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 02/02/2023

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FIVE OAKS REHABILITATION AND CARE CENTER	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 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite 1/26/2023 through 1/27/2023 and 2/2/2023 and offsite 1/28/2023 through 2/1/2023. Three of seven complaint allegations resulted in deficiency. Intakes NC 00196275, NC 00196996, NC 00197472, NC 00197531, NC 00197567, and NC 00197574 were investigated. Intakes NC 00197472, NC 00197567 and NC 00197574 resulted in immediate jeopardy. Event ID: XQ5811. Immediate Jeopardy was identified at: CFR 483.25 at tag F 689 at a scope and severity of J. The tag F 689 constituted Substandard Quality of Care. Immediate Jeopardy began on 1/13/2023 and was removed on 1/26/2023. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews with staff, Medical Director, Mental Health Nurse Practitioner (NP) and record review, the facility failed to provide close supervision of Resident #1 who was assessed as	F 689	Resident#1 was affected by the deficient practice and was discharged on 2/13/2023. On 1/27/2023 Resident#5 and Resident#6 were observed by the	3/2/23

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

Electronically Signed | 02/24/2023

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 689	Continued From page 1 confused, impulsive, unsafe, with a history of falls and at risk for further falls. The facility failed to observe the condition of Resident #1 after an unwitnessed fall, report the observation to a nurse with any urgency, provide continuous monitoring after Resident #1 was found with his neck entrapped by a bed control cord and observed that his face was blue. Resident #1 was found on 1/13/23 after 7:00 PM by Nurse Aide (NA) #3 prone with his feet on the floor, but she did not enter the room to see his condition. Nurse #1 entered the room and found Resident #1 with his right side against his bed. His neck was entrapped by the bed control cord that was attached to the bed and the siderail. Resident #1 was left in this condition when Nurse #1 left the room to get help. Emergency Medical Services (EMS) was called on 1/13/23 and pronounced his death in the facility at 7:39 PM. This failure occurred for 1 of 8 sampled residents reviewed for supervision to prevent accidents (Resident #1). Additionally, the facility failed to store bed control cords per manufacturer recommendations for the prevention of tripping hazards for 2 of 8 sampled residents reviewed for supervision to prevent accidents (Residents #5 and #6). Residents #5 and #6 are cited at scope and severity level of D (no actual harm with the potential for minimum harm that is not immediate jeopardy). Immediate jeopardy began on 1/13/23 when NA #3 failed to observe the condition of Resident #1 when she saw his feet on the floor in a prone position after an unwitnessed fall. Immediate jeopardy was removed on 1/26/23 when the facility provided an acceptable credible allegation of an immediate jeopardy removal plan. The	F 689	surveyor as having their chords wrapped around the siderail(s). 1.29.2023, facility Staff were made aware of the surveyor's observation. On 1.27.2023, the administrator was made aware that the facility would not be placed back into compliance related to observations of bed chords made by the surveyor. The facility was notified at that time of the surveyor's observation of resident# 6 and resident#7 in which she informed the maintenance director who corrected it immediately. On 1.29.2023, the administrator received notification of other observations of incorrect storage of chords that were made. Upon notification, Resident #5 and Resident #6 bed chords and room were observed by the administrator and were not noted to have chords wrapped around the siderails. Placement of these resident chords are being monitored utilizing the room rounding tool. Subsequently, resident #5 discharged 2.17.2023 All residents assessed to be a falls risk, confused, impulsive and unsafe would be at risk for the same deficient practice cited for resident #1. On 1.29.2023 these residents were reviewed and observed by the Director of Nursing and were not identified being confused and impulsive and unsafe with the history of falls. On 2.21.2023, all current residents were observed and charts were reviewed utilizing Fall Risk evaluations, side rail evaluations and therapy evaluations (if applicable) to identify those with confusion and impulsiveness and unsafe due to history of falls. Those residents identified	

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F 689	Continued From page 2 facility will remain out of compliance at a lower scope and severity of D (no actual harm with the potential for minimum harm that is not immediate jeopardy) to ensure the monitoring of systems put in place and to complete facility employee and agency staff in-services, orientation, and training. Findings included: A phone interview with the Mental Health NP on 1/26/23 at 2:29 PM revealed he provided mental health services once to Resident #1 on 12/15/22 due to a referral from the Medical Director for impulsivity and medication management while Resident #1 lived at an assisted living facility (ALF). He planned to see Resident #1 again on 1/16/23 but Resident #1 was discharged from the ALF at the time of this scheduled appointment. The NP stated that Resident #1 previously lived with family, then was admitted to the hospital and then to an ALF where he had been for about 1 week before the NP assessed him on 12/15/22. The NP stated Resident #1 had a sitter because of impulsivity, agitation and a history of frequent falls associated with his diagnoses of Parkinson's disease and dementia with Lewy Bodies characteristics. The NP stated that based on his assessment, he increased the dosage of Citalopram (antidepressant) from 20 mg daily to 30 mg daily for increased anxiety/impulsivity and auditory/visual hallucinations noted at the time of the assessment. The NP further stated that his hallucinations had the potential to increase his agitation due to fluctuations in his cognitive status. The NP stated that due to the Parkinson's disease and dementia, his response to medication was not predictable, unlike other psychiatric conditions. The NP stated that medication adjustments were made to help	F 689	will be rounded when in their rooms utilizing the Safety: Room Rounding Tool. Information from the tool will be utilized to identify additional resident specific monitoring needs. Resident Care plans will be updated as necessary. The review was completed by the Director of Nursing and the other designer (s). 1.26.2023 education was completed with all staff regarding Safety, Resident monitoring, Responding to incidents and accidents by the Director of Nursing and or his/her designee. The education involved review and discussion of the policy for incidents and accidents and spoke specifically to in the event of a an incident or accident, immediate assistance will be provided, or securement of the area will be initiated unless it places one at risk of harm. Examples provided during the discussion were if you thought there was an incident/accident staff would need to investigate. Staff were instructed to push the resident□s call light and or yell out for help to get immediate attention. A competency was developed 1.25.2023 to evaluate staffs□ compliance and level of understanding. The education and competency wereadded to new hire orientation 2.25.2023. On or by 03.2.2023, staff education regarding observing, removing, and reporting of potential fall hazards as well as resident conditions that place them at risk for falls. The education includes placement of call lights and bed controls to prevent fall-related incidents and will be completed by the Director of Nursing and	

