

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2026
NAME OF PROVIDER OR SUPPLIER Five Oaks Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 413 Winecoff School Road Concord, NC 28027	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations and staff interviews, the facility failed to remove expired medications stored in 2 of 3 medication rooms and 1 of 7 medication carts reviewed for medication storage (Medication Rooms for 200 and 300 halls and Medication Cart #3).The findings included:a. An observation of Medication Room for the 300 hall was conducted on 3/10/2026 at 12:22 PM in the presence of Nurse #2. The following medication was found in the medication room: one bottle of Jardiance 10 milligrams (mg) with 30 tablets (medication used to control blood sugar levels). The expiration date on the bottle was 2/17/2026. Nurse #2 confirmed the expiration date by reading aloud the date printed on the bottle. An interview with Nurse #2 was completed on 3/10/2026 at 12:25 PM. Nurse #2 reported the Unit Manager for the 300 hall would check the medication room weekly for expired medications.The interview conducted on 3/10/2026 at 12:27 PM with the 300 Hall Unit Manager revealed that she had been working at the facility for 2 months and needed to confirm with the Director of Nursing (DON) how often the Medication Room should be checked for expired medications. b. Nurse #2 remained present during the observation of Medication Cart #3 on 3/10/2026 at 12:47 PM. The observation revealed one box of Ocusoft eye cleanser wipes, 18 individually wrapped. The expiration date printed on the box was 10/2025. Nurse #2 confirmed the expiration date by reading aloud the date printed on the box. An interview with Nurse #2 on 3/10/2026 at 12:50 PM revealed that she was assigned to Medication Cart #3. Nurse #2 stated she checked her cart prior to each shift for expired medications and needed supplies. Nurse #2 reported she had checked Medication Cart #3 at the beginning of her shift but must have missed the box of eye cleanser pads. c. An observation of the Medication Room for the 200 hall was conducted on 3/10/2026 at 1:19 PM in the presence of Nurse #3. The following medication was found in the refrigerator: Promethegan 12.5 mg suppositories (medication used to treat nausea, vomiting, allergies, and for sedation) in a box containing 6 suppositories with the expiration date 1/2026. Nurse #3 confirmed the expiration date by reading aloud the expiration date printed on the box and suppositories. An interview with Nurse #3 was completed on 3/10/2026 at 1:22 PM. Nurse #3 stated that the unit managers are responsible for checking the medication rooms for expired medications weekly and a night shift nurse should check the medication room each night shift. Nurse #3 reported that if an expired medication was found, a return form should be completed and placed in return in for pharmacy to pick up on night shift. The interview conducted with the DON on 03/13/2026 at 12:48 PM revealed that each unit manager checks medication expiration dates weekly in the medication rooms and medication carts. The DON reported that nurses should check their medication carts prior to each shift and the night shift nurses are to check for expired medications in the medication rooms. The DON stated that medication expirations dates were checked because expired medications could lose their effectiveness or become more potent over time. An interview was completed on 3/13/2026 at 1:56 PM with the Administrator. The Administrator stated that he would refer</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 345186
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the DON for the process regarding staff checking for medication expiration dates.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, record review and Resident Representative (RR) and staff interviews, the facility failed to follow their infection control policy and procedures for Enhanced Barrier Precautions (EBP) by not wearing personal protective equipment (PPE) when providing high contact care for a resident with a peripherally inserted central catheter (PICC) line (flexible tube placed in a vein to administer medications) (Resident #7), a resident with a feeding tube (Resident #18), and a resident with a chronic pressure ulcer (Resident #24). This deficient practice occurred for 5 of 15 staff members observed for infection control practices (Nurse #1, Nurse #3, Nurse #4, Nurse Aide (NA) #1 and NA #3). The findings included:</p> <p>A review of the facility's policy titled Enhanced Barrier Precautions dated 7/26/2022, indicated:</p> <p>Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities.</p> <p>High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, Peripherally Inserted Central Catheter (PICC) lines, midline catheters, and wound care if deemed chronic by a medical provider or if MDRO was present.