medication Administration Records (MARs) were reviewed. The August, 2014 MAR revealed that Resident #40 had received Zyprexa 2.5 mgs on August 6, 11, 13, 14, 18, 22, 24 and 26. The MAR for September, 2014 did not indicate that Resident #40 had received Zyprexa 2.5 mgs. The MAR for October, 2014 indicated that Resident #40 had received Zyprexa 2.5 mgs on October 14, 21 and 27. The MAR indicated that the reason for giving Zyprexa was yelling and agitation. Review of the records from August to October, 2014 including the nurse's notes did not reveal that non pharmacological interventions were tried or consider prior to administering the Zyprexa. The records also did not indicate that the resident's behavior had been monitored consistently. On 11/19/14 at 10:30 AM, Nurse # 5 was interviewed. She stated that that the facility used to have a behavioral monitoring form to document behaviors of residents on psychotropic drugs but they were not using the form anymore. If the resident was exhibiting a behavior, she documented it in the nurse's notes. Nurse #5 also stated that for residents who were exhibiting	F 329	12/17/2014 Unit Manager and Social Worker advised the Medical Director of psychoactive medications that have not been used in the past 30 days or longer with request for discontinuing these medications. 4. The Social Services Director/Director of Clinical Services will conduct Quality Improvement monitoring to ensure Behavioral Monitoring sheets are completed by exception for each resident having behaviors and/or on psychoactive medications 3 times a week for 2 months, then 1 time a week for 2 months, then 1 time a month for 2 months to ensure that non-pharmacological interventions are being implemented prior to administering medications and that behaviors are being addressed appropriately. The results of the Quality Improvement monitoring will be reported by the Social Services Director/Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	12-18-14

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	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

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F 329	Continued From page 19 a behavior, she followed the doctor's order for the PRN drug. On 11/19/14 at 4:18 PM, administrative staff #1 was interviewed. She stated that she expected the nurses to monitor the behavior and to document it on the behavior flow sheet every shift on all residents receiving psychotropic drugs. Administrative staff #1 revealed that she could not find any behavior flow sheets for Resident #40 for the last three months. 2. Resident #52 was admitted to the facility on 11/9/11 with multiple diagnoses including dementia with behaviors. The annual Minimum Data Set (MDS) assessment dated 9/11/14 indicated that Resident #52 had memory and decision making problems and was on antipsychotic medication. The care plan dated 9/11/14 was reviewed. There was no care plan problem, goal and interventions for behavior management. The physician's orders for November, 2014 revealed that Resident #52 was on Zyrexa 5 milligrams (mgs) daily for dementia with behaviors and depakote 250 mgs twice a day for psychosis. On 11/19/14 at 10:30 AM, Nurse # 5 was	F 329		12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

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F 329	Continued From page 20 interviewed. She stated that that the facility used to have a behavioral monitoring form to document behaviors of residents on psychotropic drugs but they were not using the form anymore. If the resident was exhibiting a behavior, she documented it in the nurse's notes. Review of the records including the nurse's notes from August to November, 2014 was conducted. The notes did not have documentation to indicate that behavior had been monitored consistently. On 11/19/14 at 4:18 PM, administrative staff #1 was interviewed. She stated that she expected the nurses to monitor the behavior and to document it on the behavior flow sheet every shift on all residents receiving psychotropic drugs. Administrative staff #1 revealed that she could not find any behavior flow sheets for Resident #52 for the last three months. 3. Resident #51 was admitted to the facility on 6/25/13 with multiple diagnoses including dementia with behaviors. The quarterly MDS assessment dated 9/10/14 indicated that Resident #51 had memory and decision making problems and was on antipsychotic and antianxiety drugs. The care plan dated 9/10/14 was reviewed. There was no care plan problem, goal and interventions for behavior management. The physician's orders for November, 2014	F 329		12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 21 revealed that Resident #51 was on Seroquel 25 mgs at bedtime for dementia with behaviors, Ativan 1 mgs at bedtime and 0.5 mgs twice a day for anxiety and depakote 500 mgs at bedtime for dementia with behaviors . On 11/19/14 at 10:30 AM, Nurse # 5 was interviewed. She stated that that the facility used to have a behavioral monitoring form to document behaviors of residents on psychotropic drugs but they were not using the form anymore. If the resident was exhibiting a behavior, she documented it in the nurse ' s notes. Review of the records including the nurse's notes from August to November, 2014 was conducted. The notes did not have documentation to indicate that behavior had been monitored consistently. On 11/19/14 at 4:18 PM, administrative staff #1 was interviewed. She stated that she expected the nurses to monitor the behavior and to document it on the behavior flow sheet every shift on all residents receiving psychotropic drugs. Administrative staff #1 revealed that she could not find any behavior flow sheets for Resident #51 for the last three months. 4. Resident #58 was admitted to the facility on 7/5/12 and readmitted 10/3/12 with multiple diagnoses including senile dementia, Alzheimer's, psychotic disorder, depression and anxiety. A review of the Minimum Data Set (MDS) dated 9/16/14 revealed the resident was assessed as being severely impaired for cognitive skills for daily decision making. The resident was assessed as having a daily occurrence of	F 329		12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

