STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		2/22/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/08/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(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 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, psychologist and staff interviews, the facility failed to develop a comprehensive care plan for behaviors for one of three residents reviewed for accidents (Resident #1). The findings included: Resident #1 was admitted to the facility 3/31/17. Cumulative diagnoses included, in part, recurrent major depressive disorder and anxiety. A history and physical completed by the attending physician on 4/4/17 stated Resident #1 stated she was rather sad that she could not go home and there were some financial issues evidently that she continued to talk about. Psychological area was noted that Resident #1 had depression and she said she was depressed about not being able to go home. Assessment indicated generalized anxiety disorder and depression. A Mental Health Consultation by the psychologist dated 4/6/17 stated Resident #1 was seen for a routine psychotherapy visit. Visit requested by staff due to depression, due to crying, due to anxiety, due to yelling, due to irritability, due to use of psychiatric meds. Staff reported that resident had episodes of irritation/ sadness/ crying over weekend. She claimed she was going to leave and live with her sister. She stated she hated the facility and it was not what she wanted. She said she was hoping to go to an assisted living facility but finances/ insurance were barriers. She continued to view herself as special or different from peers with similar issues.	F 656	Resident #1 was discharged from the facility on January 4, 2018 and did not return. The care plan for Resident #1 was reviewed by the Care Plan team and Corporate Medical Data Set (MDS) Consultant on January 29, 2018 to identify errors in updating the care plan for Resident #1 for identified behaviors. Corporate MDS completed training for Care Plan team on January 29, 2018. This training was for Care Area Assessment (CAA) and Care Plan development, including behavior care plans. The Care Plan team consists of MDS Coordinators, Social Worker, Dietician and Activities Director. On February 5, 2018 Corporate MDS Consultant completed an audit of all current residents with identified behaviors and reviewed care plans for these residents to ensure care plans reflect identified behaviors. Of the 15 identified patients, 8 required Care Plan updates for behaviors. These care plans are updated by the Social Worker by February 22, 2018. Care Plan Team will meet weekly for 12 weeks to identify behavior areas for residents and will update care plans weekly to accurately reflect current behaviors which will be documented on the resident care plans. Social Worker	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(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 656	Continued From page 2 Following symptoms of depression were present: sadness, irritability, low motivation, anhedonia, helplessness, hopelessness, crying, mood lability. Following symptoms of anxiety were present: worry. Currently no psychotic symptoms. The consultation stated Resident #1 currently reported no thoughts of suicide or self-harm. Resident #1 currently had no thoughts to harm others or recent assaultive behaviors. An Admission Minimum Data Set (MDS) dated 4/7/17 indicated Resident #1 was admitted to the facility from another nursing facility. She was cognitively intact. Mood indicators included: feeling down, depressed 2-6 days. No behaviors were noted. A Care Area Assessment for psychotropic drugs dated 4/10/17 stated Resident #1 was taking the following psychoactive medications: Lexapro and bupropion daily to manage her moods and behaviors and a PRN (as needed) order for valium for her anxiety diagnosis. Will proceed to care plan. A Nurse Practitioner note dated 11/2/17 stated Resident #1 was seen due to refusal of fleets and suppositories and at request of resident. Neuropsychiatric exam revealed speech was normal. Affect was normal. Memory was intact. She was alert and oriented x 3. Crying and emotional. A Quarterly MDS dated 12/1/17 indicated Resident #1 was cognitively intact. Mood indicators: feeling down and depressed 7-11 days, trouble with sleep 7-11 days, tired or little energy 7-11 days, poor appetite or overeating 2-6 days. Other behavioral symptoms not directed	F 656	will update identified behaviors in Care Plans. MDS Coordinators will maintain an audit tool that will be updated weekly for new behaviors identified for residents. This tool will be maintained for 12 weeks. Audit tool will be presented to monthly Quality Assurance meeting to be reviewed during facility Quality Assurance meeting and ensure care plans have been updated to reflect resident's current need. This tool will be reviewed by the Quality Assurance meeting monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(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 656	Continued From page 3	F 656		

towards others occurred 1-3 days.

A review of Resident #1 ' s care plan revealed Resident #1 ' s care plan was reviewed on 12/12/17. There was a care plan undated with a problem that stated, in part, that Resident #1 was on psychoactive medications to manage her mood and behaviors. Staff would promote Resident #1 ' s psychosocial wellbeing. Approaches included administer medications as per physician orders and monitor for adverse reactions and report to physician if any. Psychiatric consult to follow. There was no problem that addressed her behaviors such as refusing care/ showers and manipulative behaviors.

A psychologist consultation dated 12/14/17 revealed facility staff reported Resident #1 had frequent complaints and was never satisfied. Resident #1 stated she was ok (unconvincingly). She said he knew how much she hated the facility. Resident #1 lamented that her sister was unwilling to drive up to facility to visit but was understanding of her concern for traffic. Resident #1 continued to be disparaging of staff, peers and environment. Her affect was mildly irritated. Following symptoms of depression: anger, low motivation, anhedonia, helplessness, hopelessness, melancholy. Symptoms of anxiety: ruminations over finances and her desire to leave facility.

A psychiatrist consultation dated 12/22/17 stated Resident #1 reported that she returned recently form the hospital after calling 911 for chest pain. She was labile in mood during the interaction and stated nobody helped her and she knew they talked about her. She wanted to be in another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(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 656	Continued From page 4	F 656		

facility and had been refusing antidiuretic medication but continued to complain about the fluid in her legs. She recently moved rooms and was happy with the change when the psychiatrist walked by and saw resident recently but today she cried and said she just wanted to go somewhere else and she hated it at the facility. She didn ' t think her mood would be improved until she found another place to live but recognized that her options may be limited. The psychiatrist stated there was a personality component that was driving her behavior as well. The psychiatrist increased her Lexapro to 15 milligrams daily (antidepressant medication).