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F 689	Continued From page 3 reduce the hallucinations, but often a side effect of this disease process is the inability to move, or "freeze" and the meds will only manage these symptoms, not treat the disease. He stated the response to medication was person specific, very unpredictable, and difficult to manage. A 12/31/22 hospital Health & Physical recorded that Resident #1 did not walk, was wheelchair bound and had a history of falls. A 1/12/23 hospital discharge summary recorded Resident #1 presented to the Emergency Department with altered mental status, and a reported syncope (unconscious) episode. He was diagnosed with aspiration pneumonia, and acute toxic/metabolic encephalopathy with a component of delirium (delirium and acute confusion). Resident #1 was admitted to the facility on 1/12/23 from the hospital. Diagnoses included Parkinson's disease, advanced dementia, psychotic disturbance, mood disturbance, anxiety disorder, metabolic encephalopathy, paroxysmal atrial fibrillation, and syncope with collapse (unconscious), among others. A 1/12/23 Fall Risk Evaluation, assessed Resident #1 at risk for falls due to intermittent confusion, history of falls, and balance problems while standing. The evaluation suggested fall risk interventions to include rubber soled shoes or non-skid slippers for ambulation. A phone interview with Nurse #3 occurred on 1/31/23 at 1:17 PM. Nurse #3 stated she worked on 1/12/23 on the 7:00 AM to 7:00 PM shift when Resident #1 admitted from the hospital to the facility sometime before 6:00 PM. Nurse #3	F 689	or other designee(s). As of 2/21/2023, Education regarding observing, removing, and reporting of potential fall hazards as well as resident conditions that place them at risk for falls and specific education regarding placement of call lights and bed controls has been added to new hire orientation. On 2/21/ 2023 the Administrator and Director of Nursing updated the Room Monitoring Tool to include not only observation of proper placement of bed controls and call lights to reduce falls and fall related hazards but also to monitor and note resident specific behaviors to include confused, impulsive, unsafe and a falls risk and now titled the Safety Room Rounds Observation Tool. This tool will be used daily and will be utilized by the interdisciplinary management team and others as designated by the Administrator and Director of Nursing. 2.22.2023, the interdisciplinary team was educated on the audit tool by the administrator. These audits will be done daily for 12 weeks. The results of the Room Monitoring Tool Audit will be tracked and trended by the administrator monthly and will be presented to the Quality Assurance Performance Improvement Committee. Tracking and trending will continue monthly for 3 months. Results of the audits will be reviewed at the QAPI Committee meeting for 3 months for further resolution and or monitoring if needed. The facility alleges compliance as of 3.2.2023.	

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F 689	Continued From page 4	F 689		

stated on admission, Resident #1 was weak, alert with confusion and that she was told by the hospital that he had a history of falls, atrial fibrillation, and Parkinson's disease. Nurse #3 stated on admission, Resident #1 tried to call his son by using the bed control remote because he thought it was a phone. Nurse #3 stated his family arrived and fed him his dinner meal and assisted him to use the urinal due to weakness, and he made several attempts to get up from his wheelchair unassisted.

A 1/13/23 5-Day MDS assessed Resident #1 with adequate hearing, adequate vision, usually understood by others, usually understands other, clear speech, no corrective lenses or hearing aids, and moderately impaired cognition. His mood was assessed as feeling down, depressed, hopeless, fidgety, restless, and moving around a lot more than usual. He required the physical assistance of 1 staff person for bed mobility and transfers, he did not walk, his balance during transitions was not steady but he was able to stabilize without staff assistance. It also recorded a fall in the last month prior to entry to the facility.

On 1/26/23 at 1:14 PM, Nurse Aide (NA) #1 stated in interview that she met Resident #1 on Friday 1/13/23 for the first time when she came to work at 6:45 AM. NA #1 stated that when she received a shift report all she was told was that Resident #1 was a new admission, he was at risk for falls and that he kept taking his clothes off. NA #1 stated she went to his room to meet him; he was in bed with his night gown and bed cover on the floor. NA #1 asked Resident #1 if she could get him dressed, he said yes and so she assisted him. NA #1 said when she came back to check on him before breakfast, he had taken his clothes

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F 689	Continued From page 5	F 689		

off again, so she dressed him again. NA #1 stated she brought him a breakfast tray, assisted him with his breakfast meal and placed him in his wheelchair. NA #1 stated throughout the morning Resident #1 made several attempts to get out of his wheelchair unassisted. NA #1 said Resident #1 received occupational therapy (OT) and physical therapy (PT) that morning and she asked the PT if he was safe to walk. NA #1 said the PT told her that Resident #1 was not safe to walk by himself because he was unsteady on his feet and at risk for falling. NA #1 said she observed Resident #1 in his wheelchair at the nurse's station before lunch, fed him lunch in the dining room, assisted him with toileting in his room, placed him back in his wheelchair and returned him to the nurse's station around 2:20 PM. NA #1 stated she passed him several times while he was seated at the nurse's station until she left her shift at 3:00 PM. NA #1 stated she left Resident #1 at the nurse's station at 3:00 PM with Nurse #2 because NA #3 (3:00 PM - 11:00 PM NA) had not yet arrived.

A 1/13/23 NP progress note documented Resident #1 was hospitalized for altered mental status on 12/31/22 and discharged to the facility on 1/12/23 for rehabilitation and chronic disease management. Resident #1 was assessed as forgetful, confused, oriented to person only, with decreased mobility, and poor strength.

A 1/13/23 OT evaluation assessed Resident #1 with fall risk precautions related to combativeness, agitation, confusion, and reduced cognition.

A 1/13/23 PT evaluation assessed Resident #1 with fall risk precautions related to decreased

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F 689	Continued From page 6	F 689		

balance, impulsiveness, and Parkinson's disease.

