STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/11/2017

NAME OF PROVIDER OR SUPPLIER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Due to inclement weather, this survey was extended to 12/11/17 with 12/09/17 missed as a survey day. Event ID #FI9611.	F 000		
F 567 SS=B	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of	F 567		1/8/18

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

Electronically Signed | 01/04/2018

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F 567	Continued From page 1 the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with residents and staff the facility failed to provide cognitively intact residents with access to personal funds after the facility's business office hours for 2 of 4 sampled residents reviewed for personal funds (Resident #57 and Resident #80). Findings included: Review of the information handbook included with the facility's admission packet revealed residents could access their resident trust account during the normal business office hours of 8:30 AM to 5:00 PM, Monday through Friday. 1. Resident #57 was admitted to the facility on 03/14/16. A review of the quarterly Minimum Data Set (MDS) dated 10/15/17 revealed Resident #57 was cognitively intact. During an interview on 12/05/17 at 12:27 PM Resident #78 stated she did not have access to her personal funds account on the weekends. An interview on 12/07/17 at 8:30 AM with the Business Office Manager (BOM) revealed residents could obtain funds from their personal trust account during the posted business office hours of 8:30 AM to 4:30 PM and added she or the Administrator were usually in the facility until	F 567	F tag 567 Trust Funds On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure cognitively intact residents have access to personal funds after facility business hours. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #57 and #80, it was determined that the facility failed to ensure that a facility staff member was assigned to provide access of personal funds to cognitively intact residents after the facility business hours of 8:00AM-5:00PM Monday through Friday. Residents have access of personal funds after business hours including Residents #57 and #80 On 1/4/18, the Business Office Manager (BOM) completed a QA (quality	

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F 567	Continued From page 2 5:00 PM to 6:00 PM most days. The BOM stated on the weekends, the receptionist had access to the residents personal funds account if needed. The BOM confirmed that once she, the Administrator or Receptionist had left for the day residents had no access to their personal funds if needed. An interview on 12/07/17 at 4:05 PM the Administrator confirmed residents had no access to their personal funds once she, the BOM or Receptionist had left for the day. The Administrator stated she should have provided a more thorough explanation so the residents knew the Receptionist had access to their personal funds account on the weekend if needed. During a follow-up interview on 12/10/17 at 12:01 PM Resident #78 stated she was told she could only get money out of her account during business office hours. Resident #78 added she had "never needed to get money at night or on the weekend but it would be nice to know you could in case something ever came up." 2. Resident #80 was admitted to the facility on 02/04/16. A review of the quarterly MDS dated 11/10/17 revealed Resident #80 was cognitively intact. During an interview on 12/05/17 at 1:26 PM Resident #80 stated she was unable to access her personal funds account on the weekends and was unaware if other staff had access. Resident #80 added she could only obtain funds from her personal trust account during business office hours. An interview on 12/07/17 at 8:30 AM with the	F 567	assurance) monitoring of cognitively intact residents who have personal funds maintained by facility to ensure availability of funds after facility business hours during the evenings and weekend upon request to the nursing supervisor. On 12/27/17, the Regional Director of Clinical Services provided education to the Business Office Manager and Administrator on the facility policy of ensuring resident personal funds are available to cognitively intact residents after regularly scheduled business hours. Education was inclusive of posting of business hours from 8:00AM-5:00PM with instructions on accessing personal funds after hours during the evenings and weekend upon request to the nursing supervisor, maintaining an updated trust ledger balance and withdrawal log and providing cash funds in designated, safeguarded location for after accessibility. By 1/10/18, the BOM provided education to licensed nurse supervisors on the policy and procedure of providing after hour available personal funds to cognitively intact residents upon request. On 1/4/18, a resident council meeting was held and the BOM provided additional education to residents in attendance on the process for attaining personal funds after hours. Newly hired BOM□s and nurse supervisors to be educated during orientation. Postings located at the business office and reception office doors will alert cognitively intact residents to request	

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F 567	Continued From page 3 BOM revealed residents could obtain funds from their personal trust account during the posted business office hours of 8:30 AM to 4:30 PM and added she or the Administrator were usually in the facility until 5:00 PM to 6:00 PM most days. The BOM stated on the weekends, the receptionist had access to the residents personal funds account if needed. The BOM confirmed that once she, the Administrator or Receptionist had left for the day residents had no access to their personal funds if needed. An interview on 12/07/17 at 4:05 PM the Administrator confirmed residents had no access to their personal funds once she, the BOM or Receptionist had left for the day. The Administrator stated she should have provided a more thorough explanation so the residents knew the Receptionist had access to their personal funds account on the weekend if needed. During a follow-up interview on 12/10/17 at 10:11 AM Resident #80 stated there had been times she would have liked to have access to her personal funds after hours and on the weekend in order to get snacks from the vending machine. Resident #80 added she was told staff couldn't get any money after the business office had closed for the day.	F 567	personal funds from the nurse supervisor after the regularly scheduled business hours of 8:00AM-5:00PM. The nurse supervisor will obtain and document dispersed funds for cognitively intact residents upon request from the designated, double-locked safe as available per the trust ledger. The BOM will reconcile the trust ledger and replenish funds weekly and as needed to ensure resident personal funds are available during evenings and weekends. The Business Office Manager or Administrator to complete quality assurance monitoring of five (5) cognitively intact residents to ensure the availability of trust funds after facility business hours. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months .The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive	