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F 329	Continued From page 22 behavioral symptoms not directed towards others. The resident was assessed with the use of antipsychotic medication. A review of the care plans dated 9/16/14 was conducted. The review revealed a care plan for the management of behaviors. The interventions included to monitor the resident for behaviors to assist in determining the cause. A review of the physician's orders revealed an order dated 3/27/14 stating to administer Zyprexa 5 milligrams 1 tablet by mouth twice a day as needed for psychosis. The review also revealed an order dated 8/28/14 stating to administer Seroquel 150 milligrams by mouth every morning for psychotic disorder and to administer Seroquel 200 milligrams by mouth at bedtime for psychotic disorder. A review of the Medication Administration Record (MAR) for the months of October 2014 and November 2014 was conducted. No documentation of the monitoring of behaviors was identified on the MAR for the months of October 2014 and November 2014. An interview was conducted with Administrative Staff #1 on 11/19/14 at 4:17 PM. She stated the behavioral monitoring sheets were not being utilized by the nursing staff. She further stated she expected the nursing staff to use the behavior monitoring sheets to document behaviors. 5. Resident #16 was admitted to the facility 7/9/2004 with last readmission to the facility 8/22/2008. Cumulative diagnoses included	F 329		12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 23 anxiety and organic brain syndrome. A Quarterly Minimum Data Set (MDS) dated 9/19/14 indicated Resident #16 had short term and long term memory impairment and was severely impaired in decision-making. Inattention, disorganized thinking and altered level of consciousness was noted as behavior continuously present. Medications administered during the assessment period included antipsychotic, anxiety and antidepressant medication. A care plan dated 2/10/14 and last reviewed on 9/19/14 was reviewed. There was no care plan problem, goal and interventions for behavior management. The physician orders for November 2014 revealed that Resident #16 was on Lexapro (antidepressant medication) 10 mg. (milligrams) daily for depression, Seroquel (antipsychotic medication) 12.5 mg. at 2:00PM daily and 25 mg. two tablets (50 mg) daily at 8:00PM and Xanax (anxiety medication) 0.25 mg. at bedtime. On 11/19/14 at 10:30 AM, Nurse # 5 was interviewed. She stated that that the facility used to have a behavioral monitoring form to document behaviors of residents on psychotropic drugs but they were not using the form anymore. If the resident was exhibiting a behavior, she documented it in the nurse' s notes. Review of the records including the nurse's notes from August to November, 2014 was conducted. The notes did not have documentation to indicate that behavior had been monitored consistently.	F 329		12-18-14