</p> <p>1. An observation of medication administration through a feeding tube for Resident #18, provided by Nurse #1, was made on 3/11/2026 at 2:13 PM. Resident #18's room had an Enhanced Barrier Precautions (EPB) sign posted at left side of the front door. A sign indicating Enhanced Barrier Precautions (EBP) was posted on the left side of Resident #18's doorway, stating that gloves and a gown must be worn when providing high?contact care, such as care involving a feeding tube. The personal protective equipment (PPE) was located across the hall in a white plastic bin with four drawers. Nurse #1 entered the room without wearing a gown. She cleansed hands with hand sanitizer gel and put on gloves. After completing medication administration via Resident #18's feeding tube, she cleaned and stored the medication administration syringe, then proceeded to wash her hands with soap and water at the sink.</p> <p>An interview with Nurse #1 on 3/11/2026 at 2:20 PM revealed she was aware that Resident #18 was on Enhanced Barrier Precautions. Nurse #1 stated that the EBP sign had check marks next to the required PPE needed were hand sanitizer and gloves. There was no check mark next to the gown. Nurse #1 stated that after reviewing the EBP sign, she realized she should have worn a gown while providing care for Resident #18's feeding tube. She explained after reading the sign, that the check marks were intended as bullet points for the EBP information, not as indicators of which PPE items were required.</p> <p>The interview conducted on 3/12/2026 at 2:34 PM with the Infection Preventionist (IP) revealed she provided training on Enhanced Barrier Precaution to all staff during orientation and throughout the year as needed and quarterly. She also reported she completed audits with staff quarterly to assess hand hygiene and donning PPE. The IP stated that Nurse should have worn gown and gloves when administering medications for Resident #18. The IP also reported that Nurse #18 should have used the EBP sign and previous infection control training to determine the correct PPE needed for residents on EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Director of Nursing (DON) was completed on 3/13/2026 at 12:23 PM. The DON stated that Nurse #1 should have worn a gown and gloves when administering medications through Resident #18's feeding tube.</p> <p>An interview with the Administrator was completed on 3/13/2026 at 1:30 PM. The Administrator stated he expected all staff members to use the appropriate PPE according to the enhanced barrier signs posted for each resident.</p> <p>2. A review of the facility's policy titled Enhanced Barrier Precautions dated 7/26/2022, indicated:</p> <p>Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities.</p> <p>High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, Peripherally Inserted Central Catheter (PICC) lines, midline catheters, and wound care if deemed chronic by a medical provider or if MDRO was present.</p> <p>An observation was conducted on 3/09/26 at 2:43 PM of Nurse #3, Nurse #4 and NA #1 entering Resident #7's room wearing gloves to transfer him from the wheelchair into bed using the mechanical lift. Nurse #4, Nurse #3 and NA #1 completed the transfer and Resident #7 was lowered into bed. NA #1 and Nurse #4 assisted Resident #7 with rolling to his right side to remove the lift pad, Nurse #4 placed it into a plastic bag and removed it from the room. Nurse #4, Nurse #3 and NA #1 were not wearing gowns while transferring Resident #7.</p> <p>A follow up observation and interview were conducted on 3/09/26 at 3:20 PM with Resident #7 and the Resident Representative (RR). Resident #7 was lying in bed with a sheet covering him from the waist down, but he was not wearing a shirt. Resident #7 was observed to have a PICC line with a single lumen catheter on the upper right side of his chest covered with a clear dressing. The RR stated Resident #7 was receiving antibiotics once a day through the PICC line to treat endocarditis (infection of the heart valve). There was no EBP signage posted inside or outside of Resident #7's room.</p> <p>An interview conducted with Nurse #3 on 3/10/26 at 1:19 PM revealed she was assigned to Resident #7 on 3/09/26 from 7:00 AM to 7:00 PM. She stated Resident #7 was admitted to the facility with a PICC line and was receiving IV antibiotics. Nurse #3 revealed she wore a gown and gloves when administering medication or providing any care related to the PICC line however she was not prompted to don a gown when she assisted with transferring Resident #7 because there was no EBP signage posted outside of his room. Nurse #3 indicated transferring a resident was considered a high contact care activity and she should have donned a gown prior to entering Resident #7's room.</p> <p>An interview was conducted with Nurse #4 on 3/10/26 at 1:25 PM. Nurse #4 stated she was not assigned to Resident #7 when she worked on 03/09/26 and was not aware he had a PICC line in place. Nurse #4 indicated Nurse #3 requested her assistance with transferring Resident #7 but there was no EBP signage posted outside of his room to prompt her to don a gown. Nurse #4 revealed that transferring a resident was considered high contact care and she would have donned a gown for a resident that was on EBP prior to entering the room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with NA #1 on 3/13/26 at 8:00 AM she revealed she was not assigned to Resident #7 on 3/09/26 but Nurse #3 requested her assistance to transfer him using the mechanical lift. NA #1 indicated she relied on the EBP signage posted outside of resident's room to know what PPE she needed to wear when providing care. NA #1 revealed there was no EBP signage posted outside of Resident #7's room but if it was, she would have donned a gown prior to entering the room and assisting with the transfer.