DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	COMF	E SURVEY PLETED
		345477	B. WING _				C / 25/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	20,2010
				3	864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			Α	RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157 SS=D			F	157			10/23/15
	consult with the resid known, notify the resi or an interested famil accident involving the injury and has the por intervention; a signific physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a ne existing form of treath consequences, or to	nent due to adverse commence a new form of ion to transfer or discharge					
	and, if known, the res or interested family m change in room or roo specified in §483.15(resident rights under regulations as specifi this section.	Federal or State law or ed in paragraph (b)(1) of					
	the address and phor	rd and periodically update ne number of the resident's r interested family member.					
	This REQUIREMENT	is not met as evidenced					
	Based on record rev facility failed to notify	ew and staff interviews, the the physician to obtain in unstageable pressure			Preparation and/or execution of this pl of correction do not constitute admission or agreement by the provider with the		
	ically Signed	SUPPLIER REPRESENTATIVE'S SIGNATUR	(E		TITLE		(X6) DATE 10/16/2015

Electronically Signed

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.

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED		
			A. BOILDING			С		
		345477	B. WING			09/25/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE				
				3864 SWEETEN CREEK ROAD				
THE OAK	S AT SWEETEN CREEK			ARDEN, NC 28704				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE		
F 157	Continued From page	e 1	F 15	7				
		ly admitted resident for 1 of	1 13	statement of deficience	ries. The plan of			
		for notification of changes		correction is prepared				
	(Resident #153).			because it is required				
				Federal and State reg				
	The findings included	1:						
				Resident #153 did ha				
	Resident #153 was a	-		obtained by the Direc				
		ses which included severe mellitus, catatonia, and		Services for treatmen pressure ulcer on 9/2	•			
	anxiety.			has been receiving tre				
				by the physician since				
	A review was conduc	ted of a nursing admission						
	assessment dated 09	9/21/15 at 5:30 PM. Nurse		Newly admitting resid				
	-	ment with a notation she		potential to be affecte				
		ctions of the assessment.		alleged deficient prac	tice.			
		cumentation in the nursing		Current residents, inc	lucivo of powly			
	(cm) by 2 cm opening	nt included a 3 centimeter		admitted residents, h				
	described as a press			assessment complete				
		mission nurse's note the		by the Minimum Data				
	"decub" on the buttoo	cks measured 3 cm by 2 cm.		and Wound Nurse to				
	Further documentation	on specified the area was		prior, or currently ider	ntified skin			
		saline and a dressing		impairments, had app				
	applied. No other inf regarding the pressu	ormation was provided re ulcer.		treatment orders and/ obtained for treatmen				
		#153's medical record on		The Director of Clinica				
		physician's order for		education to licensed				
	-	sure ulcer was provided.		regarding the notificat				
		rse on Resident #153's hall Irse was interviewed at 1:19		to obtain treatment or admitted resident with	• •			
		se #1 was unaware of any		impairment, or for any				
		ing Resident #153. Nurse		who develops skin im				
		ere no treatment orders for		treatment. Newly hir				
	wound care in the res	sident's medical record or on		will receive education	upon hire. Licensed			
	the resident's treatme	ent administration record.		Nurses will notify the				
				and responsible party	-			
		/23/15 at 3:28 PM, the		of skin impairment, ar				
	Director of Nursing (L	DON) confirmed Resident		orders as indicated ar	na document			

Facility ID: 923157

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345477	B. WING				C 25/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE OAK	S AT SWEETEN CREEK				864 SWEETEN CREEK ROAD RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 157	 #153 was admitted wi ulcer. The DON state on this day. She state cm by 2 cm and the b covered in yellow slou admission nurse shou physician of this wour the nurse's admission added a treatment or obtained from the phy found. An interview was cone 09/23/15 at 3:46 PM. Resident #153's nurse on 09/21/15. Nurse # wound and document resident had a pressu explained she intendet treatment order from the state on the state of the state of the state on the state of the sta	th an unstageable pressure ed she assessed the wound ed the wound measured 3 ase of the wound was ugh. The DON stated the uld have notified the nd when it was found during assessment. The DON der should have been visician when the wound was ducted with Nurse #2 on Nurse #2 stated she did e's admission assessment f2 stated she did assess the in her notes that the re ulcer. Nurse #2 ed to obtain a wound the physician who was e facility the following day,	F	157	notification in the medical record. The Director of Clinical Services/Nurse Manager will conduct Quality Improvement Monitoring of residents to ensure that any necessary treatment orders were obtained timely for any identified skin impairments. Quality Improvement Monitoring will be conduc 5 times weekly for 4 weeks, then 3 time weekly for 4 weeks, then 2 times week for 4 weeks, then 1 time weekly for 12 weeks, and/or until substantial complia is obtained using a sample size of 5 residents. The results of the Quality Improvement Monitoring will be reported to the Qual Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Nurse Manager for si months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectivened of the monitoring/observation tool for maintaining substantial compliance, and make changes to the corrective action necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Execut Director, Director of Clinical Services, Medical Director, Pharmacy Consultant Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessme Nurse.	cted es ly ince t lity x ess if if tive t,	

Facility ID: 923157

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		D HUMAN SERVICES MEDICAID SERVICES				APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE	JRVEY
		345477	B. WING		C 09/25	/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) COMPLETION DATE
F 157 F 242		2 3 ERMINATION - RIGHT TO	F 15	Date of Completion: October 23, 2015		0/23/15
	schedules, and health her interests, assess interact with members inside and outside the about aspects of his of are significant to the r This REQUIREMENT by: Based on record revi interviews the facility smoking policy that di	is not met as evidenced ews and resident and staff		Resident #14 no longer resides at the facility Resident #149¿s care plan and safe		
	without supervision and for 2 of 4 sampled resist smokers (Resident #7 The findings included The facility Smoking F provided by the Direct Policy: The Company non-smoking facility, local regulations. Resist admission that the fact or allowed to smoke of and that they must act Each resident will be quarterly to determine smoker. Procedure: Residents will be evaluations	nd at non-designated times sidents deemed safe [4, #149). Policy dated 11/30/2014 tor of Nursing (DON) read: facilities are an established unless allowed by state and idents are notified on cility is a non-smoking facility only in designated areas, lhere to the Smoking Policy. assessed on admission and e if the resident is a safe		 Resident #1492's care plan and sale smoking evaluation was completed by licensed nurse on 10/15/15 to reflect the resident is current smoking status and ability. Other residents who smoke are at risk the alleged deficient practice. The Director of Clinical Services (DCS) reviewed residents who smoke by 10/15/15 to determine their individual ability to safely smoke. The DCS creat a isk that is kept at the nurses station to aler staff of the each residents designation are either a safe smoker allowed to smoke without supervision or assistance, or ar unsafe smoker requiring assistance by staff. The DCS posted the staff-assister smoking times for those residents who 	e of eed t as	

Facility ID: 923157

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		· · ·	MPLETED
						С
		345477	B. WING		0	9/25/2015
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
				3864 SWEETEN CREEK ROAD		
INE UAN	S AT SWEETEN CREEK			ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 242	Continued From page	e 4	F 24	2		
		afe or unsafe smokers.		have been identified as ur	nsafe. Facility	
		lish Smoking Times for		smokers have a posting in	•	
		will post the Smoke Times		indicating the times that the		
		. The posting will also be		provide staff assistance for		
	present in the room o	f each resident who is		smokers. The Director of	Clinical	
	identified as a smoke			Services/ Social Services		
		supervise smoke times for		responsible for updating the	-	
		pervision. The facility will		Smokers; list with any ch		
	posted smoke times.	of who will supervise the		resident smoking designation safe or unsafe requiring at		
	•	wed to smoke without		sale of unsale requiring a	5515101100.	
		e deemed appropriate by the		Newly admitting residents	choosing to	
		okers will wear smoking		smoke will be evaluated u	-	
	aprons while smoking	-		and then at least quarterly		
		ity smoking policy revealed it		utilizing the Admission and		
		afe smokers. The policy		Collection tool and the Sa	fe Smoking	
	violated the safe smo	-		Evaluation. Any resident		
	whenever they wante			be evaluated as needed in		
		n 09/25/15 at 4:24 PM the		quarterly, and the determi		
		/ledged the facility smoking		assessment may render c	•	
		tiate between safe and Administrator stated she did		existing classification of ei Unsafe Smoker requiring		
		ing meant the resident had		Residents will be re-evalu		
		whenever they wanted.		observation/report of unsa	• •	
		admitted to the facility on			5	
	06/23/15 with diagnos	ses of hypertension,		The Executive Director re-	educated	
	diabetes, fracture and			current facility staff on res		
		The significant change		self choice by 10/16/15. T		
	Minimum Data Set (M	•		Clinical Services reeducat		
		4 was cognitively intact and		Managers and Licensed N	•	
	transfers, dressing, to	sistance with bed mobility,		10/16/15 regarding the fac and evaluation for determ	•	
	hygiene.			Smokers, and on the com		
		an dated 06/30/15 revealed		Admission/Readmission a		
	-	e potential for injury related to		Data Collection Tools, and		
		is included safe smoking		Smoking Evaluation. The		
		ssion and quarterly. Instruct		Clinical Services educated		
	the resident on smok	ing protocol, keep smoking		10/16/15 on the ¿Residen	• •	
	materials locked at nu	urso's station Drovido		posted at the nurses static	on to oncuro	

