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 _____ AUG 0 2 2011	06/23/2011

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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to provide a prompt response to a verbal complaint of missing clothing by 1 of 2 sample residents. Resident #87. Findings included: Resident #87 was admitted to the facility on 5/31/11 with diagnoses which included: congestive heart failure; hypertension; chronic fatigue syndrome; hypothyroidism; and, osteoarthritis of the left leg. Review of the admission Minimum Data Set dated 6/7/11 indicated Resident #87 was cognitively intact, but required the extensive assistance of one person with transfers and dressing. During an interview on 6/21/11 at 10:37am, Resident #87 revealed he was missing a pair of pajamas. The resident stated that he reported the missing clothing to the laundry staff when she delivered his clean laundry. The resident indicated no one has followed up with him concerning the missing pajamas.	F 166	**This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law.** #1 Res #87 pajamas were found and returned to the resident #2 Current residents are at risk for alleged deficient practice. Grievances have been reviewed for previous 3 months to identify any outstanding grievances regarding missing clothing with corrective action taken at time of discovery as indicated. #3 The process for completing a grievance / concern for lost clothing will be reviewed with residents in the next Resident Council meeting and with individual residents as needed. Re-education of the laundry personnel and facility staff for the process of reporting lost clothing using the grievance process will be completed by 7/ 21/11.Grievances / concerns are reviewed in morning meeting with Department Heads for assignment for resolution. All new employees will be educated on the grievance process during Orientation. #4 Grievances (including lost clothing) and resolutions will be presented to the Quality Improvement/Risk Management committee monthly x 12 by the Social Services Director or designee.	7/21/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/29/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	06/23/2011

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 166	Continued From page 1 Review of the Grievance/Concern Log did not reveal any documentation of any missing clothing reported by Resident #87 or his family. During an interview on 6/23/11 at 2:00pm, the facility's Social Worker (SW) indicated she had not received any reports of missing clothing or other items from Resident #87 or his family. During an interview on 6/23/11 at 2:25pm, the facility's Housekeeping/Laundry Director indicated he had not received any complaints of missing clothing belonging to Resident #87. The Director stated that if/when a resident reported missing clothing (which was included on his/her clothing inventory), the facility's Laundry Department would complete a "Missing Items" Report, and the laundry staff would search through the "No Name Rack" and look through other residents' closets. If the item(s) could not be located, he would inform the SW and the facility would replace or reimburse the resident for the missing item(s) of clothing. During an interview on 6/23/11 at 2:34pm, Housekeeping/Laundry staff #1 (H/L#1) stated that approximately 1-2 weeks ago when Resident #87 asked if she (H/L#1) had seen any of his pajamas, she told him she would "look out for them" when she worked in the laundry room later that day. H/L#1 stated revealed the missing clothing was not found that day, but she did not complete the Missing Item form or report the missing items to her Supervisor. On 6/23/11 at 2:51pm, during a second interview, Resident #87 reiterated that he was missing a	F 166		

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 _____	06/23/2011

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 166	Continued From page 2 pair of blue pajamas. During this visit the SW and H/L#1 requested and was granted permission from the resident to search his closet. As a result, the SW and H/L#1 were able to locate the bottoms of the blue pajamas, but not the top. The SW informed the resident that the facility's Laundry staff would immediately search for the pajama bottoms; and she would follow-up with him about the progress.	F 166		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to honor the food preferences of 2 of 4 sampled residents. Residents #20 and #67. Findings included: 1. Resident #67 was admitted to the facility on 3/5/11 with diagnoses which included: a fractured humerus; diabetes mellitus II; vitamin B12 deficiency anemia; hypertension; hyperlipidemia; and urinary tract infection. Review of the "Resident Food Preference" record	F 242	#1 Resident #20 and Resident #67 have had food preferences updated and are receiving food as indicated by those preferences #2 Review of current resident's preferences has been completed with corrective action taken at time of discovery as indicated. #3 Education of the dietary and nursing staff will be completed for monitoring tray cards likes and dislikes and honoring resident food choices by 7/21/11. A Quality Improvement tool will be completed reviewing ten trays daily x 14 days, then weekly x 4 weeks, then monthly x 11 to ensure resident tray card preferences are being honored and choices met. The Dietary Manager/designee will complete a Quality Improvement Tool weekly x 4 after interviewing 10 residents regarding their food preferences being met. New dietary and nursing personnel will be oriented to these procedures during orientation. #4 Dietary Manager will present results of the QI/RM tools to the QI / RM committee monthly x12 to identify trends and need for further education and/or monitoring,	7/21/2011