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F 567	Continued From page 4	F 567	Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan. AOC date= 1/8/18	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		1/8/18

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F 584	Continued From page 5 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store, dispose of and label personal hygiene items and personal equipment in 2 of 8 bathrooms observed on the 300 hall. Findings included: 1. a. Observations of the bathroom between rooms 314 and 316 at 8:57 AM on 12/06/17 revealed 2 unlabeled small basins on top of the toilet tank. One containing a toothbrush in a plastic container and a tube of toothpaste with no label. The 2nd small basin contained a white denture cup and a tube of toothpaste with no label. There was an unlabeled and unwrapped wash basin resting on the towel bar and an unlabeled and unwrapped wash basin with wet towels inside sitting on the floor of the bathroom behind the toilet and an unlabeled urinal hanging from towel bar.	F 584	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure personal hygiene items and personal equipment is stored, disposed of and labeled to maintain a safe, clean homelike . QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for two resident bathrooms between room #314 and #316 and room #313 and #315, it was determined that the	

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F 584	Continued From page 6 b. Observations of the bathroom between rooms 313 and 315 at 09:48 AM on 12/06/17 revealed 3 clear bags containing unlabeled bed pans and 1 unwrapped and unlabeled wash basin resting on top of the towel bar. c. Observations of the bathroom between rooms 314 and 316 at 12:21 PM on 12/11/17 revealed 2 small basins sitting on the toilet lid, 1 contained a toothbrush in a plastic container, mouthwash, and toothpaste all with no label and the 2nd small basin contained a denture cup, mouthwash and toothpaste with no label. Resting on the towel rack was wash basin that was unlabeled and unwrapped. d. Observations of the bathroom between rooms 313 and 315 at 12:29 PM on 12/11/17 revealed an unwrapped and unlabeled wash basin resting on the towel bar and in a plastic bag tied to the same towel rack was an unlabeled bed pan and a catheter bag with a yellow colored substance. On the other towel rack was a plastic bag with an unlabeled bed pan. On the toilet lid was an unwrapped and unlabeled catheter bag with a yellow substance. During an interview at 12:44 PM on 12/11/17, Nursing Assistant (NA) #4 confirmed she was assigned to rooms 313 through 315 on 12/11/17. The NA confirmed part of her assignment included protecting residents' personal hygiene items and equipment. NA #4 explained the catheter bag in the bathroom between 313 and 315 should have been discarded. NA #4 stated residents' personal hygiene items should be labeled and placed in a zip-lock bag. NA # stated she would replace, label, and wrap the personal	F 584	facility failed to ensure that a system was maintained and monitored for housekeeping and nursing to properly store, dispose of and label personal hygiene items and personal equipment. On 12/11/17, the nurse aide properly disposed of used catheter bag, bagged and removed soiled linens, cleaned soiled bathroom surfaces and labeled and stored personal hygiene items and equipment for resident bathrooms between room #314 and #316 and room #313 and #315. On 12/28/17, the Assistant Director of Clinical Services (ADCS) completed a QA (quality assurance) monitoring of resident bathrooms and bedrooms to ensure the proper storage, disposal and labeling of personal hygiene items and personal equipment to maintain a safe, clean homelike environment. Follow-up maintenance of resident personal space based on findings. By 1/5/18, the Assistant Director of Clinical Services (ADCS) provided education to housekeeping and nursing staff on the expectation of monitoring and maintaining resident bathrooms and bedrooms to ensure the proper storage, disposal and labeling of personal hygiene items and personal equipment to provide a safe, clean homelike environment. Newly hired housekeeping and nursing staff to be educated during orientation. Nursing staff to be responsible for labeling and bagging personal hygiene items and equipment in residents□ room upon	

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F 584	Continued From page 7 equipment items in plastic bags. NA #4 also indicated the personal hygiene items would be labeled and placed in a zip-lock bags. During an interview at 1:02 PM on 12/11/17, Nurse #3 revealed the residents' personal equipment should be stored in separate bags and labeled. Nurse #3 also revealed the catheter bag should have been discarded. During an interview at 1:09 PM on 12/11/17, the DON revealed her expectation was for staff to label and separately bag residents' personal equipment and personal hygiene items, so the items can be identified to prevent residents from using supplies that did not belong to them and to prevent spreading infections. During an interview at 1:24 PM on 12/11/17, the Administrator revealed her expectation was for staff to label and separately bag residents' personal equipment and personal hygiene items and for those items to be stored separately in a shared bathroom. The used catheter bag should not have been on the back of the toilet and should have been thrown away or correctly stored. The Administrator also revealed her expectation was for personal hygiene items to be labeled and placed in zip-lock bags for storing to prevent co-mingling resident items.	F 584	admission and as items are newly obtained labeling and proper storage items to maintain a safe, clean homelike environment. Housekeeping and nursing staff will observe resident rooms daily and follow-up based on findings. Soiled items to be bagged and disposed of or brought to dirty linen room for laundering as appropriate. The Director of Housekeeping and/or facility Department Heads to monitor resident rooms for compliance. The CNA Supervisor to complete quality assurance monitoring of five (5) resident bathrooms and bedrooms to ensure the proper storage, disposal of and labeling of personal hygiene items and personal equipment. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months .The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services,	