Facility ID: 923157

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE). 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		` '	LETED
						С
		345477	B. WING			25/2015
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				3864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 242	Continued From page	5	F 24	2		
1 212			F 24		nation of	
	designated area for s	safe smoking. Provide		staff understanding of the desig either Safe or Unsafe Smoker.		
		vised smoking times.		Smoker designation will allow the		
		ing non-smoking times.		freedom of choice to smoke at t		
		g Admission Assessment		prefer without supervision. A de		
		safety revealed Resident		of Unsafe Smoker will require s	-	
	#14 was a safe smok			assistance at designated times		
	occasionally.	er and only shoked		posted at the nurses station and		
		onducted on 09/25/15 at		residents room that chooses to		
		4 stated she began smoking		Education also included the fac		
		admitted to the facility		designated area for smoking an	-	
	•	sit outside and socialize with		utilization of safety devices such		
		the stated there had been		smoking aprons. Newly hired fa		
		ed to smoke and couldn't		will be educated upon hire.	donity otan	
		for the supervised smoking				
	-	ie was a safe smoker.		Licensed Nurses and Departme	ent	
		s interviewed on 09/25/15 at		Managers will assess any reside		
		nistrator stated a smoking		wishing to smoke upon admission		
		pleted upon admission and		readmission, at least quarterly,		
	residents were inform			any change in condition or repo		
		It the nursing station. The		unsafe smoking. Those resider		
	-	she expected staff to visually		are assessed to be safe smoke		
		ke when completing the		allowed to smoke as they desire		
		. She stated all smokers,		deemed appropriate per their ca		
		set staff supervised smoking		Those residents who are asses		
		ator stated since the facility		unsafe smokers will be provided		
		noking she thought it was at		staff supervised smoking period		
		e all residents supervised		provided assistance at those tin		
	during smoke breaks	-		staff member.	,	
		s admitted to the facility on				
		ses of right leg fracture,		The Director of Clinical Services	s/Nurse	
		muscle weakness. The		Manager/Executive Director/ Sc		
		Data Set (MDS) dated		Services Director/Activity Direct		
	08/31/15 revealed Re	esident #149 was cognitively		conduct Quality Improvement N		
	intact and required lir			of residents who smoke to valid	-	
	transfers, toileting an			compliance that each resident is	s provided	
		an dated 09/01/15 revealed		freedom of choice in regards to		
		e potential for injury related		independence with smoking as	deemed	
	to smoking. Intervent		1	appropriate per the residents ca		1

Facility ID: 923157

If continuation sheet Page 6 of 39

STATEMENT OF AND PLAN OF NAME OF PR THE OAKS (X4) ID PREFIX		MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391	
THE OAKS (X4) ID PREFIX		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED	
THE OAKS (X4) ID PREFIX		345477	B. WING		C 09/25/2015	
(X4) ID PREFIX	OVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
(X4) ID PREFIX	AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD		
PREFIX	AT SWEETEN OREER			ARDEN, NC 28704		
TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
	the resident on smoki materials locked at nu designated area for s Monitor for continued scheduled staff super Redirect resident duri Review of the Nursing dated 08/24/15 under #149 was assessed a During an interview cc 4:05 PM with Resider like to go out and smo He stated he did not I smoke breaks. The Administrator wa 10:16 AM. The Admin assessment was com residents were inform materials were kept a Administrator stated s watch a resident smo smoking assessment safe and unsafe had times. The Administrator didn't have to offer smo	ssion and quarterly. Instruct ing protocol, keep smoking urse's station. Provide moking for residents. safe smoking. Provide vised smoking times. g Admission Assessment safety revealed Resident as a safe smoker. onducted on 09/25/15 at nt #149 revealed he would oke whenever he wanted to. ike having to wait for the s interviewed on 09/25/15 at nistrator stated a smoking upleted upon admission and hed that all smoking t the nursing station. The she expected staff to visually ke when completing the . She stated all smokers, set staff supervised smoking ator stated since the facility moking she thought it was at re all residents supervised	F 24	 and individualized results of the Safe Smoking Evaluation. Quality Improvement Monitoring will be cond 5 times per week for 4 weeks, 3 time week for 4 weeks, 2 times per week weeks, and then 1 time per month for months using a sample size of 5 residents. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Social Services Director of Clinical Services/Social Services Director of tor six months and/or until substantiat compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effective of the monitoring/observation tool for maintaining substantial compliance, a make changes to the corrective action necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Exe Director, Director of Clinical Services Medical Director, Pharmacy Consultat Social Services Director, Activities Director, Maintenance Director, Dietat Director, and Minimum Data Assessin Nurse. 	lucted s per for 4 r 3 ent iality nt f ector i nt ness and in if cutive s, ant, ary ment	
	483.15(h)(2) HOUSE MAINTENANCE SER		F 25	Date of Completion: October 23, 20	15 10/23/15	
		ide housekeeping and s necessary to maintain a				

Facility ID: 923157

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345477	B. WING				C 25/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT SWEETEN CREEK		3864 SWEETEN CREEK ROAD				
	ARDEN, NC 28704						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From page sanitary, orderly, and		F	253			
	by: Based on observation facility failed to mainta environment in one react The findings included 1. a. Observations in 3:15 PM revealed React had raised, dried, white across the entire surfact nickel sized, dried or corner of the table top could be scraped off of dried orange spill was Observations of Resid 09/23/15 at 12:25 PM white crusty matter so surface of the table top orange colored spills top. The white crusty using a fingernail and sticky. Resident #61 her lunch tray a short placed on the overbeat Subsequent observat and 11:25 PM revealed crusty matter scattered of the table top and 2 colored spills at one of	room 207 on 09/22/15 at sident #61's overbed table te crusty matter scattered ace of the table top and 2 ange colored spills at one b. The white crusty matter using a fingernail and the s sticky. dent #61's overbed table on revealed a raised, dried, cattered across the entire op and 2 nickel sized, dried at one corner of the table matter could be scraped off the dried orange spill was was observed eating from time later which had been d table. ions on 09/24/15 at 8:37 AM ed a raised, dried, white ed across the entire surface nickel sized, dried orange corner of the table top. The			Resident #61's room was inspected a thoroughly cleaned by housekeeping of 9/24/15 and will continue to be cleaned routinely per the facility cleaning scheo Residents residing at the facility are at of the alleged deficient practice. The housekeeping supervisor completed a inspection of resident living areas and completed an Environmental Safety Survey on 9/25/15 to ensure facility cleanliness. Any areas identified as needing cleaning were immediately addressed by housekeeping services to provide for a clean, sanitary, orderly, a comfortable interior, at that time. The Housekeeping Supervisor reeduce current housekeeping staff regarding to policy to maintain a clean living environment for residents, and compliance with the cleaning schedule 9/25/15. Newly hired housekeeping st will be educated upon hire. Housekeeping staff will complete clear duties per the cleaning schedule to ensure compliance with facility cleanliness.	n dule. risk n o nd ated he by aff hing	
	colored spills at one of white crusty matter co	-				-	

Facility ID: 923157

	F DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TID	LE CONSTRUCTION	(V2) P	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	OMPLETED
			A. BOILDING			С
		345477	B. WING			09/25/2015
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD		
THE UAK	SAI SWEETEN CREEK			ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 253	Continued From page	N Q	Г. ОБ	2		
1 200		e shared bathroom for room	F 25		and conitany	
		15 PM revealed a dried		living areas to ensure a clean environment. Quality Improve	-	
		ately 1/2 inch wide on the		Monitoring will be conducted		
		e toilet. The dried, brown		weekly for 4 weeks, then 3 tin		
		p of the toilet base just		for 4 weeks, then 2 times wee		
	below the toilet seat a	and extended down to the		weeks, then 1 time weekly for	12 weeks,	
	caulking at the floor.			and/or until substantial compl		
				obtained using a sample size	of 10	
		ions on 09/23/15 at 12:25		resident areas.		
		1:25 AM revealed the				
		room 207 had a dried brown		The results of these Quality Ir		
	• • •	/2 inch wide on the front of The dried, brown stain		Monitors will be reported to th Assurance Performance Impr	-	
		ne toilet base just below the		Committee monthly by the Ex		
	-	led down to the caulking at		Director for six months and/or		
	the floor.			substantial compliance is obta		
				Quality Assurance Performan		
	c. Observations of th	e heating/air conditioner unit		Improvement Committee will	evaluate the	
		/15 at 3:15 PM revealed 2		effectiveness of the		
		nge colored spills on the		monitoring/observation tool fo		
	•	lose to the wall and 2 large		maintaining substantial compl		
		pencil eraser on top of the		make changes to the correctiv		
	vent.			necessary to obtain substantia		
	Subsequent observat	ions on 09/23/15 at 12:25		compliance. The Quality Ass Improvement Committee men		
	-	1:25 AM revealed the		consist of, but not limited to, t		
		r unit had 2 dime sized,		Director, Director of Clinical S		
	-	spills on the right side of the		Medical Director, Pharmacy C		
		and 2 large crumbs the size		Social Services Director, Activ		
	of a pencil eraser on	top of the vent.		Director, Maintenance Director Director, and Minimum Data A	-	
	An interview was con	ducted with the		Nurse.		
	Housekeeping Accou					
		. The HM stated there were		Date of Compliance: October	23, 2015	
		scheduled to work daily from				
		The HM explained the				
	-	he common areas first and				
	then work together to	clean all the resident rooms				