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 _____	06/23/2011

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 242	Continued From page 3 dated 3/7/11 indicated Resident #67 received a therapeutic diet of no added salt and no concentrated sweets. On section of this record revealed the following food items the resident did not eat: peas; cauliflower; chicken; and turkey. Review of the most recent quarterly Minimum Data Set (MDS) dated 5/27/11 revealed Resident #67 was cognitively intact, requiring supervision with set-up help only with eating. The MDS indicated the resident had no swallowing problems, no oral/dental problems, and no weight issues; but, the resident did receive a therapeutic diet. The review of the facility's Nutrition Progress Note dated 6/17/11 documented Resident #67 ate her meals in her room with meal tray set up by staff. Included in the note: " refer to Food Preferences Tool ". Review of the facility's menu and during a dining observation, oven fried chicken was served at lunch on 6/21/11. During an interview on 6/21/11 at 4:17pm, Resident #67 revealed she was served chicken at lunch that day which she did not eat. The resident stated that she does not like chicken and it was included on her food preference sheet and meal card as a dislike. The resident indicated that she had told staff in the past, but she continued to recieve chicken whenever it was served. Review of Resident #67's Meal/Diet Card, which was included on the resident's meal tray, documented as the resident's dislikes: cauliflower, chicken, green peas, mix vegetable,	F 242		

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 _____	06/23/2011

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 242	Continued From page 4 and turkey. The resident's dislikes were documented on Resident #67's meal/diet cards for lunch and supper. During an interview on 6/22/11 at 12:17pm, the Dietary Manager (DM) revealed food preference sheets were completed for each resident on admission to the facility and updated during residents' room visits by Dietary. The room visits of each resident were conducted twice each month for food complaints, concerns, or changes in food preferences. The DM indicated that if in compliance with the resident's diet, these preferences would be updated and transferred to the resident's meal/diet card via the facility's computer. Review of the facility's menu and during a dining observation, an open-faced turkey sandwich was served at lunch on 6/23/11. During an interview on 6/23/11 at 1:52pm, Resident #67 revealed she received a turkey sandwich that day at lunch. She stated that she did not eat the sandwich because she disliked turkey. The resident revealed that she had informed the facility's Nutritionist about receiving her food dislikes on her meal trays, she stated that she also showed the Nutritionist her meal card which documented that she was not to receive chicken and turkey with meals.	F 242		

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 _____	06/23/2011

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 242	Continued From page 5	F 242		

2. Resident # 20 was admitted to the facility on 9/23/08 and re-admitted on 5/6/08. Diagnoses included Hypoxemia, Pneumonia, Hypertension and Gastrroesophagel Reflux Disease.

A review of the facility form titled 'Resident food Preference' dated 9/24/08 indicated residents dislikes as pears and pineapple.

A review of the quarterly Minimum Data Set dated 3/15/11 revealed the resident was cognitively intact and had no memory problems. The resident required set-up with supervision and cueing for eating and was able to feed self.

On 6/21/11 at 10:08am the resident stated even though her dislikes are listed on her meal card she always was served crab cakes, pineapple and pears when it was on the menu. further discussion revealed she tells them but it still comes on her tray.

On 6/21/11 at 12noon the resident was observed eating her lunch. There were pears on her lunch tray. The diet card on the lunch tray listed her dislikes as "crab cakes - pears - pineapple." The resident stated ":see they served these (pointing to the pears) anyway they just do not pay attention."