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F 584	Continued From page 8	F 584	Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan. AOC date= 1/8/18	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence.	F 636		1/8/18

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F 636	Continued From page 9 (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes and	F 636	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive	

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F 636	Continued From page 10 contributing factors for nutrition for 2 of 5 sampled residents (Resident #39 and Resident #78). Findings included: 1. Resident #39 was admitted on 10/24/17 with diagnoses that included age-related debility, glaucoma, and depression. Review of the significant change Minimum Data Set (MDS) dated 11/23/17 revealed Resident #39 was moderately impaired in cognition and required limited assistance with eating. The MDS further indicated Resident #39 had no natural teeth. Review of the Care Area Assessment (CAA) for Nutrition dated 11/28/17 revealed triggering conditions of a low body mass index and unhealed pressure ulcer. The CAA further noted Resident #39 was at risk for declining nutritional status due to functional problems that included vision impairment, limited range of motion and inability to perform Activities of Daily Living (ADL) without significant physical assistance. The CAA did not include a comprehensive individualized analysis of findings that addressed why the triggered areas were a problem for Resident #39, contributing factors or how the problems affected his nutritional status. During an interview on 12/10/17 at 4:40 PM the MDS Coordinator stated nutrition CAAs were completed by the Dietary Manager (DM). The MDS Coordinator reviewed the nutrition CAA dated 11/28/17 for Resident #39 and confirmed it did not contain a comprehensive analysis of findings.	F 636	Director to complete a root cause analysis and to develop corresponding corrective action to ensure resident Care Area Assessments (CAA□s) for nutrition are comprehensive and complete to include the underlying causes and contributing factors . QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #39 and #78 it was determined that the facility failed to ensure that the Dietary Manager lacked knowledge on completing comprehensive, complete CAA□s for nutrition and the Minimum Data Set (MDS) registered nurse validated for completeness prior to submission. On 12/28/17, the MDS nurse completed a correction to Resident #39 Comprehensive MDS Assessment dated 11/28/17 to ensure the CAA for nutrition was completed to include the underlying causes and contributing factors. On 12/28/17, the MDS nurse completed a correction to Resident #78 Comprehensive MDS Assessment dated 8/8/17 to ensure the CAA for nutrition was completed to include the underlying causes and contributing factors. On 12/31/17, the MDS nurse completed a QA (quality assurance) monitoring of residents□ with Comprehensive	

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F 636	Continued From page 11 During an interview on 12/10/17 at 4:50 PM the DM confirmed she had received training from the corporate office on how to complete CAAs on the MDS. The DM explained the analysis of findings would typically include triggering conditions, contributing factors and implemented interventions. The DM verified she normally completes the nutrition CAAs but was on vacation when Resident #39's nutrition CAA had been completed by the DM in training. The DM reviewed the nutrition CAA dated 11/28/17 for Resident #39 and confirmed it did not contain a comprehensive analysis of findings. During an interview on 12/11/17 at 12:00 PM the Director of Nursing (DON) stated it was her expectation for the CAA to be comprehensive and accurately reflect the resident's status at the time of the assessment. 2. Resident #78 was admitted 09/14/16 with diagnoses that included diabetes and depression. Review of the annual Minimum Data Set (MDS) dated 07/28/17 revealed Resident #78 was cognitively intact and required supervision with eating. The MDS indicated Resident #78 received insulin injections daily during the 7 day assessment period. The MDS further indicated she was on a therapeutic diet and had no natural teeth. Review of the Care Area Assessment (CAA) for Nutrition dated 08/08/17 revealed triggering conditions of a high body mass index and therapeutic diet. The CAA did not include a comprehensive individualized analysis of findings that addressed why the triggered areas were a problem for Resident #78, contributing factors or	F 636	Assessments completed 12/1/17-12/31/17 to ensure Care Area Assessments for nutrition are comprehensive to include underlying causes and contributing factors. No additional follow-up was indicated. MDS nurse evaluated other Department heads who complete CAAs for understanding of completion of CAAs. Re-education provided as needed On 12/28/17, the Regional Director of Clinical Services (RDCS) provided education to the Dietary Manager and MDS nurse on the completion of comprehensive Care Area Assessments for nutrition that include the underlying causes and contributing factors per the Resident Assessment Instrument (RAI) guidelines. Newly hired Dietary Managers and MDS nurses to be educated during orientation. The Dietary Manager will complete the Care Area Assessment for nutrition for residents□ Comprehensive MDS Assessment upon admission, annual and with significant changes as appropriate to include the underlying cause and contributing factors per the RAI guidelines. The MDS nurse will monitor and review CAA for completeness prior to submission and make corrective recommendations as appropriate. The Director of Clinical Services (DCS) and/or Assistant DCS to complete quality assurance monitoring of three (3) most recent resident Comprehensive MDS Assessments for complete nutrition	