During an interview with PT #1 and OT #1 on 1/27/23 at 1:30 PM, both staff stated that they worked together with Resident #1 on 1/13/23 to evaluate and treat him sometime after 10:00 AM until about 11:30 AM. They described him as confused, able to state basic needs, like "I have to go to the bathroom, I want to get into my wheelchair, I want to get dressed, and I can do it by myself." He was described with unsteady balance and gait and had difficulty staying upright. They said when he toileted he leaned while he faced the toilet, and had to be held upright, as he did not realize he was unsafe. They described his movements as frozen, fidgety and that he had trouble with reciprocal movement, retropulsion (a tendency to walk backwards) and balance because of Parkinson's disease. They stated he could not perform functional cycling because his feet acted more like brakes, and he could not make them work. During the interview, they said he had problems with motor planning, he could understand what was said to him, but that he had difficulty performing tasks. They described him as unable to get out of bed independently, he used the side rail to pull himself up, but because he leaned, he could not independently perform the task of getting himself out of bed. PT #1 and OT #1 both said they told the Unit Coordinator, Nurse #2, and NA #1 on 1/13/23 that he needed assistance out of bed and assistance to walk, but that he was still being assessed for other needs. They stated after PT/OT treatment on 1/13/23 he was left at the nurse's station with Nurse #2.

On 1/27/23 at 8:30 AM NA #3 was interviewed by phone. NA #3 stated she was assigned to care for Resident #1 on 1/13/23 from 3:00 PM to 7:00 PM.

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F 689	Continued From page 7	F 689		

NA #3 stated when she came on shift, Resident #1 was seated at the nurse's station in his wheelchair. NA #3 said she did not receive shift report from NA #1 because she got to her assignment after NA #1 had already left. NA #3 said the only thing Nurse #2 told her was that Resident #1 was a new admission and at risk for falls. NA #3 said Resident #1 kept trying to get up from his wheelchair at the nurse's station, but each time she asked him to sit back down he complied. NA #3 said she started her rounds and at about 4:30 PM she saw Resident #1 in bed in his room dressed and wearing non-slip socks. Then between 5:15 PM and 5:30 PM, NA #3 said she took him a dinner tray and fed him dinner in bed. NA #3 said after she fed him dinner, she left him in bed, bilateral helper side rails in the up position, and his call light and bed control cords lying across his stomach. NA #3 stated on her last round, at about 6:30 PM, she walked past his room and saw he was in bed with his upper body positioned to the left of the bed and his lower body was positioned to the right. NA #3 said she repositioned him straight in bed, left his bed at regular height and placed his call light and bed control cords across his stomach. NA #3 then said sometime between 7:00 PM and 7:30 PM, she was walking towards the nurse's station, passed his room and she did not see him in bed. She said she peeked in his room and saw his feet were on the floor, with his feet facing down and his toes were touching the floor. NA #3 said she did not look to see where his upper body was, but rather went to the nurse's station and told Nurse #1 and NA #2 that Resident #1 was on the floor, then she left to go to another unit in the facility to finish her shift. NA #3 said she was suspended because she did not go into the room when she saw Resident #1 on the floor and that she did not

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F 689	Continued From page 8	F 689		

stay to help Nurse #1 get Resident #1 off the floor.

A 1/14/23, late entry progress note, completed by Nurse #1 (7:00 PM - 7:00 AM Nurse) recorded that NA #3 notified Nurse #1 around 7:15 PM on 1/13/23 that Resident #1 was on the floor. The progress note recorded that Nurse #1 grabbed a neuro-assessment sheet and the vital sign (VS) machine to go assess Resident #1. Nurse #1 observed Resident #1 on the floor in a prone (faced down) position with his head and upper trunk raised up, appearing as if he was propped up on his right arm against the bed. Upon further inspection, Nurse #1 noted Resident #1's head was caught in the cord of the bed remote control, and the left side of his face was blue. Nurse #1 attempted to sit Resident #1 up to pull his head out of the cord with no success. Nurse #1 then ran to nurse's station to ask for help, get a stethoscope, and Resident #1's code status. Nurse #2 (7:00 AM -7:00 PM Nurse) said Resident #1's code status was full code. Nurse #1 told Nurse #2 to call 911 and Nurse #1 ran back to Resident #1's room with NA #2 (7:00 PM - 7:00 AM NA) following to assist. After placing Resident #1 on his back, no pulse was palpable, and Nurse #2 came into the room and said Resident #1's code status was DNR. EMS arrived and was able to find a pulse, but CPR (cardiopulmonary resuscitation) was not started due to DNR code status. Time of death was called by EMS at 7:39 PM.

A phone interview with Nurse #1 occurred on 1/26/23 at 4:49 PM and a follow-up interview on 1/31/23 at 10:20 AM. Nurse #1 stated she came to work on 1/13/23 before 7:00 PM and all she was told when she received shift report from

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F 689	Continued From page 9	F 689		

Nurse #2 was that Resident #1 was a new admission and at risk for falls. Nurse #1 stated that NA #3 came to the nurse's station after 7:00 PM, while she was counting narcotics with Nurse #2 and said Resident #1 was on the floor. NA #3 then said, it was after 7:00 PM and she had to go to another unit to finish her shift and then she left the unit. Nurse #1 said the fall was not communicated to her with any sense of urgency, and when she was told by Nurse #2 that he was at risk for falls, Nurse #1 said she did not know if falling was routine for him and since she was about midway through the narcotic count with Nurse #2, she completed the count, obtained a neuro-assessment sheet, the VS machine and then went to Resident #1's room. Nurse #1 said this took about 2 - 3 minutes. Nurse #1 said as soon as she approached the room, she could see from the doorway that his legs and feet were on the floor in a prone position. Nurse #1 said she entered the room and saw Resident #1 on the floor with the right side of his body against the bed. Nurse #1 said as she got closer, she spoke to him, but he did not respond, so she touched him and he was warm, but she could not find his pulse. Nurse #1 said as she got closer, she saw that his face was blue, and his head was held upward by the bed control cord that was wrapped several times around the left side rail which was in the up position. Nurse #1 said his body weight was on the cord that appeared to be cutting off his air supply. Nurse #1 said she tried to lift Resident #1 off the cord, but she could not lift him off the cord alone, so she stated, "I gently put him back" and ran to the nurse's station to get help, a stethoscope and to get his code status. Nurse #1 said she told Nurse #2 how she found Resident #1, to get his code status, call 911, asked NA #2 to come help her and then she returned to the