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 _____	06/23/2011

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 242	Continued From page 6 During an interview on 6/22/11 at 12:17pm, the Dietary Manager (DM) revealed food preference sheets were completed for each resident on admission to the facility and updated during residents' room visits by Dietary. The room visits of each resident were conducted twice each month for food complaints, concerns, or changes in food preferences. The DM indicated that if in compliance with the resident's diet, these preferences would be updated and transferred to the resident's meal/diet card via the facility's computer. On 6/22/11 at 12:45pm an interview with NA # 1 who served Resident #20 her lunch revealed that she was supposed to look at the diet card and make sure the meal served was the same as what the diet card stated for type of diet, texture and that dislikes are not served. Further discussion revealed she was to call the kitchen and get the right meal sent up for the resident. When the NA was asked if she checked the tray against the diet card for Resident #20 she responded, "I did not pay any attention to it."	F 242		
F 329 SS=D	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	F 329	#1 Resident #5 blood pressure is being monitored prior to administering Nitroglycerin patch. Daily weights have been discontinued per physician order. #2 A review of residents receiving Nitroglycerin patches and Lasix has been completed for appropriate monitoring of blood pressure and weights with corrective action taken as indicated	7/21/2011

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 _____	06/23/2011

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 329	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to monitor 1. the weight for a resident receiving Lasix and 2. the blood pressure for a residents a Nitroglycerine patch as ordered by the physician for 1 of 10 sampled residents for unnecessary drugs. (Resident #5) Findings include: 1. Resident # 5 was admitted to the facility on 7/9/10. Diagnoses included Atrial Fibrillation, Pulmonary Hypertension, Hypertension, Osteoporosis, Osteoarthritis, and Gastroesophagel Reflux Disease. A review of the physician orders revealed an order dated 12/30/10 that read "decrease Furosemide(Lasix- a diuretic used to treat hypertension, acute pulmonary edema and	F 329	#3 Nursing staff re-educated on completing MAR accurately while doing changeover of MAR's monthly as well as reading MAR order entirely while administering medications. Nurse completing MAR review prior to monthly changeover will check MAR with physician orders. Second nurse will review MAR prior to change over to assure physician orders are completed accurately. Night nurses, on first of each month, will review MAR for third check to assure physician orders are documented on MAR. Unit Manager will complete a Quality Improvement tool of 10 MAR's weekly x 4, five days per week, then weekly x 4, then monthly x3 to verify physician orders are being administered correctly. New nursing personnel will be oriented to this procedure during orientation #4 DON / Unit Manager will present results of QI/RM tool to QI/RM Committee monthly x 5 to identify trends and need for further education and/or monitoring.	

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 _____	06/23/2011

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 329	Continued From page 8 edema) to 10mg daily." A review of the physician orders revealed an order with an original order date of 1/01/11 that read; "if weight gain of 3 lbs. (pounds) in 24 hours or 5 lbs. in 48 hours give extra dose of Lasix (20mg times 3 days) and notify MD (medical doctor)." A review of the MAR (Medication Administration Record) for the months of March, April, May and June 2011 revealed the weight was documented daily for the months of March, April, and May. The month of June from the 1st through the 22nd there was no weight documented. A review of the MAR for May 2011 revealed that on 5/11/11 Resident #5's weight was 100 and on 5/11/11 the weight was 108 an increase of 8 lbs. There was no documentation available in the residents medical record that she received the extra dose of Lasix for 3 days as ordered by the physician. There also was no documentation that the physician was notified of the weight gain available in the medical record. A review of the weight sheet in the medical record for Resident #5 revealed monthly weights only were recorded. On 6/22/11 at 4:35pm an interview with Nurse # 1 (works routinely on 3pm - 11pm shift on hall where resident resides) revealed that she did not see the order listed on the MAR. Reviewing the MAR Nurse #1 confirmed there was no weight documented for the month of June. The nurse indicated that she was not the nurse who would take the weight and that the NA's (nursing	F 329		

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 _____	06/23/2011

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 329	Continued From page 9 assistants) took the weights usually during the day shift. On 6/23/11 at 9:05am Nurse #3 who works 7:00am to 3:00pm revealed that she works 3 days a week and was responsible for administering medications to Resident #5. The nurse stated she worked on 6/22/11 also. When asked how the weights for Resident #5 were monitored she responded "weights are taken daily and night shift (11:00pm to 7:00am) was suppose to record it on MAR's. The NA goes by the weight list to Know who gets weight done when." Further discussion revealed that the resident has not gained any weight. When she was asked how would she knew that the response was "it should be documented in the weight book." When the nurse reviewed the MAR and the order for the extra dose of Lasix was shown to her; she responded "oh night shift records that." Nurse #3 indicated that she had not paid attention to that as night shift recorded the weights and she did not read the order in its entirety until today. On 6/23/11 at 10:50am the DON (Director of Nursing) stated she had talked with night shift regarding Resident #5's weight after the MAR was discussed with nurse #1 on 6/22/11. The DON explained that the nurse on night shift had the NA's take the weight every morning and then documented the weight on the MAR. Further discussion revealed that the night shift nurse stated "she just made a mistake and did not know why she stopped taking the weights." 2 .Resident # 5 was admitted to the facility on 7/9/10. Diagnoses included Atrial Fibrillation,	F 329		