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F 636	Continued From page 12 how the problems affected her nutritional status. During an interview on 12/10/17 at 1:44 PM the MDS Coordinator reviewed the nutrition CAA dated 08/08/17 for Resident #78 and stated it was completed by a DM who was no longer employed by the facility. The MDS Coordinator confirmed the nutrition CAA was not comprehensive and added the analysis of findings should have mentioned Resident #78 was diabetic and on a therapeutic diet. During an interview on 12/11/17 at 12:00 PM the Director of Nursing stated it was her expectation for the CAA to be comprehensive and accurately reflect the resident's status at the time of the assessment.	F 636	CAA□s per RAI guidelines. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months .The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan. AOC date= 1/8/18	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		1/8/18

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F 641	Continued From page 13 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) regarding antibiotics for 1 of 5 residents reviewed for unnecessary medications (Resident #78). Findings included: Resident #78 was admitted on 09/14/16 with diagnoses that included diabetes and depression. Review of Resident #78's medical record revealed a physician's order dated 10/12/17 which read in part, "Doxycycline (antibiotic used to treat and prevent infections) 100 milligrams twice daily for 10 days for left foot infection." Review of the quarterly MDS dated 10/27/17 revealed Resident #78 was cognitively intact and displayed no rejection of care. The MDS indicated Resident #78 received insulin injections daily during the 7 day assessment period. The MDS further indicated Resident #78 received no antibiotics. During an interview on 12/10/17 at 1:44 PM the MDS Coordinator stated she reviewed the resident's physician orders and Medication Administration Record (MAR) when completing Section N: Medications on the MDS in order to code medications administered during the 7 day assessment period. The MDS Coordinator reviewed Resident #78's MAR and acknowledged she had received antibiotics during the 7 day assessment period for the MDS dated 10/27/17.	F 641	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure the Minimum Data Set (MDS) is accurately coded the to reflect residents□ use of antibiotics. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for #78, it was determined that the facility failed to ensure that an antibiotic order was captured in Section N on a quarterly MDS. On 12/31/17, the MDS nurse completed a correction to Resident #78 quarterly MDS Assessment dated 10/27/17 to accurately reflect residents□ antibiotic use during the seven (7)day assessment period. On 12/31/17, the MDS nurse completed a QA (quality assurance) monitoring of residents□ with Minimum Data Set Assessments completed 12/1/17-12/31/17 to ensure accurate coding to Section N related to antibiotic use. No additional discrepancies noted. On 12/28/17, the Regional Director of	

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F 641	Continued From page 14 She confirmed Section N on the MDS dated 10/27/17 for Resident #78 had been inaccurately coded. During an interview on 12/10/17 at 3:50 PM the Director of Nursing stated it was her expectation for MDS assessments to be accurately coded.	F 641	Clinical Services provided education to the MDS registered nurses on the importance of a thorough resident chart review to accurately code Section N for antibiotic use during the seven (7) day assessment period for Minimum Data Sets prior to submission per the Resident Assessment Instrument (RAI) guidelines. The MDS nurse is responsible for completing resident MDS assessments upon admission, quarterly, annually and with significant change in resident condition to accurately reflect resident status and antibiotic use as coded in Section N. Prior to submission of a resident MDS assessment, the MDS nurse will revalidate coding for accuracy. Newly hired MDS licensed nurses will be education during orientation. The Director of Clinical Services (DCS) and/or Assistant DCS to complete quality assurance monitoring of three (3) most recent resident MDS Assessments for accurate coding of Section N for antibiotic use. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months .The QAPI Committee to evaluate the effectiveness	

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F 641	Continued From page 15	F 641	of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan. AOC date= 1/8/18	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to note a medication had been left off the December physician monthly orders and the Medication Administration Record (MAR) resulting in missed doses for 1 of 5 residents reviewed for unnecessary medications (Resident #5) and failed to write a physician's order as instructed by the physician to remove an elopement prevention device for 1 of 1 resident	F 658	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to meet professional standards of quality care and to ensure a.) residents are administered medications as ordered and b.) orders are obtained by the	1/8/18

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F 658	Continued From page 16 reviewed for elopement devices (Resident #6). The findings included: 1. Resident #5 was admitted to the facility 08/12/16 with diagnoses which included major depressive disorder and diabetes mellitus. A quarterly Minimum Data Set (MDS) dated 11/21/17 indicated the resident's cognition was intact. The MDS coded the resident with verbal behavioral symptoms directed toward others 1-3 days during the 7 day look back period. A review of Resident #5's medical record revealed a physician's order dated 10/13/17 for Remeron 7.5 milligrams (mg) at bedtime for decreased appetite. Further medical record review revealed the resident had some weight loss but had stabilized. A review of the 11/01/17 thru 11/30/17 monthly physician orders and MAR revealed an order for Remeron 7.5mg at bedtime. The November MAR contained nurse initials to indicate this medication was administered every night. A review of the 12/01/17 thru 12/31/17 monthly physician orders and MAR revealed there was no order for Remeron on either. Additional medical record review revealed no physician's order was written during the month of November 2017 to discontinue the Remeron. An interview was conducted with the Director of Nursing (DON) on 12/07/17 at 11:30 AM. The DON confirmed Remeron 7.5 mg was not listed on Resident #5's December 2017 monthly physician orders nor the December MAR but had	F 658	physician and transcribed onto the Treatment Administration Record (TAR) for the discontinuation of elopement prevention devices. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for a.) Resident #5, it was determined that the facility failed to acknowledge during monthly changeover and record review that the contracted Pharmacy failed to properly transcribe an order for Remeron from the November Medication Administration Record (MAR) onto the December MAR and b.) a physician order was not obtained for Resident #6 for the discontinuation of an elopement prevention device due to miscommunication between nursing. On 12/7/17, physician orders were obtained for Resident #5 to discontinue the use of Remeron due to weight stability and for Resident #6 to discontinue the elopement prevention device due to Elopement assessment indicating resident longer at risk for eloping. Corresponding care plans updated as appropriate. On 12/31/17, the Director of Clinical Services (DCS) and RN designee completed a QA (quality assurance) monitoring of residents□ physician orders from 12/1/17-12/31/17 to ensure accurate transcription onto the January MAR for	