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(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 689	Continued From page 10	F 689		

room. Nurse #1 said she and NA #2 arrived at his room and NA #2 held Resident #1 up while Nurse #1 removed his head off the bed control cord and laid him on his back on the floor. Then Nurse #2 came to his room and said his code status was DNR. EMS arrived, found a "thready" pulse that faded and EMS pronounced his death at 7:39 PM. Nurse #1 said she did not use the call light in his room or bathroom to get help, but rather left his room to get help because in her experience working at the facility sometimes the response to call lights was not fast enough, as staff may be in other resident rooms helping other residents. Nurse #1 said she did not want to go to the hallway to yell out because she did not want to alert visitors of the urgency of the situation, so she made a judgement call to go get help because she did not want other residents/visitors to hear her hollering and feel unsafe about the facility.

Nurse #2 stated in interview on 1/26/23 at 12:40 PM and in a follow up interview on 1/27/23 at 11:02 AM that she cared for Resident #1 on 1/13/23 from 7:00 AM - 7:00 PM. Nurse #2 stated Resident #1 was admitted to the facility on 1/12/23 and that during the nurse shift report all she was told was that he was at risk for falls and took his medications crushed in pudding. Nurse #2 described Resident #1 as confused, but able to follow simple commands. Nurse #2 stated Resident #1 was at the nurse's station most of the 7:00 AM - 7:00 PM shift because during the shift he required frequent verbal ques and redirection to remind him not to attempt to stand from his wheelchair unassisted and walk. Nurse #2 further stated that day (1/13/23) he was still while he was eating and that he could be easily redirected with food/drink, but when he was not

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 11	F 689		

eating, he was very busy reaching for, touching and pointing at things with his hands. Nurse #2 said she last saw Resident #1 between 6:00 PM and 6:30 PM when she administered his medication while he was in bed. He had completed his dinner meal which was fed to him by NA #3. Nurse #2 stated that around 7:00 PM she completed a med count with Nurse #1 and gave her the keys to the med cart. Then just after 7:00 PM, NA #3 came to the nurse's station and told Nurse #1 that Resident #1 was on the floor. NA #3 said she had to go finish her shift on another unit and then she left. Then Nurse #1 got the neuro-assessment and fall report sheets and went to the room. After a few minutes, Nurse #1 came back to the nurse's station and said she found Resident #1 face down with his neck lying on the cord and she could not find a pulse. Nurse #1 asked what his code status was, and asked NA #2 to come help her. Nurse #2 stated that Nurse #1 asked her to call 911, she gave Nurse #1 Resident #1's code status and then Nurse #1 returned to the room. Nurse #2 said she called 911, told the EMS dispatcher that Nurse #1 could not find a pulse for Resident #1 and that his code status was DNR. The EMS dispatcher asked Nurse #2 if he was still breathing, she yelled out to Nurse #1, but did not get an answer. Nurse #2 stated she then ran to Resident #1's room to find out if he was breathing. Nurse #2 stated when she got to Resident #1's room she saw him lying on his back on the floor on the right side of the bed, he was not wearing a shirt and there was a red mark on the right side of his neck from the Adam's apple to the right ear. He was not breathing, and his face was blue. Nurse #2 stated then EMS arrived, found a pulse for Resident #1, took over his care and Nurse #2 left the room.

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 12	F 689		

NA #2 stated in an interview on 1/26/23 at 4:16 PM that when she came to work on 1/13/23 for the 7:00 PM to 7:00 AM shift all she was told during shift report from NA #3 was that Resident #1 was a new admission and he was at risk for falls. NA #2 further stated that about 7:20 PM or 7:25 PM, NA #3 came to the nurse's station and told Nurse #1 and NA #2 that "the Resident in room 225 is on the floor." NA #3 then said that it was 7:30 PM and she had to go to another unit to finish her shift. NA #2 stated Nurse #1 gathered some papers, her stethoscope and went to the room. NA #2 stated, then Nurse #1 came back to the nurse station and asked Nurse #2 to call EMS, what his code status was, and asked for some help because his neck was caught on a cord and she could not lift him off the cord, then Nurse #1 ran back to his room. NA #2 said she went to the room with Nurse #1 to help her. NA #2 said when she walked in the room, Nurse #1 was on the floor on her knees next to Resident #1 who was also on the floor with his neck caught on the "call light cord". She said he was wearing clothes, yellow non-skid socks, his arms were behind him, palms facing up and he was lying directly on his face. Nurse #1 than asked NA #2 to hold him up so she could remove the cord from his neck. NA #2 said Resident #1 was lying on the floor with the cord underneath his neck, and it looked like the cord had cut off his air supply because his face was blue, and he was not talking. NA #2 said she held him up and Nurse #1 removed the cord; they laid him on his back and placed his head on a pillow. NA #2 said the call light and bed control cords were both wrapped tightly to the side rail, but that she could not recall if the side rail was raised or not. Nurse #2 then came to the room and said his code status was DNR, so Nurse #1 did not do CPR. Then EMS

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 13	F 689		

arrived and NA #2 said she left the room.

The Unit Coordinator was interviewed on 1/26/23 at 11:37 AM and stated that she saw Resident #1 on 1/12/23 when he arrived at the facility around 5:40 PM. She stated that she did not talk to him and left her shift around 7:00 PM. The Unit Coordinator said on 1/13/23, she arrived at the facility around 12:30 PM, saw him seated in his wheelchair at the nurse's station and asked him several times to sit in his wheelchair because he kept trying to stand and walk. She described him as pleasant, verbal, easily redirected and kept saying that he "needed to stand up to look right there, I want to look at the board." She said she asked PT if he was safe to walk, and she was told that he was not safe. The Unit Coordinator further stated she left shift on 1/13/23 around 7:00 PM and then received a call from the Director of Nursing (DON) after she left asking her to return to the facility because Resident #1 was found deceased when the nurse entered his room. The Unit Coordinator said when she arrived at the facility, the Administrator informed her that the police were in the room and that staff were not allowed to enter Resident #1's room.