Facility ID: 923157

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345477	B. WING				25/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE OAK	S AT SWEETEN CREEK				1864 SWEETEN CREEK ROAD ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	housekeeper cleaned assigned hall. The H were expected to clea surfaces in the room a overbed table, heating the base of the toilet of An interview with Hou 1:39 PM revealed the completed cleaning in for the day. Houseke always 3 housekeeper cleaned three rooms halls at the beginning #1 further stated her of dusting, emptying the with a cleaning produ toilet seat, and the ba them down with a cloa she had not cleaned in not recall if she had c week. On 09/24/15 at 1:41 F accompanied to room Resident #61's overb conditioner unit, and t shared bathroom and acceptable and would The HM could not exp room 207 had not bee 09/23/15, or 09/24/15 Housekeeper #2 had and she had already I An interview with Hou 10:15 AM revealed her routine included dusti	the resident rooms on their M stated the housekeepers an all vertical and horizontal and bathroom including the g/air conditioner unit, and every day. sekeeper #1 on 09/24/15 at housekeepers had all of the resident rooms eper #1 stated there were ers scheduled and they apiece on the 200 and 500 of the shift. Housekeeping daily routine included high trash, spraying surfaces ct including table tops, the se of the toilet then wiping th. Housekeeper #1 stated room 207 today and could leaned it any other day this PM the HM was 207 and observed ed table, the heating/air the base of the toilet in the stated it was not all be cleaned immediately. Dain how these areas in en cleaned on 09/22/15, . The HM stated he thought cleaned room 207 that day	F	253			

Event ID: IPPE11

Facility ID: 923157

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345477	B. WING			25/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE OAKS	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	wiping down the toilet Housekeeper #2 state problems and could n room 207 this week. During an interview of Administrator expected residents' room to be	including the base. ed she had memory ot recall if she had cleaned n 09/24/15 at 2:04 PM the	F 25	53		
F 281 SS=D	heating/ air conditione 483.20(k)(3)(i) SERV PROFESSIONAL ST/ The services provided	er units. ICES PROVIDED MEET	F 28	11		10/23/15
	by: Based on record revi facility failed to docun percentage of a nutrit	ional supplement as ordered of 5 residents (Resident		Resident #95 received a clarification order on 9/23/15 from the physician to discontinue recording of percentage consumed and to change the type of supplementation. Residents with physician orders for die	tary	
	with diagnoses which debility, diabetes mell A care plan updated 0 #95 with weight fluctu specified the resident adequate nutritional s within 215 to 225 pou	itus, and dementia. 02/05/15 identified Resident ation. The care plan goal would maintain an tatus by maintaining weight nds. Intervention included RD) to evaluate and make		supplementation with documented consumptions are at risk for the alleged deficient practice. The Director of Clini Services completed a review of resider with dietary supplement orders by 10/7/2015 to ensure accurate order transcription onto the Medication Administration Record. Any discrepan- identified was reported to the physician with order clarification obtained and Medication Discrepancy Report completed by the licensed nurse, at that	ical hts cy	

Event ID: IPPE11

Facility ID: 923157

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/21/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345477	B. WING		C 09/25/2015
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE OAKS	S AT SWEETEN CREEK			864 SWEETEN CREEK ROAD \RDEN, NC 28704	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 281	Continued From page	e 11	F 281		
	A guarterly Minimum	Data Set (MDS) dated		time.	
	08/04/15 indicated the moderately impaired. Resident #95 was on weighed 199 pounds. A review of Resident a revealed a note written note specified the RD centimeters (cc) of a libe offered twice a day loss. The note also s percentage of the sup Continued medical re physician's order writt specified to administe supplement twice a day percentage consumed A review of Resident a Administration Record through 8/31/15 reveat initialed as administer The percentage of su documented 6 times. documentation of com other 26 times the sup	 e resident's cognition was The MDS specified a therapeutic diet and #95's medical record in 08/07/15 by the RD. The recommended 60 cubic liquid nutritional supplement y related to recent weight pecified to document the oplement consumed. cord review revealed a ten 08/11/15. The order er 60 cc of a liquid nutritional ay and document the d. #95's Medication d (MAR) dated 08/01/15 aled the supplement was red twice a day for 15 days. pplement consumed was 		The Director of Clinical Services reeducated licensed nurses regarding accurate transcription of supplement orders onto the Medication Administra Record and documentation of administration per physician orders including recording percent consumed indicated by 10/5/15. Newly hired nur will be educated upon hire. The Director of Clinical Services and/ Nurse Supervisor will review residents validate that nurses are administering transcribing, and documenting dietary supplements per physician orders. Director of Clinical Services and/or Ne Supervisor will conduct Quality Improvement Monitoring 3 times per for four weeks, 2 times per week for 4 weeks, then 1 time per week for 4 we and then 1 time monthly for three mon The results of Quality Improvement Monitoring will be reported to the Qua Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Nurse Manager for months and/or until substantial compliance is obtained. The Quality	ation d, if rses or s to l, , urse week k eks, nths.
	09/24/15 at 2:21 PM. physician's order for t written on the MAR in	tage consumed. ducted with Nurse #1 on Nurse #1 confirmed the he nutritional supplement istructed to document the ment consumed. She		Committee will evaluate the effectiver of the monitoring/observation tool for maintaining substantial compliance, a make changes to the corrective action necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members	ind

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		ND HUMAN SERVICES			PRINTED: 10, FORM APP	ROVE
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OMB NO. 093 (X3) DATE SURV COMPLETED	EY
		345477	B. WING		C 09/25/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3864 SWEETEN CREEK ROAD		
THE UAK	S AT SWEETEN CREEK			ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE CON	(X5) IPLETION DATE
F 281	Continued From page	e 12	F 28	1		
	stated she did admin Resident #95 but forg percentage consume supplement. An interview was con Nursing on 09/24/15 documenting the perc consumed by the res givers to be able to e the supplement. The of intake of the nutriti have been document An interview was con 09/24/15 at 2:57 PM. had administered the Resident #95. She a	ister the supplement to got to document the d each time she offered the ducted with the Director of at 2:22 PM. She explained centage of supplement ident allowed other care valuate the effectiveness of DON stated the percentage onal supplement should		 consist of, but not limited to, the Director, Director of Clinical Serv Medical Director, Pharmacy Cor Social Services Director, Activiti Director, Maintenance Director, Director, and Minimum Data Ass Nurse. Date of Completion: October 23 	vices, nsultant, es Dietary sessment	
F 311 SS=D	stated the resident lik always drank 100%. overlooked documen intake. 483.25(a)(2) TREATM IMPROVE/MAINTAIN A resident is given th	ting the percentage of MENT/SERVICES TO NADLS e appropriate treatment and	F 31	1	10/2	3/15
	specified in paragrap This REQUIREMENT by: Based on record rev interviews the facility ordered restorative n	 br improve his or her abilities h (a)(1) of this section. is not met as evidenced iew and resident and staff failed to provide physician ursing services to 1 of 1 herapy for a maintenance 		Resident #73 was recently disc from skilled therapy on 10/12/15 referral to Restorative Nursing fo continued utilization of the NuSt	with a	

Facility ID: 923157

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		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 10/21/2019 RM APPROVED IO. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		345477	B. WING		0	C 9/25/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT			
				3864 SWEETEN CREEK ROA	D		
THE OAKS AT SWEETEN CREEK				ARDEN, NC 28704			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 311	Continued From page	e 13	F 3 ²	11			
	program (Resident #		10				
	program (resident #	73).		Residents requiring a	assistance with		
	The findings included	1:		Activities of Daily Livi			
					ctice. The Director of		
	Resident # 73 was ad	dmitted to the facility on		Clinical Services, Re	hab Program		
	11/29/13 with diagno			Manager, and Minim			
		dominant side, spasm of		completed a restorati	-		
	muscle, and difficulty	walking.		evaluation of current	-		
	Poviow of the guarte	rly Minimum Data Set (MDS)		residents that could b	on 10/2/15. Identified		
	-	aled Resident #73's cognition		residents were referre			
		as able to make her needs		Nurse and restorative			
		y MDS noted Resident #73		initiated as recomme			
		ssistance for bed mobility		Program Manager or	-		
	and transfer and wall	king with extensive					
		once or twice. The quarterly			or of Clinical Services		
		d Resident #73 received 5		provided education to			
		apy with a total of 195		Clinical Services, Re			
	minutes during the 7	day look back period.		Rehab Program Man	-		
	Bovious of Devoiced T	herapy (PT) documentation		regarding implementa program to promote r			
		73 was on the PT caseload 5			ctivities of daily living.		
		/01/15 through 08/12/15 for		The Director of Clinic			
	-	s, therapeutic activities, and		Restorative Nurse ed			
	-	of a PT discharge summary		aides by 10/16/15 an	d competencies were		
	dated 08/12/15 revea	aled the physical therapist		completed to assure	understanding of		
		orative nursing maintenance			ed Restorative Nurse		
		with staff regarding the		Aides will be educate			
		rogram (RNP) and the		Residents will be scre	-		
		ne NuStep (recumbent cross		Restorative Nurse up			
		eek. The physical therapist Resident #73 had a guarded		readmission, quarterl significant change in	-		
		g the lack of RNP in the		identified residents w			
		ic nature of her condition.		restorative program a			
	,			promote independent			
	Review of the medica	al record revealed a		daily living.			
	physician's order for						
	discontinued from PT			The Director of Clinic			
	referred to the RNP f	or NuStep.		Nurse Supervisor cor	nduct Quality		