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
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 24 On 11/19/14 at 4:18 PM, administrative staff #1 was interviewed. She stated that she expected the nurses to monitor the behavior and to document it on the behavior flow sheet every shift on all residents receiving psychotropic drugs. Administrative staff #1 revealed that she could not find any behavior flow sheets for Resident #16 for the last three months.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain the medication error rate at 5% or below by not following the doctor's orders. There were 2 errors of 26 opportunities for error resulting in a 7.69% error rate. Findings included: 1. Resident #64 had a doctor's order dated 7/24/14 to increase prednisone (steroid drug) to 10 milligrams (mgs) daily and to give it with supper. Resident #64 had diagnoses which included chronic respiratory failure and chronic obstructive pulmonary disease (COPD). The meal times were reviewed. Supper trays were scheduled to be served on the hall where Resident #64 resided at 5:50 PM. On 11/18/14 at 5:00 PM, Resident #64 was	F 332	F-332 1. Resident # 64 is now receiving the medication appropriately with supper on 11/19/2014 as prescribed on 7/24/2014. Resident #88 received prescribed medication as ordered on 11/19/2014 within the required time frame as given by the staff nurse assigned to the resident, at that time. 2. All residents residing in the facility have the potential to be affected. 3. All nurses were retrained on 11/18/2014 – 12/17/2014 concerning the six Rights of Medication Pass and the need for accuracy for medication administration when a medication is specifically supposed to be administered with food. Director of Clinical Services/Assistant Director of Clinical Services/Nurse Manager has conducted Medication Pass Observation with each nurse, as of 12-17-14. No nurses have worked/will work prior to receiving the required retraining or Medication Pass Observation by the Director of Clinical	12-18-14

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
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F 332	Continued From page 25 observed during the medication pass. Nurse #6 was observed to prepare and to administer the resident's medications including prednisone 10 mgs tablet. Resident #64 had not had supper yet. On 11/18/14 at 5:05 PM, Nurse #6 was interviewed. She acknowledged that she should have administered the prednisone with supper but she did not. She further indicated that supper trays were served on the hall at 6:00 PM. #2: A review of the physician's orders for Resident # 88 revealed an order dated 11/18/14 which stated " Colace 100 milligrams by mouth twice daily. " On 11/19/14 at 8:22 AM, Nurse #3 was observed during medication administration. Nurse #3 failed to administer Colace 100 milligrams by mouth during medication administration. An interview was conducted with Nurse #3 on 11/19/14 at 8:50 AM. Nurse #3 stated Colace was written on the medication administration record to be given at 9:00 PM and therefore was not given during the morning medication pass.	F 332	Services/Assistant Director of Clinical Services/Nurse Manager. Any notable errors made by a nurse during the medication pass observation will be addressed immediately by the Director of Clinical Services/Assistant Director of Clinical Services/Nurse Manager, and the nurse will be retrained. 4. The Director of Clinical Services/Assistant Director of Clinical Services will complete random medication pass observations with 1 nurse per shift each week for 3 months and then 1 nurse per shift 1 time monthly for 3 months. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Assistant of Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses.	F 356	F – 356 1. On 11/19/2014, the daily staffing sheet was posted in a prominent place accessible to residents and visitors and reflected accuracy of staffing by the Director of Clinical Services.	12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 356	Continued From page 26 - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to accurately post the nurse staffing information. The findings included: An observation was made of the Daily Nursing Staffing Form dated 11/17/14. The staffing form stated there was a total of one registered nurse (RN) and three licensed practical nurses (LPN) working during the first shift. There were three licensed practical nurses observed working on 11/17/14 during the first shift. A registered nurse was not observed working on 11/17/14 on the	F 356	2. The Director of Clinical Services/Nurse Manager will post a legible and accurate Daily Staffing Sheet in a prominent place accessible to the residents and visitors Monday – Friday then the Weekend Nurse Supervisor/Nurse Manager will post a legible and accurate Daily Staffing Sheet in a prominent place accessible to the residents and visitors on Saturday and Sunday. The Daily Staffing Sheet will be updated and maintained throughout the day by the Director of Clinical Services/ Weekend Nurse Supervisor/Nurse Manager. 3. The Facility Interdisciplinary Departmental Team was retrained by the Executive Director on 12/17/2014 on the importance of posting a legible and accurate Daily Staffing Sheet in a prominent place accessible to the residents and visitors. 4. The Human Resource Professional will conduct Quality Improvement monitoring Monday – Friday for the presence of the posting of a legible and accurate Daily Staffing Sheet in a prominent place accessible to the residents and visitors. The Clinical Care	12-18-14

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

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	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