A 1/13/23 Emergency Medical Service (EMS) Patient Care Record documented that EMS responded to a 911 cardiac arrest call on 1/13/23 at 7:26 PM from the facility for Resident #1. The EMS Patient Care Record recorded that EMS arrived at the facility on 1/13/23 at 7:31 PM and found Resident #1 unresponsive, apneic (not breathing), and with a faint pulse. Staff reported to EMS that Resident #1 was "found on the ground belly down with his neck held up by the coiled cord on the remote to bed control. " Staff also reported to EMS that NA #3 helped scoot

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 14	F 689		

Resident #1 back on the bed at approximately 7:15 PM on 1/13/23. When staff returned at 7:30 PM Resident #1 was found with his neck held up by the bed control cord. Staff pulled the cord from the neck of Resident #1, laid him on the floor and called 911. When EMS personnel arrived Resident #1 had a faint carotid pulse, but was apneic (not breathing). EMS attempted to pace (controlled pulses delivered to mimic a normal heart rhythm) Resident #1, but he remained with pulseless electrical activity and apneic. Due to Resident #1's advanced directive for DNR, EMS pronounced his death at 7:39 PM.

A phone interview with the Lead Paramedic on 1/28/23 at 8:45 AM, revealed she completed the EMS Patient Care Record for Resident #1. She stated EMS dispatcher received a cardiac arrest call from the facility on 1/13/23 and was advised the patient had a DNR code status which meant chest compressions could not be performed to sustain life. She stated when EMS arrived, she observed Resident #1 face up on the floor next to the bed, he had a big bruise on his neck that looked like the bed control cord which extended from his left ear lobe to the midline of his neck, but the mark was not on the right side. He had a "thready" pulse, so EMS put defibrillator pads on his chest to check his heart rate. His heart rate (HR) was low, he was brady (slow hear rate), and he was not breathing. EMS attempted to pace him with the defibrillator pads to diffuse the HR but was unsuccessful as he was in respiratory failure with pulseless electrical activity. She stated chest compressions were not performed due to the DNR code status, so his death was pronounced by EMS at 7:39 PM. The Lead Paramedic stated she did not see the bed control cord on him because when EMS arrived, he was

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 15	F 689		

off the cord lying on the floor on his back. The Lead Paramedic stated EMS called the police to come and investigate, because staff said they scooted him up in bed at 7:15 PM and then about 7:26 PM or 7:27 PM staff said they found him lying on his belly on the floor on the bed control cord and called EMS due to cardiac arrest.

Resident #1's death certificate recorded that Resident #1 expired on 1/13/23 at 7:39 PM after a fall from bed with his neck caught on the call light cord. His primary cause of death was arteriosclerotic cardiovascular disease due to positional asphyxiation and ligature strangulation.

A 1/14/23 24-hour Initial Report signed by the Administrator recorded the reason for the report was reasonable suspicion of a crime, with serious bodily injury. The 24-hour Initial Report recorded Resident #1 was suspected to have an unwitnessed fall and loss of consciousness on 1/13/23 at approximately 7:00 PM which resulted in his death. The incident was reported to law enforcement on 1/13/23 at 7:55 PM and investigated.

The facility's 5-day Investigation Report and summary of findings signed by the Administrator on 1/20/23 recorded that on 1/13/23, Resident #1 was suspected of having an unwitnessed fall and subsequent cardiac arrest resulting in his death. At approximately 7:05 PM Nurse #1 received a report from the NA #3 who had been caring for Resident #1 that he had a fall. Nurse #1 stated she grabbed the VS machine and went to the room where she observed Resident #1. She described his upper body was somewhat propped up next to the bed which was in a low position to the floor and the lower part of the body on the

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 16	F 689		

floor. Resident #1's head/upper body were in an upright position not touching the floor and he was laying on a cord. Nurse #1 attempted to remove Resident #1 from laying on the cord, but stated she physically was unable to do so and so she had to exit the room to get assistance. Nurse #1 returned to the room with the NA #2 and was able to remove Resident #1 from laying on the cord. EMS arrived while Resident #1 was being evaluated by Nurse #1. EMS was able to obtain a pulse for Resident #1 described as "thready". During the evaluation of the event EMS determined Resident #1 was without a pulse at 7:39 PM and due to his DNR code status, EMS pronounced his death. The facility's 5-day Investigation Report and summary of findings also indicated that based on the initial reports provided to EMS by facility staff, law enforcement was contacted to assess the situation. It recorded that the investigation did not reveal criminal activity but did provide opportunity to enhance staff education on safety responding to incidents/accidents, assistive devices, admissions/UDAs (assessments), abuse and neglect, and documentation.

The Assistant Director of Nursing (ADON) stated in an interview on 1/31/23 at 12:35 PM that she was in the facility on 1/13/23 getting ready to leave the facility when Nurse #1 called her and said to tell NA #3 to come back to Resident #1's room. She stated she was informed by Nurse #1 that Resident #1 had expired. The ADON stated she went to Resident #1's room and saw him on the floor on his back away from the bed with EMS in the room trying to get his pulse. The ADON said she saw a red mark on his neck from mid neck to the left side of his neck that looked to her that it came from the bed control cord. EMS said

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 17	F 689		

the police would have to be called for a crime scene investigation. The ADON then said she sent a text message to the DON advising her of the incident.

During an interview with the DON on 1/27/23 at 11:14 AM, she stated she only saw Resident #1 once on 1/13/23 after 5:00 PM while he was in the facility and at that time he was reaching for things while seated in his wheelchair at the nurse's station. The DON stated she was notified via a text message from the ADON on 1/13/23 at 7:35 PM that Resident #1 was in cardiac arrest after a fall in the facility, EMS was in the facility and his code status was DNR. The DON stated she contacted the ADON by phone in the facility, and the ADON informed her that it appeared the cardiac arrest resulted from an accidental strangulation. The DON stated she then called the Administrator and they both arrived at the facility around 8 PM. She stated when she arrived the Administrator and police were in the facility, but staff were not allowed access to Resident #1's room. The DON stated she took a few moments to gather herself and then started interviewing staff. The DON stated that during the investigation, the room was assessed to determine how the incident could have occurred and the call light and bed control cords were tightly wrapped around the lower grab area of the assist side rail. The DON stated that staff were educated and completed competency tests to stay with the resident after an incident/accident when you call for help and enter the resident's room to see the resident if you think they may have fallen.