</p> <p>An interview was conducted with the Infection Preventionist on 3/12/2026 at 2:46 PM. She stated during the morning clinical meeting new admissions were discussed including if they had a catheter, feeding tube, PICC line and/or wounds. The Infection Preventionist revealed she was responsible for identifying when a resident should be placed on EBP, obtaining the physician's order and posting the signage outside of their room. She stated Resident #7 should have been placed on EBP due to having a PICC line but somehow it was overlooked and she did not obtain the order or post the signage outside of his room. The Infection Preventionist revealed Nurse #4, Nurse #3 and NA #1 should have donned a gown prior to entering Resident #7's room and assisting with the transfer</p> <p>An interview was conducted with the Director of Nursing (DON) on 3/13/26 at 9:07 AM. She stated the Infection Preventionist was responsible for identifying residents that required EBP, obtaining the physician's order and posting the signage. The DON indicated when a resident was on EBP staff were required to wear a gown and gloves prior to entering the room to provide high contact care which included transfers. She stated due to Resident #7 having a PICC line he should have been placed on EBP when he was admitted to the facility and signage should have been posted outside of his room. The DON revealed Nurse #3, Nurse #4 and NA #1 should have donned a gown and gloves prior to entering Resident #7's room and assisting with the transfer.</p> <p>3. A review of the facility's policy titled Enhanced Barrier Precautions dated 7/26/2022, indicated:</p> <p>Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities.</p> <p>High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, Peripherally Inserted Central Catheter (PICC) lines, midline catheters, and wound care if deemed chronic by a medical provider or if MDRO was present.</p> <p>An observation and interview was conducted with Resident #24 on 3/9/2026 at 10:45 AM. Two empty intravenous (IV) antibiotic bags were observed hanging by the bedside. Resident #24 stated that she had an infection and a wound on her buttocks. Resident #24 reported she received the IV antibiotic medication at night. When asked how she was given the medication, Resident #24 pulled down the neckline of her gown and revealed a central line catheter (a long flexible tube inserted into a large vein leading to the heart for intravenous access) in her chest with an intact dressing and stated, I have this.</p> <p>An observation conducted on 3/10/2026 at 1:23 PM noted Nurse Aide (NA) #3 entering Resident #24's room carrying a pair of gloves. Resident #24's room had an Enhanced Barrier Precautions (EBP) sign posted to the right side of the door and personal protective equipment (PPE) was located outside of</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>the door in a plastic 2-drawer storage container. The EBP sign indicated that everyone must clean their hands before entering and leaving the room. The sign went on to state that all healthcare personnel must wear gloves and a gown for the following high contact resident care activities: dressing/bathing/showing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care for any skin opening requiring a dressing. NA #3 was not wearing a gown. NA #3 was observed after several minutes walking around the end of Resident #24's bed. NA #3 was wearing gloves but continued care without donning a gown. NA #3 was observed walking to Resident #24's closet and obtaining an item from the closet, returned to the bedside and was not wearing a gown. Upon completion of care for Resident #24, NA #3 exited the room wearing gloves and carrying a clear bag of trash.</p> <p>An interview with NA #3 was conducted on 3/10/2026 at 1:40 PM as she exited Resident #24's room. NA #3 was shown the Enhanced Barrier Precautions sign and asked what it meant. NA #3 stated she was aware Resident #24 was on Enhanced Barrier Precautions due to open wounds and infections. NA #3 stated a gown was only required when performing dressing changes.</p> <p>An interview was conducted 3/12/2026 at 1:30 PM with the Infection Preventionist. She stated that NA #3 should have worn both gloves and a gown when entering the room to provide high contact care to Resident #24 due to Resident #24's open wounds on her sacrum and current infections. The Infection Preventionist indicated that the Enhanced Barrier Precaution sign was posted next to the door and NA #3 had received training on Enhanced Barrier Precautions during orientation when hired and yearly through online training modules.</p> <p>An interview on 3/13/2026 at 12:44 PM with the Director of Nursing (DON) revealed Resident #24 had open wounds, infections, and a central line. Due to Resident #24 requiring Enhanced Barrier Precautions for these conditions, NA #3 should have worn both gown and gloves when she provided care to Resident #24.</p> <p>An interview was conducted on 3/13/2026 at 1:55 PM with the Administrator. The Administrator stated he expected staff to wear the required PPE when providing care to residents on Enhanced Barrier Precautions.</p>		