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F 658	Continued From page 17 been on the November 2017 monthly physician orders and November MAR. The DON was unable to find a physician's order to discontinue the Remeron. The DON confirmed Resident #5 missed 6 doses of Remeron from 12/01/17 thru 12/06/17. The DON explained the facility's process of reconciling monthly physician orders from the previous month with the new month's orders to ensure the resident was getting correct medications. She further explained the hall nurse for each shift checked the orders and should have found the Remeron was missing. The DON added the nurses just missed that Remeron was not on the December physician orders and MAR. The DON stated she expected medications to be correct and for physician's orders to be followed. An interview was conducted with the facility Family Nurse Practitioner (FNP) on 12/07/17 at 5:09 PM. The FNP stated she did not see any harm caused to the resident for missing 6 doses of Remeron. The FNP explained the Remeron was used as an appetite stimulator for Resident #5. Since the resident's weight had stabilized over the past several months, she had written an order today to discontinue the Remeron. The Pharmacy that printed the physician monthly orders and MARs was notified and asked for an explanation of why the Remeron was left off the December monthly physician orders and MAR. After 3 phone calls, they were still investigating this issue. 2. Resident #6 was admitted to the facility on 10/24/17 with diagnoses that included anxiety, depression and other symptoms and signs involving cognitive functions and awareness.	F 658	medications and for elopement prevention devices on the TAR for implementation or discontinuation of elopement prevention devices per current Elopement Risk Assessments as indicated to meet professional standards of quality care. Follow-up clarification orders were obtained and transcribed as appropriate. By 1/8/18, the ADCS will provide education to licensed nurses on following physicians orders to meet professional standards of quality care. Education inclusive, but not limited to, obtaining, transcribing and administering medications and elopement prevention device orders, completing a comprehensive review month over month review of medication orders for accurate transcription onto the MAR and of elopement prevention devices onto the TAR as ordered. The Director of Clinical Services to be responsible for completing or delegating the monthly MAR/TAR review for accurate transcription of physician orders month over month. The licensed nursing assessing a resident for the necessity or discontinuation of an elopement prevention device will be responsible for obtaining and transcribing the order onto the TAR as received by the physician. Third shift licensed nurses will serve as a second check and be responsible for reviewing daily orders for accurate transcription and report discrepancies to the physician and Director of Clinical Services as appropriate for corrective	

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F 658	Continued From page 18 Review of the admission Minimum Data Set (MDS) dated 11/01/17 revealed Resident #6 was cognitively intact and displayed no wandering behaviors. The MDS further indicated Resident #6 required supervision to limited staff assistance with activities of daily living. Review of the nurses' notes for Resident #6 revealed an entry dated 11/13/17 which read in part, "resident wandering around facility looking for a way to go home, confused, wanderguard (elopement prevention device) to right ankle per physician order." Review of Resident #6's medical record revealed a physician's order dated 11/13/17 which read in part, "wanderguard for exit seeking behaviors." Review of Resident #6's Treatment Administration Record (TAR) for December 2017 revealed an undated order which read, "wanderguard for exit seeking behaviors, check placement every shift and check functioning every 11 PM to 7 AM shift." The TAR further indicated the order had been initialed as completed for the 11 PM to 7 AM shift on 12/06/17 and 12/07/17. An observation of Resident #6 on 12/06/17 at 10:18 AM revealed she did not have a wanderguard in place. An observation and interview with Resident #6 on 12/06/17 at 3:30 PM revealed she did not have a wanderguard in place. Resident #6 confirmed that she had been wearing a wanderguard but the nurse had removed it "about one week ago" when she had left the facility for an appointment. An observation of Resident #6 on 12/07/17 at	F 658	action. The DCS and/or Unit Manager will review physician orders during daily clinical meeting for accuracy. Newly hired licensed nurses will be educated upon hire. The Director of Clinical Services (DCS) and/or Assistant DCS to complete quality assurance monitoring of three (3) current month resident MARs for accurate medication transcription and of three (3) current month resident TARs for accurate elopement prevention device orders. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months .The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides	