During an interview with the Administrator on 1/27/23 at 2:56 PM, he stated he was notified via

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 18	F 689		

phone by the DON on 1/13/23 after 7PM that Resident #1 had a fall, EMS was called due to cardiac arrest and pronounced his death in the facility. He stated that EMS thought the circumstances of his death warranted investigation, so they notified the police. He stated when he arrived at the facility around 8:30 PM, several police officers were in Resident #1's room and no one could access the room. He stated that the DON, ADON and the Administrator began conducting an investigation, by interviewing staff and learned that NA #3 did not go into Resident #1's room when she thought he may have fallen, Nurse #1 found him with a cord pressed against his neck and left the room to get help, rather than calling for assistance from the room, so they started looking at the investigation from a safety perspective. He stated the facility's investigation could not determine who wrapped the bed control cord around the side rail, Resident #1, or staff. He stated they went room to room, looked at assessments for assist side rails, placement of bed remotes, tripping hazards like hanging cords obstructions, and clutter in rooms to ensure there were no other opportunities for a resident to fall under similar circumstances.

The Medical Director (MD) stated in an interview on 1/26/23 at 12:15 PM that he was notified by the facility on 1/13/23 of the incident for Resident #1. The MD stated Resident #1 was assessed by the NP on 1/13/23 after admission to the facility. The MD stated based on the description of events for Resident #1, somehow Resident #1 rolled out of bed onto the bed cord and when Nurse #1 found him, she tried to lift him off the cord. The MD stated that Resident #1's mental status was previously assessed without suicidal ideations, and not a danger to himself or others. He came

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 19	F 689		

to the facility from the hospital for rehab. The MD stated he had a diagnosis of dementia and was assessed with confusion on admission. On the day of the incident, he was put to bed appropriately, staff came back a short period later and this horrible incident occurred. The MD stated that he did not know exactly how the cord was positioned but an unfortunate thing occurred, the arrhythmia occurred in light of the hypoxia and appears to be part of the cause of death. In a follow up phone interview on 1/27/22 at 3:00 PM, the MD stated that it doesn't take long for a person to show signs of hypoxia when they are not breathing it can appear within minutes. He stated that if the nurse responded in 2 - 3 minutes of being notified that Resident #1 was on the floor, he felt that was an appropriate response time and it would not have made a clinical difference if she had arrived sooner.

The Administrator and DON were notified of immediate jeopardy on 1/27/23 at 4:08 PM.

The facility provided the following allegation of immediate jeopardy removal plan:
1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.
a. Resident #1 admitted on 1/12/2023 with diagnoses that include Parkinson's, syncope with collapse, and Paroxysmal Atrial Fibrillation, metabolic encephalopathy, cognitive communication deficit; muscle wasting and atrophy; unspecified dementia, among other diagnoses.
b. Resident #1 was assessed/evaluated to be impulsive, unsafe, and a fall risk.
c. On 1.13.2023 at approximately 6:40 p.m., CNA#1 repositioned resident#1 who was noted to

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 20	F 689		

be laying diagonal in bed.
d. On 1.13.2023 at or shortly after 7:00 p.m. C.N.A#1 reported to the nurse without urgency that resident#1 had fell. CNA#1 observed the resident's leg on the floor as he was in a prone position but failed to go in and check on him/her prior to reporting the residents' fall.
e. The oncoming-shift nurse responding to the fall stated that the resident was unresponsive to touch or verbalization. He/she stated she could see something under the neck of resident #1 that looked like a cord. According to the nurse's statement the resident's head was being held upward by the cord. The nurse stated she tried to get the resident off the cord but was not physically able to do it by herself. The Nurse then ran to the nursing station (approximately 60 ft from the resident's room) to gain immediate assistance and returned with a CNA who assisted in getting the resident repositioned on to his back.
f. On 1/14/2023 a review of all resident assessments for bed mobility assistance was performed by the Director of Nursing and or the nurse management team which identified falls risk, impulsive, and or any other unsafe behavior. As a result of the review and out of an abundance of precautions, all residents were identified to have the risk to be unsafe, impulsive or a falls risk.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete
a. CNA#1 completed her shift at or around 11:30 p.m. on 1.13.2023 and has not been allowed to return to work.
b. 1.13.2023 100% of all staff who worked were educated on "Safety, responding to incidents and

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 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	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 689	Continued From page 21	F 689		

accidents" prior to the start of their shift except those who were educated during the shift that the incident occurred. The education included review and discussion of the policy for incidents and accidents which directly speaks to "in the event of an incident or accident, immediate assistance will be provided, or securement of the area will be initiated unless it places one at risk of harm. In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet." During the discussions examples of "if you thought" an incident occurred you need to go see/investigate. Accordingly, as of 1/13/2023, no resident was cared for by any staff member who had not already been trained and or educated on "Safety, responding to incidents and accidents". Verbal competencies were initiated on 1/13/2023 with the education. A written competency was developed 1.25.2023 to ensure staff retained the information received from the education as the staff had received multiple educations during this time. The written competency is now included in the new hire orientation effective 1.25.2023.

c. CNA#1 was officially suspended on 1/16/2023 pending the results of the investigation. At the completion of the investigation the facility reached out to CNA#1 to clarify information he/she had provided in regard to the incident, but CNA#1 has never returned communication. Subsequently, CNA#1 was terminated 1.24.2023 for failure to cooperate with an internal investigation including, but not limited to investigations of violations of work rules.

d. A surveillance tool has been created through QAPI (1/16/2023) to increase surveillance of residents who have been identified as needing assistance with bed mobility due to behaviors that

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 02/02/2023

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

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F 689	Continued From page 22	F 689		

make them unsafe or impulsive or a falls risk. The tool was created for the use of the interdisciplinary management team and nursing supervisor to use as they rounded on resident rooms. The surveillance tool was introduced to the team by the Administrator on 1.17.2023.
e. Reviewing of the oncoming-shift nurse's statement regarding having to leave the resident and run to get assistance was investigated by the administrator, director of nursing, and the vice president of clinical on 1/14/2023. According to the nurse's statement, after failing at trying to remove the resident from his/her current position she ran to the nursing station to get immediate assistance. There are call alert systems located in the residents' room and in the bathroom but utilizing them does not identify the alert as an emergency nor does it guarantee an immediate physical response. The oncoming-shift nurse ran to the nursing station which is approximately 60 feet to get immediate assistance and returned to the resident's room where a CNA assisted her with repositioning the resident on his back.