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIDI	LE CONSTRUCTION		O. 0938-039 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED	
						С	
		345477	B. WING		09/25/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD			
	SAI SWEETEN CREEK			ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 311	Continued From page	e 14	F 31	1			
				Improvement Monitoring of 10 re	esidents to		
	-	on 09/23/15 at 10:15 AM		validate that each resident is rec			
		there was not sufficient		restorative services if indicated.			
		her needs because she had		Improvement Monitoring will be			
	weeks and this was v	ive nursing services for 6		3 times per week for 8 weeks, 2 week 4 weeks, 1 time per week			
		rery important to her.		weeks, and then 1 time monthly			
	An interview with the	Therapy Program Manager		months.			
		PM revealed NA #2 had been					
	trained to assist Resi	dent #73 on the NuStep at		The results of the Quality Improv	/ement		
		arge from therapy services.		Monitoring will be reported to th			
		revealed the Therapy		Assurance Performance Improv			
		d not know how functional		Committee monthly by the Direc			
		s at the time of Resident		Clinical Services/Restorative Nu	rse for six		
	#73's discharge from 08/12/15.	therapy services on		months and/or until substantial compliance is obtained. The Qu	olity		
	00/12/13.			Assurance Performance Improv			
	An interview was con	ducted with the		Committee will evaluate the effe			
		24/15 at 3:16 PM. During the		of the monitoring/observation to			
	interview the Adminis	strator stated the facility did		maintaining substantial compliar	nce, and		
	not currently have a f	formalized restorative		make changes to the corrective	action if		
		e Administrator explained		necessary to obtain substantial			
		time restorative aides until		compliance. The Quality Assura			
	the middle of June 20	It out on medical leave. The		Improvement Committee member consist of, but not limited to, the			
		stated some days NA #2		Director, Director of Clinical Serv			
		group of residents with		Medical Director, Pharmacy Cor			
		nd other days he had a		Social Services Director, Activiti			
		on the hall. Restorative		Director, Maintenance Director,			
		eviewed during the interview		Director, and Minimum Data Ass	essment		
		r confirmed Resident #73		Nurse.			
		n of services provided to		Data of Completions, October 20	2015		
	Resident #73.			Date of Completion: October 23	, 2015		
	During an interview of	on 09/25/15 at 11:49 AM NA					
	-	difficult since May of 2015					
		se he had been pulled to the					
		iven a resident assignment.					
	NA #2 further stated I	he had not been able to					

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345477	B. WING		C 09/25/2015	
NAME OF P	ROVIDER OR SUPPLIER		[;	STREET ADDRESS, CITY, STATE, ZIP CODE		5/25/2015
				3864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 311	Continued From page	e 15	F 311			
		on the NuStep in August				
F 312 SS=D	483.25(a)(3) ADL CA DEPENDENT RESID		F 312	2		10/23/15
	daily living receives t	able to carry out activities of he necessary services to on, grooming, and personal				
	by: Based on observation interviews the facility 2 of 3 dependent res of daily living (Reside The findings included 1. Resident #61 was			Resident #61's nails were clean 9/25/15 by the Director of Clinica Services and will continue to rec assistance with nail care from far nursing personnel as needed. R #95's nails were trimmed on 9/28 certified nurse aide and will conti receive assistance with nail care facility nursing personnel as nee	l eive cility esident 5/15 by a nue to from	
	infection. Review of the admiss (MDS) dated 08/05/1 moderately impaired extensive assistance Review of the Care A Summary for Activitie Functional/Rehabilita	sion Minimum Data Set 5 revealed Resident #61 had cognition and required with personal hygiene. Area Assessment (CAA) es of Daily Living (ADL) tion Potential dated 08/05/15 61 required total assistance		Residents who are dependent w Activities of Daily Living are at ris alleged deficient practice. Depen resident nails were assessed by staff on 10/5/15 for cleanliness, I and smooth edges. Nail care wa provided where appropriate at th facility nursing personnel. The Director of Clinical Services reeducated nursing staff regardir residents nails by 10/16/15. New	th sk for the ndent nursing ength, is at time by ng care of	
	-	n dated 08/09/15 revealed self care deficit due to the		nurses and nurse aides will be e upon hire. Dependent residents	ducated	

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		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345477	B. WING	С	
		343477		STREET ADDRESS, CITY, STATE, ZIP (09/25/2015
NAME OF P	ROVIDER OR SUPPLIER				JODE
THE OAK	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD ARDEN, NC 28704	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETE
F 312	Continued From page	2 16	F 31	2	
1 012	inability to complete s		Г) I		kly during
		care plan noted Resident #61		receive nail care twice wee showers, and randomly as	
	required extensive as	•		identified debris, soiling, or	
	interventions including			during routine activities of	
	Review of the care ka	ardex at the nurses's station		The Director of Clinical Se	rvices and/or
	revealed Resident #6	1's required the assistance		Nurse Supervisor will conc	luct Quality
	of one staff member f	or nail care, combing her		Improvement Monitoring o	fdependent
	hair, and perineum ca	are.		residents' nails 3 times per	
				weeks, then 2 times per w	
		s shower schedule revealed		weeks, then 1 time per we	
		heduled for showers on Irday during the second shift 4).		and then monthly for 1 mo cleanliness and appropriat	
				The results of the Quality I	mprovement
	Observations of Resid	dent #61's fingernails were		Monitoting will be reported	
	as follows:			Assurance Performance Ir	-
		PM black debris was noted		Committee monthly by the	
	hand.	ring fingernail on her right		Clinical Services/Nurse Su months and/or until substa	-
		5 PM black debris was		compliance is obtained. T	
		le and ring fingernail on her		Assurance Performance Ir	-
		all five fingernails on her left		Committee will evaluate th	
	hand.			of the monitoring/observat	
		AM black debris was noted		maintaining substantial co	-
	under all ten fingerna			make changes to the corre	
	- On 09/25/15 at 8:47 under all ten fingerna	AM black debris was noted		necessary to obtain substa compliance. The Quality A	
		113.		Improvement Committee n	
	An interview with Nur	se Aide (NA) #3 on 09/25/15		consist of, but not limited t	
		he cleaned and trimmed		Director, Director of Clinica	
	-	f he had time and there		Medical Director, Pharmac	-
		ned to light duty that cleaned		Social Services Director, A	
		's fingernails. NA #3 noted		Director, Maintenance Dire	-
	-	d a shower team a few		Director, and Minimum Da	la Assessment
		ents typically had fingernails showers. NA #3 confirmed		Nurse.	
	-	Resident #61 on 09/23/15,		Date of Completion: Octo	per 23. 2015
	09/24/15, and 09/25/2				

Facility ID: 923157

		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345477	B. WING			C 09/25/2015	
NAME OF PI	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE OAK	THE OAKS AT SWEETEN CREEK				3864 SWEETEN CREEK ROAD ARDEN, NC 28704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	CTIVE ACTION SHOULD BE COMPLE ICED TO THE APPROPRIATE DAT	
F 312	Resident #61's finger An interview was com- Director of Nursing (A AM. The shower she the interview and the showered Resident # During an interview of Director of Nursing (D fingernails should be checked during daily needed. At 9:55 AM to Resident #61's roo fingernails. The DON	hails needed to be cleaned. ducted with the Assistance DON) on 09/25/15 at 9:30 ets were reviewed during ADON confirmed NA #4 had 61 on 09/23/15. In 09/25/15 at 9:52 AM the DON) stated resident's cleaned during showers and care and cleaned as the DON was accompanied m to observe Resident #61's I confirmed Resident #61 aned from under all ten	F	312	2		
	05/13/15 with diagnos progressive debility, o mellitus. A quarterly I dated 08/04/15 indica was moderately impa Resident #95 underst understood, and requ assistance with dress A care plan updated 0 #95 with inability to co independently. The o	lementia, and diabetes Minimum Data Set (MDS) ted the resident's cognition ired. The MDS specified ood others, was verbally ired extensive staff ing and personal hygiene. 08/09/15 described Resident omplete self care tasks					