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F 658	Continued From page 19 12:08 PM revealed she did not have a wanderguard in place. During an interview on 12/07/17 at 12:18 PM Nurse #3 stated a wanderguard device was ordered for Resident #6 shortly after her admission due to her confusion and exit seeking behaviors. Nurse #3 added during a discussion with the Administrator and Director of Nursing (DON) on 12/01/17 it was decided to reassess Resident #6 for elopement risk since her confusion and exit seeking behaviors had improved. Nurse #3 confirmed she had removed the wanderguard device from Resident #6 on 12/04/17 after she had been reevaluated and determined to no longer need the wanderguard device. Nurse #3 verified she had forgotten to write the order to discontinue the wanderguard device when it had been removed from Resident #6 on 12/04/17. During an interview on 12/07/17 at 12:40 PM the DON confirmed the wanderguard device was no longer appropriate for Resident #6 after she had been reassessed for elopement risk and Nurse #3 had forgotten to write the order to discontinue. The DON stated she would have expected for the order to be written when the wanderguard device had been removed from Resident #6.	F 658	and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan. AOC date= 1/8/18	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		1/8/18

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F 677	Continued From page 20 Based on observations, record review, and staff interviews the facility failed to provide nail care to 1 of 5 residents reviewed for activities of daily living (Resident #44). The findings included: Resident #44 was admitted to the facility 07/27/16 with diagnoses which included anxiety and dementia. A quarterly MDS dated 09/08/17 indicated the resident's cognition was moderately impaired and the resident required extensive staff assistance for all activities of daily living except eating which required limited staff assistance. A care plan dated 10/08/17 described Resident #44 with a self-care performance deficit. The care plan goal specified the resident would receive appropriate staff assistance for personal care. Interventions included extensive assist of staff regarding grooming. An observation 12/05/17 at 10:29 AM revealed Resident #44's fingernails extended 1/8 to 1/4 of an inch beyond her fingertips. All 5 nails on each hand were observed with debris caked under each nail. An additional observation 12/07/17 at 8:23 AM revealed the fingernails remained unchanged in appearance and debris under each nail. During this observation Resident #44 stated she was proud of her long nails and wanted to keep them long. An interview with Nursing Assistant (NA) #2 was conducted 12/07/17 at 2:55 PM. NA #2 stated	F 677	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure residents dependent on assistance of staff with ADLs receive nail care per their plan of care. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #44, it was determined that the facility failed to monitor that nursing staff observed nails cleanliness during scheduled showers and daily hygiene care for dependent residents. On 12/7/17, NA #2 cleaned and filed Resident #44 nails. Nail care to be provided by certified nursing assistants and monitored by for compliance. On 12/29/17, the Assistant DCS and CNA Supervisor completed a QA (quality assurance) monitoring of dependent residents to ensure nails were cleaned, trimmed and free from jagged edges per plan of care. Follow up/nail care provided as indicated by findings By 1/8/2017, the Assistant Director of Clinical Services (ADCS) provided education to nurse aides and licensed nurses on the policy for providing and monitoring routine resident nail hygiene.	

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F 677	Continued From page 21 nail care which was described as cleaning and filing the nails was part of the shower routine. The NA confirmed he and NA #1 had given Resident #44 a shower today. When asked if nail care was included in the shower procedure, he replied he thought NA #1 did nail care. An observation was conducted on 12/07/17 at 4:57 PM with NA #2. Resident #44's nails remainded as previously observed. The NA confirmed debris was under each nail on both of Resident #44's hands. NA #2 began cleaning each nail with an emery stick. Caked debris was removed from underneath each of Resident #44's fingernails. NA #2 stated the debris appeared to be caked food. NA #2 was unaware Resident #44's nails were not clean. NA #1 was not available for interview. An interview was conducted with the Director of Nursing (DON) on 12/07/17 at 5:18 PM. The DON stated staff should evaluate fingernails every day for cleanliness. The DON added showers were an excellent opportunity to clean the nails.	F 677	Nursing staff to observe residents nails for length, smooth edges and cleanliness during routine hygiene care and provide nail care as appropriate or per resident choice. Nail care to be provided and documented per weekly bathing schedule and as needed and/or requested by the resident. The licensed nurse supervisor to monitor nail care by routine random observations and by review of shower documentation for compliance. Newly hired nurse aides and licensed nurses to be educated upon hire. The CNA Supervisor to complete quality assurance monitoring of 5 random dependent residents to ensure appropriate nail care per plan of care or per resident choice. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive	

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F 677	Continued From page 22	F 677	Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan. AOC Date: 1/8/18	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide a smoking apron for 1 of 1 resident reviewed for smoking (Resident #44) and failed to provide a slip resistant pad on a wheelchair used as a fall prevention device for 1 of 2 residents reviewed for falls (Resident #12). The findings included: 1. A facility smoking policy revised 10/01/17 specified the Center would provide a safe,	F 689	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure smoking aprons are worn by residents assessed as unsafe to smoke independently and slip resistant pads are placed in wheelchairs per safety care plan if indicated to prevent falls and maintain resident safety. QAPI committee members in attendance included the	1/8/18

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designated smoking area for residents. The Center will have safety equipment available in designated smoking areas including: smoking blankets, smoking aprons, a fire extinguisher and non-combustible self-closing ashtrays.

Resident # 44 was admitted to the facility 07/27/16 with diagnoses which included cognitive impairment and anxiety.