Date alleged for immediate jeopardy removal: 1.26.2023

The facility's immediate jeopardy removal plan was validated on-site on 2/2/23, for a removal date of 1/26/23 with observations, staff interviews and record review.

The validation of the immediate jeopardy removal plan included staff interviews on in-service education and a post test of the policy and procedures titled Incidents and Accidents. Interviews with staff and a review of the agendas revealed the education included instruction to observe a resident's condition after a fall, stay

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F 689	Continued From page 23	F 689		

with the resident after a fall, obtain help if needed, while remaining with the resident, by using the call light system, phone or to call out for help and proper placement of cords for the call system and bed control. The facility provided audits, monitoring tools, documentation of in-services and post-tests for review regarding observation of a resident's condition after a fall, staying with a resident after a fall, and calling for help using the call system, phone or call out for help.

A review of the Invacare User Manual for CS7 Series Beds revealed bed controls (pendant) were only to be placed in three ways:

1. on the pendant holster that is positioned between the top side rail bars
2. attached to the back of either side of the head end
3. attached to the bed linen via a pendant clip.

The User Manual further revealed improper installation and improper use of the bed control could cause harm. Extra cable should be routed and secured to the bed to prevent tripping hazards. Otherwise, injury may occur.

2 a. Resident #5 was admitted to the facility on 4/20/2015 with diagnoses that included dementia.

The quarterly Minimum Data Set (MDS) dated 12/29/22 assessed Resident #5 with severe cognitive impairment. She required extensive assistance with bed mobility, and total dependence with transfers and toileting. Resident #5 was a fall risk, non-ambulatory and required a wheelchair for mobility.

Resident #5's care plan dated 1/17/23 indicated

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F 689	Continued From page 24	F 689		

she was a fall risk due to use of prescribed psychotropic medication and required fall precautions with interventions that included assistance with transfers, wheelchair cushion, concave mattress, keep call bell within reach, monitor for side effects to medication and notify the physician as needed. Resident #5 had an Activities of Daily Care (ADL) deficit related to decreased mobility and difficulty processing needs. Interventions included use of bilateral side rails to aid in turning and positioning.

An observation on 1/27/23 at 4:48 PM revealed Resident #5 lying in bed. The bed control cord was wrapped around the side rail with the pendant dangling over the side rail. The pendant was not attached to the Velcro located on the side of the bed frame, or the pendant holder or head end.

2 b. Resident #6 was admitted on 3/10/22 with diagnoses that included receptive expressive language disorder, gout, and acid reflux.

The quarterly MDS dated 3/10/22 indicated Resident #6 had moderate cognitive impairment, required extensive assistance with bed mobility, transfers, and required total assistance with toileting.

A care plan dated 9/8/22 revealed Resident #6 was a fall risk due to weakness and need for assist with transfers for safety. Psychotropics and pain management had the potential for side effects that included the potential for a fall. The goal to minimize a fall risk through interventions that included anticipate and meet needs, two-person assist with transfers, be sure call light was within reach and call bell use was

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F 689	Continued From page 25 encouraged for assistance as needed. Resident #6 needed prompt response to all requests for assistance. An observation on 1/27/23 at 4:50 PM of Resident #6's bed control pendant which was attached to it cord revealed the bed control cord was wrapped around side rail several times, then tucked between the mattress and side rail, which allowed the bed control pendant to hang over the side rail. An interview with the Maintenance Director on 1/27/23 at 4:50 PM indicated Resident #6's bed control cord was tucked under her mattress and looped through the bed rail. He further indicated bed control cords were not to be wrapped around side rails according to the manufacturer's user manual because it was a hazard. An interview with the Administrator on 1/27/23 at 5:20 PM indicated he was unaware bed control cords were being wrapped around side rails. He educated staff on how to position the bed controls and how to remind residents that bed control cords could not be wrapped around side rails, according to the user manual. He further indicated he instructed staff to perform additional observations of resident rooms to assure bed control pendants were not wrapped around the side rails.	F 689		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data	F 867		3/2/23

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F 867	Continued From page 26	F 867		

collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions

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F 867	Continued From page 27	F 867		

aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The

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	345186	A. BUILDING _____ B. WING _____	C 02/02/2023

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F 867	Continued From page 28 number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions for F 689, Free of Accident Hazards, Supervision, Devices which were put into place because of the recertification and complaint investigation survey of 5/16/22. F 689, Free of Accident Hazards, Supervision, Devices was recited on the current complaint	F 867	Resident #1 was affected by the deficient practice and was discharged on 1/13/2023. Police/EMS were notified, MD and Family were notified and incident with Resident #1 was reported to State. Resident#5 and Resident#6 were observed by the surveyor as having their cords wrapped around the siderail(s). 1.29.2023, facility Staff were made aware of the surveyor’s observation. On	