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 _____	06/23/2011

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 329	Continued From page 10 Pulmonary Hypertension, Hypertension, Osteoporosis, Osteoarthritis, and Gastrroesophagel Reflux Disease. A review of the physician orders revealed an order with an original date of 7/9/10 that read; Nitroglycerin 0.2mg/hr(milligram released per hour) patch. Apply patch topically every morning (remove at bedtime) Hold for SBP (systolic blood pressure) < (less than) 100. A review of the MAR (Medication Administration Record) for the months of April, May and June 2011 revealed no documentation that a blood pressure had been taken prior to administration of the Nitroglycerin patch. A review of the vital sign sheet located in the medical record for Resident #5 revealed blood pressures were recorded weekly. A review of the nurses notes from April through June 22, 2011 revealed there was no blood pressure documented as being taken prior to the administration of the Nitroglycerine patch. On 6/22/11 at 4:57pm an interview with the DON revealed the nurses would document the blood pressure on the MAR. The DON stated her expectation would be the nurse would take the blood pressure before administering the nitroglycerine patch and record the blood pressure on the MAR. The DON and the unit manager reviewed Resident #5's MAR's and confirmed the blood pressure was not documented as being taken before the patch was applied. They reviewed the medical record for the resident and were not able to find any daily blood pressure that had been taken.	F 329		

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 _____	06/23/2011

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 329	Continued From page 11 On 6/23/11 at 9:05am Nurse #3 who works 7:00am to 3:00pm revealed that she works 3 days a week and was responsible for administering medications to Resident #5. The nurse stated she worked on 6/22/11 also and did not take the blood pressure yesterday. Further discussion revealed "to be honest with you this is first time I saw it needed to be done."	F 329		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to provide a diet with the texture as ordered by the physician for 1 of residents. (Resident #20) Findings include: Resident # 20 was admitted to the facility on 9/23/08 and re-admitted on 5/6/08. Diagnoses included Hypoxemia, Pneumonia, Hypertension, Diabetes Type II and Gastroesophagel Reflux Disease. A review of the quarterly Minimum Data Set dated 3/15/11 revealed the resident was cognitively intact and had no memory problems. The resident required set-up with supervision and cueing for eating and was able to feed self. A review of the re-capped physician orders dated	F 367	#1 Resident #20 is currently receiving diet as ordered by physician. #2 A review of current resident orders to tray cards to assure diets and texture of foods are recorded as ordered by physician, completed by 7/21/2011. #3 Re-educate dietary staff to provide consistency and prescribed diet for each resident per physician order. Licensed nurses re-educated on following physician orders to be completed by 7/21/2011.The Dietary Manager/designee will complete a Quality Improvement tool after reviewing ten trays daily x 14 days, then weekly x 4 weeks, then monthly x 11 to ensure correct diet and diet consistency is provided to the resident. New employees will be oriented to this process during orientation. #4 Dietary Manager / designee will present results of the QI / RM tools to the QI / RM committee monthly x one year for accuracy to identify trends and need for further education and/or monitoring.	7/21/2011