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F 356	Continued From page 27 first shift. An interview was conducted with Nurse #4 on 11/17/14 at 1:20 PM. Nurse #4 stated there was not a RN working during the first shift. An observation was made of the Daily Nursing Staffing Form dated 11/18/14. The staffing form stated there was a total of one RN and four licensed practical nurses working during the first shift. There were four licensed practical nurses observed working on 11/18/14 during the first shift. A registered nurse was not observed working on 11/18/14 during the first shift. An interview was conducted with Nurse #4 on 11/18/14 at 2:54 PM. Nurse #4 stated there was not a RN working during the first shift. An interview was conducted with Administrative Staff #6 on 11/19/14 at 9:13 AM. She stated the Nurse Unit Manager did not administer direct patient care. An interview was conducted with Administrative Staff #1 on 11/19/14 at 9:20 AM. She stated the Nurse Unit Manager was a RN and was documented on the Daily Nursing Staffing Form dated 11/17/14 and 11/18/14 as working on first shift. An interview was conducted with the Nurse Unit Manager on 11/19/14 at 9:27 AM. She stated she performed administrative duties on 11/17/14 and 11/18/14.	F 356	Liaison will conduct Quality Improvement monitoring Saturday and Sunday for the presence of the posting of a legible and accurate Daily Staffing Sheet in a prominent place accessible to the residents and visitors. The results of the Quality Improvement monitoring will be reported by the Human Resources Professional/Executive Director to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 28 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard expired	F 431	F-431 1. On 11/19/14 the Director of Clinical Services removed 3 bottles of expired ear drops/earwax removal aid, 4 patches of nicotine transdermal 21 milligrams patch and 2 bottles of Novolog 70/30 insulin. These medications were returned to the pharmacy or discarded per facility policy by the Director of Clinical Services on 11/19/2014. 2. All residents residing in the facility have the potential to be affected. All medication/treatment carts and medication/storage rooms in the facility were checked for expired medications by the Director of Clinical Services and Nurse Manager on 11/20/2014. All expired medications and/or biologicals were discarded or returned to the pharmacy per facility policy on 11/20/2014. 3. All nurses were retrained on 12/10/2014 regarding checking for expired medications prior to administering the treatment /medication and removing/ returning expired medications this education also included proper labeling of multi dose vials/liquids/ointments (i.e.	12-18-14