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F 867	Continued From page 29 investigation survey of 2/2/23. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This tag is cross referenced to: F 689: Based on interviews with staff, Medical Director, Mental Health Nurse Practitioner (NP) and record review, the facility failed to provide close supervision of Resident #1 who was assessed as confused, impulsive, unsafe, with a history of falls and at risk for further falls. The facility failed to observe the condition of Resident #1 after an unwitnessed fall, report the observation to a nurse with any urgency, provide continuous monitoring after Resident #1 was found with his neck entrapped by a bed control cord and observed that his face was blue. Resident #1 was found on 1/13/23 after 7:00 PM by Nurse Aide (NA) #3 prone with his feet on the floor, but she did not enter the room to see his condition. Nurse #1 entered the room and found Resident #1 with his right side against his bed. His neck was entrapped by the bed control cord that was attached to the bed and the siderail. Resident #1 was left in this condition when Nurse #1 left the room to get help. Emergency Medical Services (EMS) was called on 1/13/23 and pronounced his death in the facility at 7:39 PM. This failure occurred for 1 of 8 sampled residents reviewed for supervision to prevent accidents (Resident #1). Additionally, the facility failed to store bed control cords per manufacturer recommendations for the prevention of tripping hazards for 2 of 8 sampled residents reviewed for supervision to prevent accidents (Residents #5	F 867	1.27.2023, the administrator was made aware that the facility would not be placed back into compliance related to observations of bed cords made by the surveyor. The facility was notified at that time of the surveyor's observation of resident# 6 and resident#7 in which she informed the maintenance director who corrected it immediately. On 1.29.2023, the administrator received notification of other observations of incorrect storage of cords that were made. Upon notification, Resident #5 and Resident #6 bed cords and room were observed by the administrator and were not noted to have cords wrapped around the siderails. Placement of these resident cords are being monitored utilizing the room rounding tool. Subsequently, resident #5 discharged 2.17.2023 On 1/16/2023 the facility's Quality Assurance and Performance Improvement (QAPI) committee met and performed root cause analysis. Based on the result of the root cause analysis, implemented procedures, and monitor the interventions to address Accident Hazards, Supervision and Devices. All residents assessed to be a falls risk, confused, impulsive and unsafe would be at risk for the same deficient practice cited for resident #1. On 1.29.2023 residents #5 and #6 were reviewed and observed by the Director of Nursing and were not identified being confused and impulsive and unsafe with the history of falls.	

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F 867	Continued From page 30 and #6). During the complaint investigation survey of 2/2/23, the facility failed to closely monitor Resident #1 who was assessed as confused, impulsive, unsafe and with a history of falls, observe the condition of Resident #1 after an unwitnessed fall, report the observation to a nurse with any urgency, provide continuous monitoring after Resident #1 was found with his neck entrapped by a bed control cord and observed that his face was blue. Resident #1 had an unwitnessed fall resulting in his death. F 689: Based on record review, observations and interview with staff, Medical Director, and the Nurse Practitioner the facility failed to increase supervision of Resident #57, knowing he had a history of removing his wanderguard (a device that triggers alarms and can lock monitored doors to prevent a resident from leaving unattended) device and failed to monitor the placement of Resident #57's wanderguard. On 3/17/22, he exited the facility without staff's knowledge and was found at the end of the parking lot near the road. Resident #57 was lying on the ground with his wheelchair behind him. He was not injured. 1 of 2 residents were reviewed for wandering behaviors. During the recertification and complaint investigation survey of 5/16/22, the facility failed to increase supervision of Resident #57 who had a history of wandering behavior and left the facility without staff's knowledge. During an interview with the Administrator and	F 867	On 2.21.2023, all current residents were observed and charts were reviewed utilizing Fall Risk evaluations, side rail evaluations and therapy evaluations (if applicable) to identify those with confusion and impulsiveness and unsafe due to history of falls. Those residents identified will be rounded when in their rooms utilizing the Safety: Room Rounding Tool. Information from the tool will be utilized to identify additional resident specific monitoring needs. Resident Care plans will be updated as necessary. The review was completed by the Director of Nursing and the other designer (s). 1.26.2023 education was completed with all staff regarding Safety, Resident monitoring, Responding to incidents and accidents by the Director of Nursing and or his/her designee. The education involved review and discussion of the policy for incidents and accidents and spoke specifically to in the event of an incident or accident, immediate assistance will be provided, or securement of the area will be initiated unless it places one at risk of harm. Examples provided during the discussion were if you thought there was an incident/accident staff would need to investigate. Staff were instructed to push the resident□s call light and or yell out for help to get immediate attention. A competency was developed 1.25.2023 to evaluate staffs□ compliance and level of understanding. The education and competency were added to new hire orientation 2.25.2023. On or by 03.2.2023, staff education	

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	345186	A. BUILDING _____ B. WING _____	C 02/02/2023

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F 867	Continued From page 31 Director of Nursing (DON) on 2/2/23 at 12:56 PM, they stated that they were not employees at the facility when the immediate jeopardy deficiency regarding elopement occurred on the 5/16/22 recertification and complaint survey. They stated the current concern related to accidents involved Nurse Aide (NA) #3 who did not check on Resident #1 after a fall and Nurse #1 left the Resident rather than calling for help from the room. The Administrator and DON stated that they were not familiar with the circumstances regarding the immediate jeopardy on the 5/16/22 survey to compare the two deficiencies. The Administrator stated that after he came on board, the 5/16/22 survey was discussed in the July 2022 QAPI meeting and then the discussion regarding the 5/16/22 survey dropped off the QAPI committee agenda. The Administrator stated the facility did not discuss incidents/accidents in the November QAPI committee meeting because there were no concerns at that time.	F 867	regarding observing, removing, and reporting of potential fall hazards as well as resident conditions that place them at risk for falls. The education includes placement of call lights and bed controls to prevent fall-related incidents and will be completed by the Director of Nursing and or other designee(s). 2/27/2023 the Administrator reviewed facility QAPI program and provided re-education to the QAPI committee members. On 2/21/ 2023 the Administrator and Director of Nursing updated the Room Monitoring Tool to include not only observation of proper placement of bed controls and call lights to reduce falls and fall related hazards but also to monitor and note resident specific behaviors to include confused, impulsive, unsafe and a falls risk and now titled the Safety Room Rounds Observation Tool. This tool will be used daily and will be utilized by the interdisciplinary management team and others as designated by the Administrator and Director of Nursing. On or by 3/2/2023 the interdisciplinary team was educated on the audit tool by the administrator. These audits will be done daily for 12 weeks. Staff education will be monitored by the Director of Nursing or designee (s) and will be reported to the QAPI committee meeting for 3 months for further resolution if needed. The result of the Room Monitoring Audit will be tracked and trended monthly by the	

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F 867	Continued From page 32	F 867	administrator and will be presented to the Quality Assurance Process Improvement Committee. Results of the audits will be reviewed at the QAPI Committee meeting for 3 months for further resolution if needed. The facility alleges compliance as of 3.2.2023.	