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 _____	06/23/2011

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 367	Continued From page 12 June 1 through 6/30/11 revealed the Diet was listed as NAS (no added sugar). A further review of the physicians re-cap orders for the months of January, February, March, April, and May 2011 revealed the residents diet was NAS. On 06/21/2011 at 10:08am Resident #20 stated her food comes copped up and it is tasteless. "I have no idea why my food comes that way." On 6/21/11 at 12noon Resident #20 was observed eating her lunch. The meat was served chopped as indicated on the dietary card. The dietary card on the tray indicated a NAS (no added sugars) diet with chopped meat. resident eating lunch chopped meat on plate plate guard in place regular utensils On 6/22/11 at 12:30pm Resident #20 was observed eating lunch. The lunch tray she received had a regular pork chop on it. The resident stated "I am enjoying this picking up the pork chop and chewing on it." On 6/22/11 at 12:45pm an interview with NA #2 who served Resident #20 her lunch tray revealed "if what is on tray does not match the tray card we are suppose to go back and tell the kitchen to get it right. When NA#2 reviewed the diet card she stated ""I never paid attention to that." (referring to the way the meat was served.) On 6/23/11 at 10:45am an interview with the Dietary Manager (DM) revealed that she had changed Resident #20's meal to copped meats because she requested it. She had trouble cutting up her food. The DM was asked when this change took place, she reviewed the residents	F 367		

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 _____	06/23/2011

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 367	Continued From page 13 medical record and could not find any information indicating when she changed the diet. The DM went to her office and returned at 11:00am and stated "I can't find a change order for chopped meat I guess I did not do one it just slipped by me."	F 367		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interview, the facility failed to provide assistance for a resident with tremors for 1 of 1 sampled resident. (Resident #20) Findings include: Resident # 20 was admitted to the facility on 9/23/08 and re-admitted on 5/6/08. Diagnoses included Hypoxemia, Pneumonia, Hypertension and Gastroesophagel Reflux Disease. A review of the facility form titled 'Rehabilitation Screening Form Nursing Referral to Rehabilitation' dated 6/23/10 revealed a quarterly review that stated "the resident had a modified independent self feeding after set up with built up utensils and plate guard." A review of the quarterly Minimum Data Set dated 3/15/11 revealed the resident was cognitively	F 369	#1 Resident #20 has adaptive equipment available as resident accepts use. #2 A review of current residents having dietary adaptive devices has been completed to assure all residents have equipment needed to facilitate meal assistance. #3 Re-educate dietary and nursing staff on verifying adaptive equipment is available per physician order as documented on tray ticket. To be completed by 7/21/2011. The Dietary Manager/designee will complete a Quality Improvement Tool five times per weeks x 14 days then weekly x 4, then monthly x 3 to validate adaptive equipment is available for use by residents requiring them. #4 Dietary Manager/designee will report results of audit for assessing adaptive equipment availability on tray to Quality Improvement/Risk Management Committee monthly x4 to identify trends and need for further education and/or monitoring.	7/21/2011

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 _____	06/23/2011

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 369	Continued From page 14 intact and had no memory problems. The resident required set-up with supervision and cueing for eating and was able to feed self. A review of the current dietary care plan with a review date of 3/21/11 revealed that listed under approaches was "provide plate guard and build up spoon utensil for her." On 6/21/11 at 12noon the resident was observed eating lunch using regular utensils with a plate guard in place. On 6/22/11 at 12:30pm Resident #20 was observed eating lunch. The resident had regular utensils and a plate guard was attached to her plate. The dietary card on the lunch tray indicated she was to have blue handle fork and spoon. On 6/22/11 at 12:45pm an interview with NA#1 who served the lunch trays on D hall (hall where resident #20 resides) stated "If what is on tray does not match the tray card we are suppose to go back and tell the kitchen to get it right." The NA looked at the dietary card from Resident #20's tray and stated "I did not know she needed built up utensils." On 6/22/11 at 12:50pm an interview with NA#3 who provides care to the resident routinely revealed that if tray did not have what was on card "we are to take back to kitchen." The stated while looking at the dietary card from Resident #20's tray "I was unaware of the built up utensils, I knew about the plate guard." On 6/22/11 at 12:52pm NA#2 who was helping to serve the lunch trays after reviewing the dietary	F 369		