An annual Minimum Data Set (MDS) dated 07/28/17 indicated Resident #44 was a tobacco user. The MDS further indicated the resident's cognition was moderately impaired, required extensive staff assistance for all activities of daily living except for eating which required supervision, and demonstrated bilateral lower extremity impairment of range of motion. The MDS assessed the resident's mobility as dependent on using a wheelchair.

A care area assessment (CAA) associated with the annual MDS described Resident #44 as able to verbalize needs to staff, required extensive staff assist with activities of daily living related to bilateral lower extremity weakness and impaired mobility. The CAA further described the resident with chronic back pain impeding her mobility and used a broda chair (a wheelchair with a high back that tilts to a reclining position to provide comfort and relief of chronic pain) for mobility.

A quarterly MDS dated 09/08/17 indicated the resident's cognition was mildly impaired. The MDS further described the resident required extensive staff assistance for all activities of daily living except eating which required limited staff assistance. The MDS also indicated the resident used a wheelchair for mobility.

Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director.

Through Root Cause Analysis and based on the findings for a.) Resident #44, it was determined that the facility failed to ensure staff who supervise unsafe smokers comply with donning aprons on resident to prevent accidents and for b.) Resident #12, it was determined that the facility failed to ensure nursing staff monitor dycem for placement in residents wheelchair for fall management per safety care plan. Resident #44 to continue to don an apron while smoking and Resident #12 to continue to have dycem placed in wheelchair per their safety care plan.

On 12/12/17, the ADCS and licensed nurse designee completed a QA (quality assurance) monitoring of resident smokers to ensure residents assessed as unsafe to smoke independently don aprons for safety and residents with safety devices for fall management are in place per current plan of care.

By 1/8/18, the Assistant Director of Clinical Services (ADCS)provided education to nursing staff and department heads on the importance of monitoring unsafe smokers for donning aprons while smoking and ensuring fall management safety devices are in place per residents plan of care. Newy hired nursing staff and

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F 689	Continued From page 24 A safe smoking evaluation dated 09/28/17 indicated Resident #44 did not have fine motor skills needed to securely hold cigarettes. Needs apron was written in by this statement. Review of other areas evaluated revealed Resident #44 was unable to safely light cigarettes with a lighter, utilize an ashtray safely and properly and extinguish cigarettes safely and completely when finished smoking. Comments written on the form included resident was unable to balance self in chair. Also, unable to light cigarette and properly use ashtray. This evaluation was signed by Nurse #2 who was not available for interview. A care plan entitled safety-Smoking revised 10/31/17 identified Resident #44 with a potential for injury due to being a smoker with poor safety awareness. The care plan goal specified the resident would not pose a threat to self/others or surroundings during smoking. Interventions included safe smoking assessment quarterly and provide smoking apron as needed. An observation conducted 12/06/17 at 4:15 PM revealed Resident #44 in the designated smoking area in a reclining wheelchair positioned next to a round table. The resident was observed smoking a cigarette. The resident was by a round table that contained an ashtray. The resident was observed shaking ashes from the cigarette toward the ashtray with not all the ashes landing in the ashtray. Resident #44 was not wearing a smoking apron. Facility staff that was supervising the residents was sitting at another round table and was approximately 6 feet away from Resident #44. The resident's clothing did not demonstrate any signs of damage from smoking.	F 689	department heads to be educated during orientation . The licensed nurse to be responsible for implementing nursing interventions and/or physician orders as indicated to prevent accidents. During supervised smoking for unsafe smokers, the designated staff smoking supervisor to ensure an apron is applied. The ongoing monitoring to ensure compliance with smoking aprons and continued placement of safety devices for fall management to be the responsibility of nursing staff throughout their shift and department head will make observations during daily mock survey rounds and follow-up as necessary. The Director of Clinical Services or Licensed Nurse Supervisor to complete quality assurance monitoring of unsafe smokers while smoking for apron use and of 3 residents at risk for falls for placement of safety devices per plan of care. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and	

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F 689	Continued From page 25 An interview with Nursing Assistant (NA) #5 on 12/07/17 at 11:20 AM revealed different NAs were assigned to supervise residents assessed as unsafe smokers for each designated smoking time. When asked how they knew who was a safe smoker and who was not, NA #5 referred to a sheet posted at the nurses' station. The sheet was divided into 2 sections. One section listed the names of residents deemed safe smokers. The other section listed names of residents deemed unsafe smoker. Resident #44's name was noted on the unsafe smoker list. There was no notation of which residents required smoking aprons. An observation on 12/07/17 at 4:48 PM revealed NA #2 was supervising Resident #44 while smoking. The resident was observed in a reclining wheelchair, was covered with a cotton blanket used on resident beds and smoking a cigarette. No evidence of burns were noted on the blanket. No smoking apron was observed. An ashtray was positioned on the resident's chest and ashes were noted in and around the ashtray. When Resident #44 was finished with the cigarette, the resident placed the lighted cigarette butt in the ashtray. NA #2 was observed removing the ashtray and extinguishing the cigarette. At this time NA #2 was asked how he knew which residents required smoking aprons. NA #2 stated there were a couple of residents that required smoking aprons but the NA did not provide names of those residents. An additional observation on 12/10/17 at 11:00 AM revealed the Business Office Manager (BOM) was supervising the residents deemed as unsafe smokers. Resident #44 was observed in the reclining wheelchair and was not wearing a	F 689	make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan. AOC Date: 1/8/18	

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smoking apron. After Resident #44's cigarette had been lit and the resident had taken 2 puffs, the MDS Coordinator came out to the smoking area and provided a smoking apron for Resident #44. When asked where the smoking aprons were kept, the staff opened the box that contained residents' cigarettes. The aprons were located at the bottom of the box under the tray that held the cigarettes.