Facility ID: 923157

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) D	DATE SURVEY COMPLETED
		345477	B. WING	B. WING			C 09/25/2015
NAME OF PI	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS AT SWEETEN CREEK					3864 SWEETEN CREEK ROAD ARDEN, NC 28704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 312	next 90 review period routine nail care. An interview was con 09/22/15 at 3:23 PM. were observed to be was observed jagged and all nails had poin from the sides of his f stated he could not re were cut. He stated h like they should be. An observation on 09 Resident #95's finger At 1:00 PM, Nurse Aid returning Resident #9 wheelchair following a this time revealed his unchanged. An observation on 09 Resident #95's finger length with pointed co sides of his fingertips An interview was con on 09/24/15 at 10:17 provided during show needed, washing hair hair washed, and cutt An additional observa- revealed Resident #9 unchanged.	 Interventions included ducted with Resident #95 on At that time, his fingernails uneven in length. One nail across the top of the nail, ted corners that protruded fingertips. Resident #95 emember the last time they ne would like them trimmed /23/15 at 8:23 AM revealed nails remained untrimmed. de (NA) #1 was observed 95 to his room in a a shower. An observation at fingernails were /24/15 at 9:42 AM revealed nails remained uneven in orners protruding from the ducted via phone with NA #1 AM. NA #1 stated care ters included shaving if if the resident wanted their ting fingernails if needed. ation on 09/25/15 at 9:54 AM 5's fingernails remained w was conducted with NA #1 	F	312	2		
	on 09/25/15 at 10:03	w was conducted with NA #1 AM. NA #1 stated she r Resident #95 on Tuesday					

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-				FORI	M APPROVED D. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	345477	B. WING			C / 25/2015
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD ARDEN, NC 28704		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
09/22/15. She added team that the facility ji NA #1 stated she did was worried he might she did not think nurs of diabetic residents. An interview was com- Nursing (DON) on 09, this interview, Reside observed. The DON needed to be rounded corners. 483.25(c) TREATMEN PREVENT/HEAL PRE Based on the compre resident, the facility m who enters the facility does not develop pre- individual's clinical co they were unavoidabl pressure sores receiv services to promote h prevent new sores from This REQUIREMENT by: Based on observation interviews, the facility for an unstageable pr residents reviewed fo #153). The findings included	 she was part of a shower ust started 2 weeks ago. not know Resident #95 and be diabetic. NA #1 added e aides could cut fingernails ducted with the Director of /25/15 at 10:15 AM. During nt #95's fingernails were stated Resident #95's nails d and smoothed on the NT/SVCS TO ESSURE SORES hensive assessment of a nust ensure that a resident without pressure sores ssure sores unless the ndition demonstrates that e; and a resident having res necessary treatment and ealing, prevent infection and om developing. is not met as evidenced ns, record review, and staff failed to initiate treatment essure ulcer for 1 of 2 r pressure ulcers (Resident 		Resident #153 had a skin assessme completed on 9/23/15 by the Director Clinical Services and physician order were obtained, transcribed to the Treatment Administration Record, an initiated for continued treatment of a pressure ulcer. The wound was measured and staged by the Register	of s d red	10/23/15
Resident #153 Was a				NGS	
	S FOR MEDICARE & I F DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER S AT SWEETEN CREEK SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR I Continued From page 09/22/15. She added team that the facility j NA #1 stated she did was worried he might she did not think nurs of diabetic residents. An interview was com- Nursing (DON) on 09, this interview, Reside observed. The DON needed to be rounded corners. 483.25(c) TREATMEN PREVENT/HEAL PRE Based on the compre resident, the facility m who enters the facility does not develop pres- individual's clinical co they were unavoidabl pressure sores receiv services to promote h prevent new sores from This REQUIREMENT by: Based on observation interviews, the facility for an unstageable pro- residents reviewed fo #153). The findings included	CORRECTION DENTIFICATION NUMBER: 345477 ROVIDER OR SUPPLIER SAT SWEETEN CREEK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 09/22/15. She added she was part of a shower team that the facility just started 2 weeks ago. NA #1 stated she did not know Resident #95 and was worried he might be diabetic. NA #1 added she did not think nurse aides could cut fingernails of diabetic residents. An interview was conducted with the Director of Nursing (DON) on 09/25/15 at 10:15 AM. During this interview, Resident #95's fingernails were observed. The DON stated Resident #95's nails needed to be rounded and smoothed on the corners. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to initiate treatment for an unstageable pressure ulcer for 1 of 2 residents reviewed for pressure ulcers (Resident	S FOR MEDICARE & MEDICAID SERVICES IF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 345477 B. WING	S FOR MEDICARE & MEDICAID SERVICES # GERGENCIES CORRECTION (X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 345477 5: WING SOVIDER OR SUPPLIER STREET ADRESS, CITY, STATE, ZIP CODE SAT SWEETEN CREEK STREET ADRESS, CITY, STATE, ZIP CODE SMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG Continued From page 19 09/22/15. She added she was part of a shower team that the facility just started 2 weeks ago. NA #1 stated she did not know Resident #95 and was worried he might be diabetic. NA #1 added she did not thin Aurse aldes could cut fingemails of diabetic residents. F 312 An interview was conducted with the Director of Nursing (DON) on 09/22/15 at 10:15 AM. During this interview, Resident #955 nails needed to be rounded and smoothed on the corners. F 314 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility failed to initiate treatment of or an unstageable pressure ucler for 10 2 residents reviewed for pressure ulcer for 10 2 residents reviewed for pressure ulcers (Resident #153). Resident #153 had a skin assessme completed on 9/23/15 by the Director Clinical Services and physician order were obtained, transcribed to the Traatment Administration Record, an initiated for continued treatment of a pressure ulcer. T	MENT OF HEALTH AND HUMAN SERVICES FOR SP COR MEDICARE & MEDICALD SERVICES OMB NC or DEFICIENCIES OMB NC or DEFICIENCIES OMB NC or DEFICIENCIES OMB NC STREET ADDRESS, DITY, STATE, 2P CODE 384 SWETEN CREEK SAT SWEETEN CREEK STREET ADDRESS, DITY, STATE, 2P CODE SUPPLIER STREET ADDRESS, OTTY, STATE, 2P CODE SAL SWEETEN CREEK STREET ADDRESS, OTTY, STATE, 2P CODE SUPPLIER STREET ADDRESS, OTTY, STATE, 2P CODE STREET ADDRESS, SUPPLIER STREET ADDRESS, STATE, 2P CODE

Event ID: IPPE11

Facility ID: 923157

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		MEDICAID SERVICES				B NO. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION) DATE SURVEY COMPLETED	
			A. BUILDING				
		345477	B. WING			C 09/25/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT		09/25/2015	
				3864 SWEETEN CREE			
THE OAK	S AT SWEETEN CREEK			ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COP	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 314	Continued From page	20	E 24	4			
F 314	Continued From page		F 31				
		ses which included severe mellitus, catatonia, and		Clinical Service	/23/15 by the Director of s.		
	difficty.			Current residen	its have the potential to be		
	A review was conduct	ted of a nursing admission			alleged deficient practice.		
		0/21/15 at 5:30 PM. Nurse		A skin assessm	ient was completed on		
	#2 signed the assess	ment with a notation she		facility residents	s by the Minimum Data		
		ctions of the assessment.			urse and Wound Nurse by		
		escribed as stuporous,			cumented on the Weekly		
		ometimes understood			eview form. Any identified		
		nent documentation included			ts, pressure and		
		y 2 cm opening in the			vere assessed and		
	-	d as a pressure ulcer.			the Pressure Ulcer		
		d in an admission nurse's			Pressure Skin Condition		
		he buttocks measured 3 cm sumentation specified the			ensed nurse and reported s physician and new		
	area was cleaned wit				s were obtained.		
		other information was			ind documented as		
	provided regarding th			appropriate.			
	A review of Resident	#153's medical record on		The Director of	Clinical Services		
	09/23/15 revealed no	physician's order for		reeducated lice	nsed nurses by 10/1/15 on		
		sure ulcer was provided.			mpletion of the Weekly		
	· · ·	se on Resident #153's hall			eviews and the initiation of		
		rse was interviewed at 1:19		a Pressure Ulce	er Record and/or		
		se #1 was unaware of any			Skin Condition Record for		
		ing Resident #153. Nurse		-	entified. The education		
		ere no treatment orders for			mely physician notification,		
		sident's medical record or on			arting new treatment		
	the resident's treatme	ent administration record.			nscription onto the		
	A				ment Administration		
		/23/15 at 1:35 PM with			hired nurses will receive		
		esident #153 did have an			g new hire orientation.		
		x area. The opening was A yellow slough was			nave a weekly skin		
		e base of the wound. Nurse			mpleted by a licensed y skin concerns. Any skin		
		know this wound existed.			will be reported to the		
	# 1 Stated She did 1101	KHOW THIS WOULD EXISTED.			e licensed nurse and new		
			1		C IICCHSEU HUISE AHU HEW	1	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/21/2 FORM APPROV OMB NO. 0938-03
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477		B. WING		C 09/25/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				3864 SWEETEN CREEK ROAD	
THE OAKS AT SWEETEN CREEK			ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETING THE APPROPRIATE DATE
F 314	Director of Nursing (I #153 was admitted w ulcer. The DON also assessed the wound wound measured 3 c the wound was cover DON stated the admin notified the physician found during the nurs The DON added a tre been obtained from t wound was found. An interview was con 09/23/15 at 3:46 PM. Resident #153's nurs on 09/21/15. Nurse # wound and documen resident had a press she did cleanse and same kind of dressing to do the assessmen intended to obtain a w the physician that wa facility the following c Nurse #2 described t upon admission with	DON) confirmed Resident vith an unstageable pressure	F 3	14 and transcribed onto the Administration Record an Record or Non-Pressure Record as appropriate. A will round weekly with the physician to assess, mea document the condition o the Pressure Ulcer Recor of Clinical Services, the M Set Nurse, Dietary Manage Manager will discuss ider during a weekly wound m necessary treatment and being provided to promote prevent infection, and pre development of new sore The Director of Clinical Set Manager will complete Qu Improvement Monitoring of skin assessments, Pressu and/or Non-Pressure Skir Records and Treatment A Records if indicated on 5 times per week for 4 week per week for 4 weeks, the 3 months to validate com alleged deficient practice. The results of the Quality Monitoring will be reported Assurance Performance I Committee monthly by the Clinical Services/Nurse M months and/or until subst compliance is obtained. Assurance Performance I Committee will evaluate to of the monitoring/observal	d Pressure Ulcer Skin Condition A nurse manager wound sure, and f the wound on d. The Director finimum Data ger, and Nurse atified residents leeting to ensure services are e healing, went the s. ervices/Nurse uality of the weekly ure Ulcer Record in Condition administration residents 5 ks, then 2 times en 1 timer per for pliance with the Improvement e Director of lanager for six antial The Quality mprovement he effectiveness