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
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F 431	Continued From page 29 medications on 1 (A/E hall medication cart) of 3 medication carts and 1 of 1 medication room. Findings included: 1. On 11/19/14 at 2:45 PM, the medication room was observed. Three bottles of ear drops/earwax removal aid and 4 patches of nicotine transdermal 21 milligrams (mgs) patch were observed in the drawers with the expiration date of 10/2014. On 11/19/14 at 3:05 PM, Nurse # 5 was interviewed. She stated that the central supply staff was responsible for checking the expiration dates of the medications in the medication room. On 11/19/14 at 4:00 PM, the central supply staff was interviewed. She stated that she checked the medication room for expired medications every Monday and Friday. She indicated that the last time she checked the medication room was on Monday and there were no expired medications found. #2: A review of the Insulin Storage Recommendations Policy dated 3/31/14 revealed Novolog 70/30 expired 28 days after the opening date when stored at room temperature. An observation of the A and E Hall medication cart on 11/19/14 at 2:45 PM revealed one opened vial of Novolog 70/30 insulin labeled with an opened date of 10/14/14. The observation also revealed one opened vial of Novolog 70/30 insulin labeled with an opened date of 10/19/14.	F 431	insulin, Tuberculin, Pneumovax, Prostat, eye drops, nasal spray) per facility policy. Nurses were taught to use the guide for recommended medication storage located on their MAR to determine if a particular medication expires prior to the expiration date located on the packaging. 4. The Director of Clinical Services/Assistant Director of Clinical Services will conduct Quality Improvement monitoring of each cart 2 times weekly for 2 months, then 1 time weekly for 2 months, then 1 time a month for 2 months. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Assistant of Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 30 An interview was conducted with Nurse #3 on 11/19/14 at 2:46 PM. She stated she did not know how long a vial of Novolog insulin was to be used after the date the vial was opened. Nurse #3 also stated there was not a staff member responsible for routinely checking the medication carts for expired medications. She stated if an expired vial of insulin was found on a medication cart, the nurse was expected to remove the vial from the cart. An interview was conducted with Administrative Staff #1 on 11/19/14 at 3:34 PM. Administrative Staff # 1 stated the nurses were expected to check the expiration date of medications prior to administration and to pull expired medications from the medication cart and send them back to the pharmacy.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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	F 441	F – 441 1. On 10/29/2014 Resident #54 received a PPD skin test, however the resident has an allergy to Aplisol. The Medical Director and Responsible Party were notified staff nurse. A chest x-ray was obtained on 11/3/2014 and the Medical Doctor and Responsible Party were notified of the results staff nurse. On 11/5/2014, the physician was in the facility to see Resident #54 and noted that resident has had no adverse effects from the PPD skin test given on 10/29/2014. The Physician documented in his	12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 31 (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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a policy and procedure to address residents with positive tuberculosis testing for one of one sampled resident (Resident #54). The findings included: North Carolina Public Health State guidelines titled Control Measures-Tuberculosis effective 8/1/2012 stated, in part, "(e) Persons with a positive tuberculin skin test or IGRA (interferon gamma release assay) shall be evaluated by an interview to screen for symptoms and a chest x-ray if they do not have a documented chest x-ray that was performed on the date of the positive test or later. (f) Treatment and follow-up for tuberculosis infection or disease shall be in	F 441	11/5/2014 progress note that resident #54 stated that she has had some reaction in the past but no history of Tuberculosis. New orders were received from the physician on 11/4/2014 to obtain sputum for Acid Fast Bacilli in the am times 3 days to start on 11/5/2014; however the resident was asymptomatic and was unable to give sputum sample. On 11/6/2014 a sputum sample was obtained and sent to the laboratory with results of no Acid Fast Bacilli seen. On 11/7/2014, a sputum sample was obtained and sent to the laboratory with results of no Acid Fast Bacilli seen. Resident was unable to produce sputum culture from 11/8/2014-11/9/2014 due to non-productive cough, however resident was able to produce sputum culture on 11/10/2014 which was sent to the laboratory with results of no acid fast bacilli noted. On 11/18/2014 resident #54 was sent to the hospital for a chest x-ray which showed no evidence of Tuberculosis. 2. All residents residing in the facility have the potential to be affected. An audit of all resident charts was completed by the Director of Clinical Services and	12-18-14

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F 441	Continued From page 32 accordance with the recommendations and guidelines from the Centers for Disease Control and Prevention." There was no facility policy/ procedure that addressed residents with positive tuberculin testing. Resident #54 was admitted to the facility 12/6/11. Cumulative diagnoses included: hypertension, seizure disorder and chronic cough. The immunization record for Resident #54 was reviewed and revealed a tuberculin skin test (test done to determine if a resident has/ has been exposed to tuberculosis) was administered on 10/29/14 with result 30 mm. induration. An induration of greater than or equal to 15 mm. is classified as positive. Resident #54 had a previous tuberculin skin test administered on 12/6/11 with result 30 mm. (millimeters) induration (an abnormal hard spot) and it was noted on her physician orders for January 2012 that she had an allergy to Aplisol (tuberculin test). A review of physician orders for November 2014 indicated Resident #54 had an allergy to Aplisol. A chest x-ray result dated 11/3/14 stated, in part, "Conclusion: right lower lobe and left upper lobe atelectasis (collapsed or airless state of the lung) or pneumonia. Tuberculosis cannot be excluded." A physician's order dated 11/4/14 stated to obtain a sputum AFB (acid fast bacillus) x 3 days. This is a test performed to determine if a person has active tuberculosis.	F 441	Nurse Manager on 11/17/2014 to ensure that PPD has been administered to residents accordingly and that the residents' allergies are listed in the medical records. 3. Retraining was provided to all licensed nurses on checking allergies before administering PPD to residents on 11/19/2014 by the Director of Clinical Services. This retraining also included proper documentation of PPD on residents' charts. The Director of Clinical Services also educated on the facility's Tuberculosis policy which included the Center for Disease Control guidelines on for administration of the tuberculin skin test and the steps to follow in the instance of a potential positive screen (i.e. notify the local health care provider and local health department and follow recommendations/orders given to the facility by the local health care provider and local health department). 4. The Director of Clinical Services/Assistant Director of Clinical Services will conduct Quality Improvement monitoring of 5 residents' charts 1 time weekly for 2 months to ensure accuracy of properly	12-18-14