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 _____	06/23/2011

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 369	Continued From page 15 card for Resident #20 stated "I never paid attention to that I knew she had a plate guard." On 6/23/11 at 10:50am an interview with the Dietary Manager revealed that she had to take off the built up utensils from the diet card because she did not have an order for it. "I changed the built up utensils because I could not find an order for it, the dietary card yesterday (6/22/11) just slipped by me." Further discussion revealed that therapy told her to use built up utensils however she looked through all the therapy notes and could not find anything. On 6/23/11 at 2:50pm an interview with the Director of the Therapy department revealed that Resident #20 had not been evaluated since the original recommendation for the plate guard and built up utensils was first completed (April 2010). Further discussion revealed that once the recommendation was given to the dietary departed and the nursing staff was trained on how to use any special equipment the therapy department did not re-evaluate the need unless the nursing department contacted therapy that there was a problem or concern. She indicated that no one from the nursing department notified her of any concerns regarding the use of the built up utensils that she could remember. The director of therapy also indicated that the responsibility to obtain a physician order for any of the recommendations made was the nursing department. On 6/23/11 at 4:00pm an interview with Resident #20 revealed that she had tremors and tried to use the built up utensils but then they stopped coming on her tray. Further discussion revealed	F 369		

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 _____	06/23/2011

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 369	Continued From page 16 that the tremors had increased lately and it was difficult to grab the utensils with her fingers they would fall out of her hand.	F 369		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and pharmacy interview the facility's licensed pharmacist failed to identify the lack of monitoring for; 1. the weight for a resident receiving Lasix and 2. the blood pressure for a residents a Nitroglycerine patch as ordered by the physician for 1 of 10 sampled residents for unnecessary drugs. (Resident #5) Findings include: Resident # 5 was admitted to the facility on 7/9/10. Diagnoses included Atrial Fibrillation, Pulmonary Hypertension, Hypertension, Osteoporosis, Osteoarthritis, and Gastroesophagel Reflux Disease. A review of the physician orders revealed an	F 428	#1 Resident #5 is having blood pressure taken prior to administration of Nitroglycerin patch as ordered by physician on 6/23/2011. Daily weights were discontinued by physician on 6/23/2011. #2 Review of current resident charts receiving Lasix and/or Nitroglycerin patches has been completed to verify physician orders are correctly recorded on MAR's / TAR's. #3 Re-educate nurses completing MAR's / TAR's of need for accuracy in documenting physician orders correctly. To be completed by 7/21/2011. Nurse completing MAR review prior to monthly changeover will check MAR with physician orders. Second nurse will review MAR prior to change over to assure physician orders are completed accurately. Night nurses, on first of each month, will review MAR for third check to assure physician orders are documented correctly on MAR's / TAR's and sign as completely reviewed. Pharmacy consultant will review previous month orders to monitor nursing compliance with physician orders. DON and Administrator will review pharmacy consultant report monthly for identified omissions. Pharmacy consultant has been re-educated for providing information in the pharmacy report regarding documenting errors / concerns for missing MAR information on 7/18/2011 by the Director of Nursing. Unit Manager will complete a Quality Improvement tool of 10 MAR's Weekly x 4, five days per week, then weekly x 4, then monthly x3 to verify physician orders are being administered correctly.	7/21/2011

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 _____	06/23/2011

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 428	Continued From page 17 order dated 12/30/10 that read "decrease Furosemide(Lasix- a diuretic used to treat hypertension, acute pulmonary edema and edema) to 10mg daily." A review of the physician orders revealed an order with an original order date of 1/01/11 that read; "if weight gain of 3 lbs. (pounds) in 24 hours or 5 lbs. in 48 hours give extra dose of Lasix (20mg times 3 days) and notify MD (medical doctor)." A review of the MAR (Medication Administration Record) for the months of March, April, May and June 2011 revealed the weight was documented daily for the months of March, April, and May. The month of June from the 1st through the 22nd there was no weight documented. A review of the MAR for May 2011 revealed that on 5/11/11 Resident #5's weight was 100 and on 5/12/11 the weight was 108 an increase of 8 lbs. There was no documentation available in the residents medical record that she received the extra dose of Lasix for 3 days as ordered by the physician. There also was no documentation that the physician was notified of the weight gain available in the medical record. A review of the weight sheet in the medical record for Resident #5 revealed monthly weights only were recorded. A review of the monthly pharmacy review notes contained no information regarding the lack of monitoring for the weights or the missed extra Lasix that was to be given with a weight gain when the resident had a gain of 8lbs on 5/12/11.	F 428	#4 Pharmacy consultant report concerning MAR omissions will be presented to the QI/RM committee monthly x12 by the DON. DON or Unit Manager will report results of the Quality Improvement tool x 4 months to identify trends and need for further education and/or monitoring.	