Facility ID: 923157

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345477	B. WING				C 25/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
	THE OAKS AT SWEETEN CREEK			38	864 SWEETEN CREEK ROAD		
THE UAR	SAI SWEETEN CREEK			Α	RDEN, NC 28704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	IX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 314 F 328 SS=D	483.25(k) TREATMEN NEEDS The facility must ensu proper treatment and special services: Injections; Parenteral and entera Colostomy, ureterosto Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT by: Based on observation interviews the facility ordered continuous of while in her wheelcha saturation greater tha	NT/CARE FOR SPECIAL are that residents receive care for the following		314	maintaining substantial compliance, an make changes to the corrective action necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Execut Director, Director of Clinical Services, Medical Director, Pharmacy Consultant Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessme Nurse. Date of Completion: October 23, 2015 Resident #26 was assessed by the licensed nurse on 9/22/15 and no harm was noted. Resident continues to rece oxygen as ordered by the physician via oxygen concentrator and/or portable oxygen tank.	if tive t, , ent ive	10/23/15

Event ID: IPPE11

Facility ID: 923157

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345477	B. WING		C 09/25/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 328	Continued From page	23	F 32	28		
	diagnoses including of Review of a care plan Resident #26 required the goal stated Residus saturation checked per the O2 to keep her O2 90%. Interventions in in resident symptoms administer oxygen as protocol, and if O2 sa notify the physician for Review of Resident # Physician's Orders re O2 at 3 liters/min (I/m and for her O2 satura shift. Review of the quarter 09/02/15 revealed Re impaired cognition an therapy during the 14 Observations of Reside - On 09/22/15 at 12:3 wheelchair in her roor bed with a NC in her was attached to a por holder on the back of on O2 tank's oxygen of the red zone indicatin Resident #26 was in r - On 09/22/15 at 12:5	mitted on 01/14/15 with thronic respiratory failure. In dated 04/12/15 revealed d oxygen (O2) therapy and ent #26 would have her O2 er the schedule and to titrate 2 saturation greater then iccluded: monitor for changes and report to the physician, ordered, change tubing per turation drops below 90% or orders. 26's September 2015 vealed she was to be given in) via a nasal cannula (NC) tion to be monitored every 4y Minimum Data Set (MDS) sident #26 had moderately d had received oxygen day assessment period. dent #26 were as follows: 2 PM she was sitting in her m facing the wall behind her nostrils. The oxygen tubing table O2 tank located in a her wheelchair. The needle gauge was at the bottom of g the tank was empty.		 Residents with orders for continuous oxygen have the potential to be affilibly the alleged deficient practice. The Director of Clinical Services compliance with treatments. Nursing staff was in-serviced by the Director of Clinical Services by 10/regarding administering oxygen the as ordered via oxygen concentrated portable tank, and the operation of equipment and supplies. Newly hit nursing staff will be educated upor The licensed nurse will observe reswith oxygen each shift to validate compliance with oxygen administration Record. The Director of Clinical Services/N Manager will perform Quality Improvement Monitoring of resider oxygen therapy to validate compliate times per week for 4 weeks, per week for 8 weeks, then monthl months using a sample size of 5 ref. The results of the Quality Improvement Committee monthly by the Director Clinical Services/Nurse Manager for months and/or until substantial compliance is obtained. The Qualit Assurance Performance Improvement 	ected The eted a ders by oxygen e 15/15 erapy r and/or oxygen red hire. sidents ation ent urse ts with ince 2 times y for 3 esidents ment Quality ient of or six ty	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 10/21/2015 APPROVED . 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345477	B. WING			(09/2	, 25/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE		
			3	864 SWEETEN CREEK ROAD			
THE OAK	S AT SWEETEN CREEK		A	RDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 328	bed with a NC in her r was attached to a por holder on the back of on O2 tank's oxygen of the red zone indicatin Resident #26 was in r - On 09/22/15 at 1:22 wheelchair in her roor bed with a NC in her r was attached to a por holder on the back of on O2 tank's oxygen of the red zone indicatin Resident #26 was in r - On 09/22/15 at 1:26 walked behind and pa her roommate. NA #5 O2 tank to see if Resi Resident #26 was in r - On 09/22/15 at 1:28 room and picked up F NA #5 did not check t Resident #26 had O2 was in no visible distr An interview with Nurs PM revealed NAs cou oxygen tanks and wo they needed assistant was accompanied to 1 checked her oxygen s and confirmed the oxy Nurse #3 stated Resid switched over to the or stated she had not se earlier this morning. I	nostrils. The oxygen tubing table O2 tank located in a her wheelchair. The needle gauge was at the bottom of g the tank was empty. no visible distress. PM she was sitting in her m facing the wall behind her nostrils. The oxygen tubing table O2 tank located in a her wheelchair. The needle gauge was at the bottom of g the tank was empty. no visible distress. PM Nurse Aide (NA) #5 ast Resident #26 to check on 5 did not check the portable dent #26 had O2 available. no visible distress. PM NA #5 returned to the Resident #26's meal tray. he portable O2 tank to see if available. Resident #26 ess. se #3 on 09/22/15 at 1:37 fild change out portable uld let the nurses know if ce. At 1:39 PM Nurse #3 Resident #26's room and saturation which was 88% ygen tank was empty.	F 328	Committee will evaluate of the monitoring/obser maintaining substantial make changes to the co- necessary to obtain sub compliance. The Quali Improvement Committee consist of, but not limitee Director, Director of Clin Medical Director, Pharr Social Services Directoo Director, Maintenance I Director, and Minimum Nurse. Date of Completion: O	vation tool for compliance, an orrective action bstantial ity Assurance ee members ed to, the Execu- nical Services, macy Consultant or, Activities Director, Dietary Data Assessme	d if tive t, nt	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345477	B. WING _				C /25/2015	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAK	S AT SWEETEN CREEK				864 SWEETEN CREEK ROAD NRDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 328 F 353 SS=E	An interview with NA a revealed NAs were al portable oxygen tanks empty. NA #5 stated the gauge on the port not notice Resident # was empty or that Re connected the the oxy was in the room earlied During an interview of Director of Nursing (D check the portable ox assisted them to their the tank when it was of stated she expected t portable oxygen tanks change as needed. T revealed residents wit oxygen should be pla concentrator when the 483.30(a) SUFFICIEN PER CARE PLANS The facility must have provide nursing and m maintain the highest p and psychosocial wel determined by residen individual plans of car The facility must prov numbers of each of th personnel on a 24-ho	#5 09/22/15 at 1:42 PM lowed to change resident's is if they noticed they were she did not usually check able oxygen tanks and did 26's portable oxygen tank sident #26 was not ygen concentrator when she er. n 09/22/15 at 2:50 PM the DON) stated NAs should ygen tanks when they wheelchairs and change empty. The DON further he NAs to monitor resident's is throughout their shift and the interview further th orders for continuous ced on the oxygen ey were in their rooms. NT 24-HR NURSING STAFF e sufficient nursing staff to elated services to attain or practicable physical, mental, l-being of each resident, as int assessments and re.		328			10/23/15	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345477	B. WING				C 25/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE OAK	S AT SWEETEN CREEK				864 SWEETEN CREEK ROAD RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 353	Except when waived section, licensed nurs personnel. Except when waived section, the facility mo	under paragraph (c) of this	F3	353			
	by: Based on record revi interviews, the facility nursing staff to offer p nursing services to 1	is not met as evidenced ews and staff and resident failed to provide sufficient ohysician ordered restorative of 1 resident reviewed for of daily living (Resident			Resident #73 was recently discharged from skilled therapy on 10/12/15 with a referral to Restorative Nursing for continued utilization of the NuStep. Resident #73 will continue to receive restorative care as appropriate. Residents requiring assistance with		
	This tag is cross-refer F311: Maintaining Ac Based on record revie interviews the facility ordered restorative no resident referred by th program (Resident #7 An interview was con Nursing (DON) on 09 DON stated the facilit	rred to: tivities of Daily Living: ew and resident and staff failed to provide physician ursing services to 1 of 1 herapy for a maintenance			Activities of Daily Living are at risk for alleged deficient practice. The Directo Clinical Services, Rehab Program Manager, and Minimum Data Set Nurs completed a restorative nursing evaluation of current residents to ident residents that could benefit from a restorative program. Identified resider were referred to the Restorative Nurse and restorative programs were initiated recommended. The Regional Director of Clinical Servi provided education to the Director of	or of se ify hts d as	
	this. In a continued intervie the DON stated nurse	ew on 09/25/15 at 2:36 PM, aides were supposed to e nursing services into daily			Clinical Services, Restorative Nurse, a Rehab Program Manager on 10/15/15 regarding implementation of a restorat program to promote residents independence with activities of daily liv	ive	