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F 441	Continued From page 33 A review of the medical record for Resident #54 revealed there were no sputum culture results on the chart. On 11/17/14 at 4:30PM, Administrative staff #1 stated she knew that Resident #54 had a positive tuberculin skin test and that the facility was getting a chest x-ray. She said she was not aware of the chest x-ray results dated 11/3/14. Administrative staff #1 stated they had not received the results of the AFB sputum culture and she would call the laboratory to see if results had been completed. She stated she expected nursing staff to follow physician orders if a resident had a positive tuberculin skin test. Administrative staff #1 stated she did not know if the facility had a policy and procedure regarding positive tuberculin skin testing results and what to do if that occurred. On 11/17/14 at 6:25PM, Resident #54's physician was interviewed and stated he had not ordered a tuberculin skin test to be administered on 10/29/14. He stated he would never order a second tuberculin skin test to be administered if a previous test had been determined to be positive. The physician stated he was aware of the x-ray results done on 11/3/14 and felt it was not a good quality x-ray and stated the x-ray should have been repeated and he would order one to be done on 11/18/14. On 11/18/14 at 2:47PM, Nurse #1 stated she administered the tuberculin skin test to Resident #54 on 10/29/14. She stated she was not aware that Resident #54 had a previous positive reaction to the tuberculin skin test in 2011. Nurse	F 441	documented allergies and vaccinations & also to ensure that vaccinations have given and documented appropriately, then 5 resident charts 2 times a month for 2 months, then 5 resident charts monthly for 2 months. The results of the Quality Improvement monitoring will be reported by the Director of Clinical Services/Assistant of Director of Clinical Services to the Quality Assurance Performance Improvement Committee monthly times 6 months for continued substantial compliance and/or revision.	12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 34 #1 stated she was given a list of residents who needed annual tuberculin skin tests and administered the tuberculin skin tests from that list and did not review the charts prior to administration to determine if that resident had a prior positive test. On 11/18/14 at 3:37 PM, Administrative staff #2 stated they had reviewed all the facility's policies regarding tuberculin skin testing and they could not find a policy regarding positive tuberculin skin testing and she felt they would refer to the CDC (Center for Disease Control) guidelines. On 11/18/14 at 5:00PM, the facility provided AFB sputum results dated 11/6/14, 11/7/14 and 11/10/14-all were negative for AFB. The results of a chest x-ray done on 11/18/14 indicated evidence of pulmonary edema (fluid accumulation in the lungs) and bibasilar lung consolidation (fluid in the bottom of both lungs).	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520	F – 520 1. An Impromptu Quality Assurance Performance Committee meeting was held on 11/19/2014 conducted by the Executive Director to include the Interdisciplinary Team and overseen by the Regional Director of Clinical Services to discuss the North Carolina State Survey Team's findings/suggestions and the Facility 2567 and Plan of Correction. 2. All residents residing in the facility have the potential to be affected.	12-18-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	C 11/20/2014