A nursing note dated 12/22/17 at 12:37 PM indicated that periods of anxiety were noted for Resident #1. Redirection was provided as needed. She voiced no complaints of pain. Resident #1 refused Lasix today. Resident is own Responsible Party (RP).

A nursing note dated 12/22/17 at 9:59 PM indicated Resident #1 was medicated as scheduled for pain and PRN (as needed) Tylenol was given. She then called 911 and ambulance personnel called the facility to verify if resident was having an emergency. An explanation was given that resident had been medicated as directed and just came back from hospital with appointment to go see vascular surgeon on 28th. Resident #1 was then notified that the ambulance was not coming. She then proceeded to call 911 again and requested the police to come to the facility. A police officer came and talked to Resident #1. When he came out, he said she was requesting to be transferred to (name hospital) as she had just come from (name) hospital and nothing was done for her. Her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(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 656	Continued From page 5	F 656		

physician was notified for new orders.

On 1/24/18 at 2:29 PM, an interview was conducted with Nurse #1. He said Resident #1 was alert and oriented and able to communicate all her needs. He said Resident #1 was verbally mean to some staff. She would refuse medications and would refuse to use the bathroom and her reason was that the other resident used the bathroom. They gave her a commode and she refused it. They moved her to another room where she would have the bathroom to herself and she would refuse. For the first 3-4 months, she took her showers, then began to refuse with no reason. Some days she would ask to get up early and when first shift came, she would refuse the shower stating she was already up.

On 1/24/18 at 2:50 PM, an interview was conducted with Nurse #2. She stated Resident #1 was on her regular assignment. In general, there were times she was talkative and laughing and going to activities. If she did not get her way immediately, she would sit in the hall and make a crying noise without tears. Every day at 6:00 PM, she would ring her call light to get in the bed. Staff would let her know we would put her in bed as soon as they could and she would sit in the hallway and make a crying noise without tears until she got put in bed. The unit manager tried to accommodate her several times with getting up and going to bed but she kept changing her mind.

On 1/24/18 at 3:30 PM, an interview was conducted with Nurse #3. She stated Resident #1 had a diagnosis of depression. Resident #1 had some gait issues and had fallen several times when she was in the community. As her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	**413 WINECOFF SCHOOL ROAD CONCORD, NC 28027**

(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 656	Continued From page 6	F 656		

gait declined, her depression became worse-crying, anger, isolation, worry, blaming others for lack of her ability to do things. She would not be consistent with her wants and needs and would flip flop over making a schedule that was pleasing to her. For example, she would say she wanted to get up at 6:00 AM, then would refuse to have night shift get her up. When Nurse #3 spoke to the Resident about her refusal to get up, Resident #1 would say they wouldn ' t get her up. Her routine was changed as she requested and staff tried to accommodate her as much as possible but she would change the times she wanted to get up. She refused medications, refused treatments, refuse to elevate her legs and refuse to take showers. Resident #1 was her own RP and could make those decisions.

On 1/24/18 at 4:18 PM, an interview was conducted with Nurse #4. She stated Resident #1 was on her regular assignment. She said Resident 1 told her many times that she disliked the facility. She refused medications and treatments at times. Resident #1 was quick to be able to change her personality. She would cry for attention and then quickly redirect herself if it was something she wanted to do. She complained about not being able to use the restroom because of various reasons. One day she would hate every staff member in the building and would yell at other residents and cry without tears and curse at staff.

On 1/24/18 at 5:05 PM, an interview was conducted with the Social Services Director. She stated when Resident #1 came to the facility in March 2017, she got Resident #1 set up with psychiatric services. The psychologist knew Resident #1 from a previous facility. The Social

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(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 656	Continued From page 7	F 656		

Services Director stated Resident #1 would complain about something but, when asked, would say that everything was fine. She displayed manipulative behaviors throughout her stay at the facility. She also stated a friend of Resident #1 told her that Resident #1 had displayed this ongoing behavior for years. The Social Services Director stated she was made responsible for behavior care plans last week. She was unaware there was not a care plan for behaviors for Resident #1 and stated they had discussed Resident #1 ' s manipulative behaviors and refusals of meds/ showers in care plan meetings in the past.

On 1/24/18 at 5:20 PM, an interview was conducted with the MDS Coordinator who stated she had previously been responsible for behavior care plans. When asked about Resident #1, she reviewed the last MDS completed 12/1/17 and stated she was aware of resident being noncompliant with diet. She indicated that if Resident #1 had behaviors such as manipulative behaviors, refusing care/ meds and harming herself, she should have had a care plan in place. She was not sure why there was not a care plan for Resident #1 ' s behaviors.

On 1/25/18 at 8:22 AM, an interview was conducted with the psychologist. He stated he had had known Resident #1for about 2 years. He said he saw her at least one to two times a month and over the holidays, he made more frequent visits because Resident #1 had been complaining more. The psychologist said Resident #1 had a personality disorder and did not take any responsibility for her behaviors. She would blame others for everything and did not take responsibility for her actions. He stated Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	**413 WINECOFF SCHOOL ROAD CONCORD, NC 28027**

(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 656	Continued From page 8 #1 did have short term and long term memory impairment. The longer you talked with her, you would see the confusion become apparent. On 1/25/18 at 12:15 PM, the Administrator stated the facility had recognized on 1/11/18 there was a problem with the development of comprehensive care plans to address the mental, physical and psychosocial needs of the residents and they were in the process of putting a Quality Improvement Plan for MDS/ Care plans into place. He said Resident #1 should have had a care plan in place for her behaviors.	F 656		