Facility ID: 923157

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O							
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				0. 0938-0391 SURVEY LETED
		345477	B. WING			C 09/25/2015	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	25/2015
_			3864 SWEETEN CREEK ROAD				
THE OAK	S AT SWEETEN CREEK			A	RDEN, NC 28704		
(X4) ID PREFIX TAG			ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 353	working in range of m DON explained the fa restorative nursing. In a continued intervie the Administrator cont	to dine at meal times and otion while dressing. The cility had no formal ew on 09/25/15 at 4:36 PM firmed the day shift was ff so restorative nursing	F	353	The Director of Clinical Services and Restorative Nurse educated restorative aides by 10/16/15 and competencies w completed to assure understanding of skills. Newly hired restorative aides will be educated upon hire. Residents will screened by the Restorative Nurse upor admission, readmission, quarterly, and with a significant change in condition. Those identified residents will be referre to a restorative program as appropriate promote independence with activities of daily living. The Restorative Aides will responsible for providing restorative car as appropriate per the resident's care plan. In the absence of the Restorative Aide the Restorative Nurse and/or othe member of Nurse Management will be designated to ensure the delivery of resident specific restorative care in accordance with the care plan to maint or improve each residents' abilities. The Director of Clinical Services and/or Nurse Manager will conduct Quality Improvement Monitoring of 10 resident validate that each resident is receiving restorative services if indicated. Qualit Improvement Monitors will be complete times per week for 8 weeks, 2 times per week 4 weeks, 1 time per week for 4 weeks, and then 1 monthly for 2 month The results of the Quality Improvement Monitoring will be reported to the Qual Assurance Performance Improvement Committee monthly by the Director of Clinical Services/Restorative Nurse for months and/or until substantial	rere ll be on ed to f be re er ain s to y ed 3 er s.	

Event ID: IPPE11

Facility ID: 923157

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DEPART CENTER	FORM	D: 10/21/2015 MAPPROVED D: 0938-0391					
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345477	B. WING _				C 25/2015
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		IREET ADDRESS, CITY, STATE, ZIP CODE		
	S AT SWEETEN CREEK			38	364 SWEETEN CREEK ROAD		
	SAT ONCE TEN ONCE IN			Α	RDEN, NC 28704		
(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 353 F 371 SS=E	483.35(i) FOOD PRO STORE/PREPARE/SI The facility must - (1) Procure food from considered satisfactor authorities; and (2) Store, prepare, dis under sanitary conditi This REQUIREMENT by: Based on observation facility failed to date 1 juice, 1 opened conta	CURE, ERVE - SANITARY sources approved or ry by Federal, State or local	F 3		compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectivened of the monitoring/observation tool for maintaining substantial compliance, an make changes to the corrective action necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Execut Director, Director of Clinical Services, Medical Director, Pharmacy Consultant Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessme Nurse. Date of Completion: October 23, 2015	d if tive t, , ent	10/23/15

Facility ID: 923157

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		ND HUMAN SERVICES			PRINTED: 10/21/20 FORM APPROVE OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345477	B. WING		09/25/2015		
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	S AT SWEETEN CREEK		3	8864 SWEETEN CREEK ROAD			
			4	ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETIO		
F 371	Continued From page	e 20	F 371				
1 0/1	sandwiches stored re	eady for use and 4 healthy	F 37 1	date found in the nourishment roor	n.		
	 sandwiches stored ready for use and 4 healthy shakes in 1 of 1 nourishment refrigerator. The findings included: An initial tour of the kitchen was made on 09/22/15 at 10:45 AM with the Dietary Manager (DM). The tour included observations of the facility's nourishment room that revealed the following items not labeled or dated stored ready for use: 1 uncovered, undated opened container of orange juice in a clear multi-use serving pitcher, confirmed by the DM as orange juice 1 uncovered, undated opened container of cranberry juice in a clear multi-use serving pitcher, confirmed by the DM as cranberry juice 1 covered, undated bowl of applesauce not in the original container, confirmed by the DM as cranberry juice 1 and ½ trays of hard pimento cheese and peanut butter sandwiches undated and stored ready for use, confirmed by the DM as snack used for residents 4 healthy shakes (a fortified nutritional supplement), confirmed by the DM as not having a thaw date and use by date indicated on the carton that specified the supplement be used within 14 days of thawing An interview was conducted on 09/25/15 at 8:36 AM with the Unit Manager. She stated it was her responsibility to check the nourishment refrigerator juices, applesauce and healthy shakes dates Monday through Friday. She stated the orange juice and cranberry juice should be dated with the date it was prepared and disposed of at the end of that day the applesauce should have been dated with the date it was placed in the bowl and discarded at the end of the day as well. She stated the nurse supervisor should check dates on the weekends. She further stated 			Residents residing at the facility ar as related to the alleged deficient p The Dietary Manager/ Department member will inspect the kitchen an nourishment rooms to validate that items are expired, improperly sealed/stored, or mislabeled. Food identified will be disposed of per co policy. The Dietary Manager educated cur staff by 10/16/15 on proper disposa expired, improperly sealed/stored, unlabeled food items. The Executi Director educated current member Interdisciplinary Team inclusive of departmental directors and adminis personnel on proper disposal of ex- improperly sealed/stored, and unla	bractice. d t no d items ompany rrent al of and ive s of the facility strative pired, beled		
				food items. Newly hired staff will b educated upon hire. The Executive Director and/or Interdisciplinary Team inclusive of t departmental directors and adminis personnel will complete Quality Improvement Monitoring of the kito and nourishment room 5 times per for 4 weeks, 3 times per week for 4 weeks, 2 times per week for 4 wee time per month for 2 months to ens compliance with food storage. The results of the Quality Improver Monitoring will be reported to the 0 Assurance Performance Improver Committee monthly by the Executi	facility strative then week t ks, 1 sure ment Quality hent		

Facility ID: 923157

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		C
		345477	B. WING		09/25/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE OAK	S AT SWEETEN CREEK		-	864 SWEETEN CREEK ROAD ARDEN, NC 28704	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 371	it was the dietary staf and date any snacks nourishment refrigera snacks. An interview was com AM with the Director stated it was her expa and check sandwiche refrigerator used for r Manger's responsibili everything else store stated juice and apple original container tha nourishment refrigera with the date it was p discarded at the end During an interview c 1:35 PM with the Die sandwiches in the ref labeled with the date the sandwiches were was unaware of the c sandwiches stored for how long they had be further stated the hea been labeled with the out of the freezer to b were only good for us date. She stated she	f's responsibility to check or sandwiches in the ator used for resident ducted on 09/25/15 at 9:39 of Nursing (DON). She ectation for dietary to date es in the nourishment esident snack and the Unit ty to check dates on d in the refrigerator. She esauce that was not in its t was stored in the ator should have been dated laced in the refrigerator and	F 371	Director for six months and/or until substantial compliance is obtained Quality Assurance Performance Improvement Committee will evalue effectiveness of the monitoring/observation tool for maintaining substantial compliance make changes to the corrective ac necessary to obtain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Ex Director, Director of Clinical Service Medical Director, Pharmacy Consu Social Services Director, Activities Director, and Minimum Data Asses Nurse. Date of Completion: October 23,	. The late the e, and tion if ce skecutive es, ultant, etary ssment
	them having no thaw 483.75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANS	ERS/MEET	F 520		10/23/15
	A facility must mainta assurance committee	in a quality assessment and			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345477	B. WING				C 25/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
	S AT SWEETEN CREEK			3	3864 SWEETEN CREEK ROAD		
THE UAK	SAI SWEETEN CREEK			4	ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	nursing services; a ph facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to and assurance activit develops and implem action to correct ident A State or the Secret disclosure of the reco except insofar as suc compliance of such co requirements of this s	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of iffied quality deficiencies. cary may not require rds of such committee h disclosure is related to the committee with the	F	520			
	by: Based on observatio and resident interview Assessment and Assum monitor the plans of a quality deficiencies and the areas of respirato living, notification of c staffing. This was fo of respiratory care whe recertification survey recited on the current deficiency in the area was originally cited of December of 2014, ref	is not met as evidenced ns, record reviews, and staff vs the facility's Quality urance Committee failed to action to correct identified nd maintain compliance in ry care, activities of daily hanges, and sufficient r one deficiency in the area aich was originally cited on a in October of 2014 and recertification survey. One of activities of daily living n a complaint investigation in ecited again during a on in April of 2015 and			The Regional Director of Clinical Serv provided education on 10/9/15 to members of the Quality Assurance Improvement Committee inclusive of th Executive Director, Director of Clinical Services, Minimum Data Assessment Nurse, Dietary Director, Maintenance Director, Activities Director, and Social Services Director on the Federal Regulation F520 QAA Committee and facility's Policy and Procedure for Qua Assurance. Newly hired Interdisciplina Team Members will be educated upon hire.	ne the lity ary	