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F 520	Continued From page 35 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility's Quality Assessment and Assurance Committee failed to ensure that action plans developed for the 8/22/13 and 7/22/12 recertification surveys were implemented, monitored and revised as needed to ensure compliance was achieved and sustained. The facility had a pattern of repeat deficiency in development of care plans, and infection control (2013) and posted nurse staffing information and services to maintain wellbeing (2013 and 2012). Findings included: This tag is cross referred to: 1. F279 - Development of Care Plans: Based on record review and staff interview, the facility failed to address the behavior in the care plan for 3 of 5 sampled residents receiving psychotropic medications (Resident #52, #51 and #16). During a recertification survey 8/22/13 the facility was cited for F279 for failing to care plan for antidepressant medications and swallowing	F 520	3. During the Impromptu Quality Assurance Performance Committee meeting held on 11/19/2014 additional plans for correction were discussed including retraining, corrective action and follow up monitoring for previous deficiencies (2012 and 2013) F-279, F-309, F-356, and F-441 as well as additional deficiencies for 2014 recertification survey, F-164, F-278, F-318, F-329, F-332, F-431 and F-520. F – 279 Resident #52 longer resides in the facility. Residents #51 and #16 Care Plans and Minimum Data Sets have been reviewed for accuracy of interventions and medications for behaviors. Retraining has been completed with the Interdisciplinary Team and the nursing staff for accuracy of Care Plans and Minimum Data Sheets additional audits will be conducted and reported to the Quality Assurance Performance Committee monthly. F-309 the Fluid Restriction for resident #50 was discontinued on 11/19/2014 by the physician. Retraining has been completed by the Director of Clinical Services completed with the Interdisciplinary Team and the nursing staff for regarding fluid restrictions and appropriate documentation of Intake and Output when ordered. Additional audits will be conducted and reported to the Quality Assurance Performance Committee monthly. F – 356 on 11/19/2014 the daily staffing sheet was posted in a	12-18-14

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F 520	Continued From page 36 problems. 2. F309 - Services to Maintain Wellbeing: Based on resident interviews, staff interviews, record reviews and observations, the facility failed to monitor fluid intake for one of one resident (resident # 50) on dialysis with fluid restriction. During a recertification survey 8/22/13 the facility was cited for F309 for failing to ensure a diuretic medication was administered as ordered. During a recertification survey 7/26/12 the facility was cited for F309 for failing to put pain interventions in place and for not providing skin care services as ordered.	F 520	prominent place accessible to residents and visitors and reflected accuracy of staffing by the Director of Clinical Services. Moving forward an accurate daily staffing sheet will be posted daily in a prominent location by the Director of Clinical Services or Designee Monday through Friday and by the weekend nurse manager or designee on Saturday and Sunday. The daily staffing sheet will be additionally checked Monday through Friday by the human resource professional and the Clinical liaison on Saturday and Sunday for accuracy and prominent placement. F – 441 Resident #54 did not have an adverse effect from receiving the Tuberculin skin test and the resident chart has been updated with an allergy to Aplisol. All resident charts were reviewed and updated for allergies and documentation of allergies as well as PPD skin test and the proper documentation. The Interdisciplinary Team and the licensed nursing staff have been retrained on proper documentation of allergies and administration of PPD skin test by the Director of Clinical Services on 12/1/2014. 4. On 11/19/2014 retraining of the Interdisciplinary Team on the Quality Assurance Committee meeting was completed by the Executive Director and the Regional Director of Clinical Services. Additional training was completed by the Regional Director of Clinical Services on Quality Assurance	12-18-14
	3. F356: Posted Nurse Staffing Information: Based on observations and staff interviews, the facility failed to accurately post the nurse staffing information. The F356 citation for the 11/20/14 survey was for inaccuracy in the accounting of Registered Nursing staff. During a recertification survey 8/22/13 the facility was cited for inaccurate census on the posted nurse staffing information. During a recertification survey 7/26/12 the facility was cited for inaccurate census on the posted nurse staffing information. 4. F441 - Infection Control: Based on record review and staff interviews, the facility failed to develop a policy and procedure to address residents with positive tuberculosis testing for			

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F 520	Continued From page 37 one of one residents (Resident #54). During a recertification survey 8/22/13 the facility was cited for F441 for failing to post isolation signs on room doors for residents on isolation precautions. Administrative Staff #6 was interviewed 11/20/14 at 10:13 and stated that she was aware of the pattern of repeat deficiencies. She said that the facility had a quality assurance committee that met quarterly at a minimum. Administrative Staff #6 indicated that she believed the cause of the repeat deficiencies was significant turnover in the nursing department and the challenges of effectively communicating, to new staff, the improvement practices that have been put in place.	F 520	monitoring and improvement with the Interdisciplinary Team on 12/5/2014.The Quality Assurance Committee will have a scheduled meeting monthly to report and correct identified quality deficiencies. This meeting will be conducted by the Executive Director and will include the Interdisciplinary Team and will be overseen by a member of the Regional Corporate team monthly times 6 months for continued substantial compliance and/or revision.	12-18-14