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 _____	06/23/2011

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 428	Continued From page 18 On 6/23/11 at 11:45am a telephone interview with the pharmacist was conducted. The pharmacist stated he did include monitoring in his reviews each month at the facility. Further discussion revealed that he was not aware of the order regarding giving extra dose of Lasix for weight gain. He also stated that when he was in the facility he does not have access to the current MAR's the only access was to the MAR's filled in the charts. 2 .Resident # 5 was admitted to the facility on 7/9/10. Diagnoses included Atrial Fibrillation, Pulmonary Hypertension, Hypertension, Osteoporosis, Osteoarthritis, and Gastroesophagel Reflux Disease. A review of the physician orders revealed an order with an original date of 7/9/10 that read; Nitroglycerin 0.2mg/hr(milligram released per hour) patch. Apply patch topically every morning (remove at bedtime) Hold for SBP (systolic blood pressure) < (less than) 100. A review of the MAR (Medication Administration Record) for the months of April, May and June 2011 revealed no documentation that a blood pressure had been taken prior to administration of the Nitroglycerin patch. A review of the vital sign sheet located in the medical record for Resident #5 revealed blood pressures were recorded weekly. A review of the nurses notes from April through June 22, 2011 revealed there was no blood pressure documented as being taken prior to the	F 428		

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 _____	06/23/2011

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 428	Continued From page 19 administration of the Nitroglycerine patch. A review of the pharmacy review notes from April through June 16, 2011 revealed no documentation regarding the facility nurses not taking the blood pressure prior to administrating the Nitroglycerine patch. On 6/23/11 at 11:45am a telephone interview with the pharmacist was conducted. The pharmacist stated he did include monitoring in his reviews each month at the facility. Further discussion revealed that he assumed the nurses were checking the blood pressure before administering the Nitroglycerine patch and did not look for it. He also stated that when he was in the facility he does not have access to the current MAR's the only access was to the MAR's filled in the charts.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING 01 - MAIN BUILDING 0106 08 B. WING	2011 07/22/2011

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
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/22/2011 the following sprinkler locations were found not in compliance. The locations are noted below: 1. The exit overhang at the laundry/therapy exit had its sprinkler head block by the air curtain assembly. This condition does not allow the sprinkler head at that location throw water to all portions of that area. 2. The cleaning storage closet in dietary near the freezer and cooler did not have a sprinkler head installed. NOTE: This was a condition noted be the facility and its sprinkler contractor and is scheduled to be reinstalled. CFR#: 42 CFR 483.70 (a)	K 056	This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law. #1 1) The sprinkler head that was being blocked by the air curtain at the laundry / therapy exit has been identified and has been relocated to an area in the same general location that does allow the sprinkler head to provide coverage to all portions of this area. 2) Sprinkler heads in the facility have been identified for possible impeded water flow. Sprinkler heads are placed in locations that allows them to provide coverage for the area that they are intended to provide coverage. 3)During sprinkler head maintenance, sprinkler head installations and facility renovations, sprinkler head locations will be pre inspected to ensure the area that the sprinkler head is placed allows the sprinkler head to provide full protection in that area. 4)Maintenance Director / designee will complete and present a quality improvement tool, checking 10 sprinkler heads daily, weekly x4, then monthly x2 to the QI/RM committee to verify that sprinkler heads are placed in locations that allows unimpeded water flow in order for them to provide full coverage for the area that they are intended to provide coverage. #2 1)The sprinkler head that is required to be located in the cleaning closet in Dietary near the freezer and cooler has been installed. 2)Areas of the facility that require sprinkler protection have been inspected ensuring that a sprinkler head is installed in those locations. 3)Prior to and after sprinkler head maintenance, sprinkler head installations and facility renovations, areas that require sprinkler protection will be inspected to ensure a sprinkler head is located in those areas. 4)Maintenance Director / designee will complete and present a quality improvement tool, checking 10 sprinkler heads daily, weekly x4, then monthly x2 to the QI/RM committee verifying areas that require sprinkler protection have a sprinkler head installed at these locations.	8/4/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8/4/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.