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O							
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /		E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY PLETED	
		345477	B. WING _				C 25/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
				3	864 SWEETEN CREEK ROAD			
THE OAK	S AT SWEETEN CREEK			A	ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 520	recited again on the c One deficiency in the changes was originall investigation in Decer the current recertificat in the area of sufficier cited on a complaint in and recited again on t survey. The continued facility during four fed showed a pattern of th sustain an effective Q Findings included: This tag is cross refer 1a. F 157: Notificatio record review and sta failed to notify the phy orders for an unstage on a newly admitted r reviewed for notificatio #153). During a complaint in 17, 2014 the facility we immediate family mer psychotropic medicati facility was recited on survey for failing to no pressure ulcer noted of assessment of a resid	area of notification survey. area of notification of y cited on a complaint mber of 2014 and recited on tion survey. One deficiency at staffing was originally nvestigation in April of 2015, the current recertification d non-compliance of the eral surveys of record he facility's inability to muality Assurance Program. red to: n of Changes: Based on ff interviews, the facility visician to obtain treatment able pressure ulcer noted esident for 1 of 4 residents on of changes (Resident vestigation on December vas cited for failure to notify nbers of a change in ions for a resident. The the current recertification of the nursing admission dent. Daily Living: Based on reviews, and staff interviews ovide nail care for 2 of 3	F 5	520	The Quality Assessment and Assuranc Committee will meet at a minimum of monthly. A member of the Regional support team inclusive of, but not limite to, the Regional Clinical Director, Regio Director of Operations, Regional Direct of Resident Assessment, Regional Director of Human Resources, and/or Regional Director of Nutritional Service will attend the monthly Quality Assessment and Assurance Meeting. The Regional Support staff will evaluate the on-going Quality Improvement Monitors to validate substantial compliance is maintained and recommend changes to the corrective actions to obtain compliance if necessa Quality Improvement Monitors will be monitored initially for a minimum time period of six months, or longer if necessary to successfully evaluate ongoing compliance with regulatory requirements. Upon successful, sustained compliance the identified are will be reviewed quarterly there after by the facility members of the Quality Assessment and Assurance Committee and Regional Support for the ongoing effectiveness of the program. Quality Improvement Monitors may be reinitiate at any time if compliance is not maintained. Resident #153 did have physician orde obtained for treatment of the unstageat pressure ulcer on 9/23/15 by Director of Clinical Services. Resident #153 has been receiving treatments as ordered to	ed onal or s, e ary. e ed rs ole f		
	observations, record in the facility failed to pro-	reviews, and staff interviews			pressure ulcer on 9/23/15 by Director of Clinical Services. Resident #153 has	ſ		

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	-	ID HUMAN SERVICES MEDICAID SERVICES		FORM	APPROVED		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345477	B. WING			C 25/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAKS	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 520	daily living (Resident During a complaint in 17, 2014 and an addi investigation on April cited for not providing and incontinence care on the current recertif keep residents' finger c. F 328: Respiratory observations, record the facility failed to pr continuous oxygen th her wheelchair to mai greater than 90% for respiratory care (Resi During a recertificatio 2014 the facility was oxygen therapy while wheelchair. The facil current recertification oxygen therapy to a r d. F 353: Sufficient Na record reviews and st the facility failed to pr to offer physician orde services to 1 of 1 resi	#61 and #95). vestigation on December tional complaint 8, 2015, the facility was assistance with toileting e. The facility was recited fication survey for failing to nails clean and trimmed. Care: Based on review, and staff interviews ovide physician ordered erapy to a resident while in ntain an oxygen saturation 1 of 1 resident reviewed for ident #26). n survey of November 26, cited for failing to provide a resident was in a ity was cited again on the survey for failing to provide esident in a wheelchair. urse Staffing: Based on aff and resident interviews, ovide sufficient nursing staff ered restorative nursing	F 52		25/15 Jurse y g were vided 1/15 Jician wly ents ring rses ensed Jician ation nent se to t		
	the facility was cited f nursing staff to provid to incontinent residen	vestigation of April 8, 2015 for failing to provide sufficient te timely incontinence care ts. The facility was cited on tion survey for failing to ursing to a resident as		Improvement Monitoring will be cond 5 times weekly for 4 weeks, then 3 ti weekly for 4 weeks, then 2 times we for 4 weeks, then 1 time weekly for 1 weeks, and/or until substantial comp is obtained using a sample size of 5 residents.	mes ekly I2		

Facility ID: 923157

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY PLETED	
		345477	B. WING			C 25/2015	
NAME OF P	ROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAK	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 520	interviews confirmed nursing services was staff. An interview was con- Administrator and Din- 09/25/15 at 4:24 PM. the past 2 weeks the for shower teams. The planned to designate concentrate on toenal Administrator stated to tank was related to a not understand how to The Administrator state working on staffing. The nurse staffing on the other	ian. Staff and resident the lack of restorative due to not enough nursing	F 52	 Resident #61's nails were cleaned by the Director of Clinical Services will continue to receive assistance nail care by facility nursing persor needed. Resident #95's nails wer trimmed on 9/25/15by a certified raide and will continue to receive assistance with nail care by facility personnel as needed. Residents who are dependent wit Activities of Daily Living are at risk alleged deficient practice. Dependent nails were assessed by r staff on 10/5/15 for cleanliness, leand smooth edges. Nail care was provided where appropriate. The Director of Clinical Services reeducated nursing staff regarding residents nails by 10/16/15. New nurses and nurse aides will be ed upon hire. Dependent residents were ceive nail care twice weekly dur showers, and randomly as needer identified debris, soiling, or rough during routine activities of daily liv The Director of Clinical Services a Nurse Manager will conduct Quali Improvement Monitoring of dependents and then monthly for 1 month for cleanliness and appropriateness of Resident #26 was assessed by the direct and the monthly for 1 month for cleanliness and appropriateness of the performance of the perf	s and e with anel as re- nurse y nursing h c for the dent nursing ngth, s g care of ly hired ucated rill ing d for any ness ing care. and/or ity ident for 8 8 s weeks, of shape.		

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	MENT OF HEALTH AN					FORM	0: 10/21/2015 1 APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345477	B. WING _			(09/2	C 25/2015
NAME OF F	ROVIDER OR SUPPLIER	-		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				3864	SWEETEN CREEK ROAD		
	S AT SWEETEN CREEK			ARD	EN, NC 28704		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	e 35	F 5	live www.oo.oo RobDregetr NDreapenTwcpaA TMirottpm Rfr	censed nurse on 9/22/15 and no harm vas noted. Resident continues to receivygen as ordered by the physician via oxygen concentrator and/or portable oxygen tank. Residents with orders for continuous oxygen have the potential to be affected by the alleged deficient practice. The Director of Clinical Services completed eview of residents with oxygen orders 0/24/15 to ensure compliance with oxyger reatments. Aursing staff were in-serviced by the Director of Clinical Services by 10/15/19 egarding administering oxygen therapy is ordered via oxygen concentrator and ortable tank, and the operation of oxyger quipment and supplies. Newly hired inursing staff will be educated upon hire The licensed nurse will observe resider with oxygen each shift to validate compliance with oxygen administration her physician's orders and document incordingly on the Medication administration Record. The Director of Clinical Services/Nurse Manager will perform Quality mprovement Monitoring of residents with oxygen therapy to validate compliance intere times per week for 4 weeks, 2 time inter week for 8 weeks, then monthly for nonths using a sample size of 5 reside Resident #73 was recently discharged rom skilled therapy on 10/12/15 with a eferral to Restorative Nursing for	ive d a by gen 5 / d/or gen ts ith es 3	

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Facility ID: 923157

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-	H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 10/21/2015 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
	345477			C 09/25/2015	
NAME OF PROVIDER OR SUPPLIE	र		STREET ADDRESS, CITY, STATE, ZIP CODE		
			3864 SWEETEN CREEK ROAD		
THE OAKS AT SWEETEN CR	EER		ARDEN, NC 28704		
PREFIX (EACH DEFIC	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	
F 520 Continued From	page 36	F 52		receive e. e with t risk for the e Director of ram Set Nurse og s to identify om a d residents ve Nurse e initiated as cal Services ector of Nurse, and 10/15/15 restorative of daily living. es and estorative tencies were nding of aides will dents will be Nurse upon terly, and ondition. be referred opropriate to ctivities of Nides will be	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345477	B. WING	B. WING			C 09/25/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
				3864 SWEETEN CREEK ROAD				
THE OAK	S AT SWEETEN CREEK			A	RDEN, NC 28704			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG			DATE		
F 520	Continued From page	: 37	F	520		er ain r s to y eted per t ity ix ess d if tive t,		

Event ID: IPPE11

Facility ID: 923157

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/21/2015 1 APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345477	B. WING			C 09/25/2015		
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
THE OAK	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD				
	I			ARDEN, NC 28704				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CON CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 520	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) F 520 Director, and Minimum Data Nurse.		DEFICIENCY) Director, and Minimum Data Assessme	nt		

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