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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forrest Oakes Healthcare Center	620 Heathwood Drive Albemarle, NC 28001

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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review, observations, and staff and Nurse Practitioner interviews, the facility failed to keep a urinary catheter bag and its tubing from touching the floor to reduce the risk of infection for 1 of 3 residents (Resident #33) reviewed. Findings included: Resident #33 was admitted to the facility on [DATE]. A Physician's Order dated 10/11/2024 indicated Resident #33 required an indwelling urinary catheter. A quarterly Minimum Data Set assessment dated [DATE] indicated he was cognitively intact and had an indwelling urinary catheter. Resident #33's Care Plan dated 3/8/2025 indicated he had an indwelling suprapubic urinary catheter. During an observation of Resident #33 on 3/12/2025 at 9:45 am he was found to be in bed and his urinary catheter drainage bag was lying on the floor beside his bed. There was no hook on the urinary catheter bag to attach it to the bed frame. Nurse Aide #1 came to the room and emptied Resident #33's urinary catheter bag and stated she would get the Unit Manager to replace the urinary catheter bag so that she could secure it to the bed and off of the floor. During an interview conducted on 3/12/2025 at 1:03 pm with the Unit Manager, who was the nurse assigned to Resident #33. She stated Resident #33 was seen by the Urologist on 3/6/2025 and his catheter, catheter tubing and urinary catheter bag were changed at the appointment. The Unit Manager stated she went to the room this morning after Nurse Aide #1 told her the bag was on the floor and changed the urinary catheter bag. The Unit Manager stated the staff should have changed his urinary catheter bag to ensure it could be hung from his bed instead of resting on the floor. An interview was conducted by phone with the Nurse Practitioner on 3/12/2025 at 5:40 pm and she stated Resident #33's urinary catheter bag should not have been on the floor. The Nurse Practitioner stated Resident #33 was verbal and was cognitively intact and could let staff know if he was having any abdominal pain or urgency. She stated since he did not have any complaints related to his catheter, she did not feel Resident #33 was harmed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Forrest Oakes Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Heathwood Drive Albemarle, NC 28001	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing was interviewed on 3/12/2025 at 4:57 pm and she stated Resident #33's urinary catheter should not have been on the floor to prevent the increased risk of infection. During an interview with the Administrator on 3/12/2025 at 5:06 pm she stated Resident #33's urinary catheter bag should not have been on the floor.