During an interview on 12/10/17 at 4:00 PM the BOM explained if the NAs were busy, she would take the residents deemed unsafe smokers out to smoke. She stated she got most of her information concerning which residents were deemed safe or unsafe smoker during the facility's morning meeting. The BOM added she did not provide a smoking apron for Resident #44 before the resident's cigarette was lit. She stated she knew the aprons were kept in the smoking box. The residents were late going out and wanted their cigarettes lit. She forgot to put the apron on Resident #44 before lighting the cigarette.

An interview was conducted with the Administrator on 12/10/17 at 3:27 PM. The Administrator stated it was her expectation for all residents that were deemed unsafe smokers to wear a smoking apron while smoking. The Administrator added the smoking apron should be in place before the cigarette was lit.

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2. Resident #12 was admitted to the facility on 06/18/12 with the diagnoses of dementia and depression.

Review of the physician treatment orders dated 11/01/17 through 11/30/17 read as place a dycem (a non-slip matting) to the wheelchair for safety and was implemented on 04/30/17.

The Care Area Assessment (CAA) of the comprehensive Minimum Data Set (MDS) dated 08/31/17 indicated Resident #12 was at risk for falls due to cognitive impairment with decreased safety awareness and limited mobility. The CAA also indicated a wheelchair was used for mobility and Resident #12 had one fall since the last assessment. The CAA included safety devices currently used were a bed alarm, a scoop mattress for the bed, and the bed was kept in the lowest position.

A review of the fall history revealed on 09/05/17 Resident #12 fell in floor from the wheelchair.

The quarterly MDS dated 11/26/17 indicated Resident #12 was severely impaired cognitively and needed extensive assistance with bed mobility and transfers and was not steady without assistance. The MDS also indicated Resident #12 had 1 fall since the previous assessment with no

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injury.

Review of the revised care plan dated 11/27/17 included a focus on safety and falls with a potential for injury as evidenced by poor safety awareness, confusion, and poor communication and comprehension. The interventions included a bed alarm and check placement every shift and function every day, occupational therapy to evaluate transfers and wheel chair mobility.

During an observation at 3:42 PM on 12/06/17, Resident #12 was leaning forward to grab at her shoe strings while sitting in her wheelchair. The dycem pad was not seen on the seat of the wheelchair.

During an observation at 4:11 PM on 12/06/17, Resident #12 was leaning forward to grab at her shoe strings while sitting in her wheelchair. The dycem pad was not seen on the seat of the wheelchair.

During an interview at 10:41 AM on 12/07/17, the Physical Therapy Assistant (PTA) #1 explained a dycem was a sticky/tacky thin pad resembling saran wrap and could be placed on the bottom and top of a wheelchair cushion to help prevent the cushion and resident from sliding forward.

During an interview at 11:22 AM on 12/07/17, PTA #2 confirmed there was no dycem pad placed on the wheelchair for Resident #12.

Review of the undated direct care staff care guide for Resident #12 revealed for safety use a dycem pad.

During an interview at 3:03 PM on 12/07/17, NA

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F 689	Continued From page 29 #4 revealed Resident #12 was assigned to her and she was responsible for checking the wheelchair for the dycem pad and explained she did not put the dycem pad on the wheelchair. NA #4 also revealed she had forgot to check the wheelchair for the dycem pad. A review of the revised care plan dated 12/07/17 revealed a dycem was added to the wheelchair as an additional approach to safety and fall prevention. During an interview at 8:17 AM on 12/08/17, the Director of Nurses revealed it was the expectation of the direct care staff to follow residents' care guide and make sure devices are in place and working properly and for nurses to check and make sure the devices are in place and working and if not to immediately place the device.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		1/8/18

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F 757	Continued From page 30 consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, physician, and staff interviews the facility failed to monitor a medication by not collecting a lab value as ordered by the physician for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #73). Findings included: Resident #73 was admitted to the facility on 12/27/16 with the diagnoses of vascular dementia, anxiety, and failure to thrive. The annual Minimum Data Set (MDS) dated 11/30/17 indicated severe cognitive impairment with physical behaviors directed towards others for 1 to 3 days and mood symptoms of feeling down, depressed, and hopeless for 1 day during the assessment look back period. A review of the revised care plan dated 11/30/17 included a focus of impaired behaviors related to cognitive loss and anxiety as evidence by violence towards others and scratching. The interventions included collect labs as ordered and report the results to physician. A review of the physician orders revealed on 11/14/17 an order was written to monitor the use of Depakote given for the diagnosis of dementia. The Medical Doctor (MD) wrote an order to collect a valproic acid level (VPA) and liver	F 757	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure diagnostic labs levels are obtained as ordered to provide proper monitoring of medications and to prevent unnecessary medication use. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #73, it was determined that the facility failed to ensure an effective and consistent communication process for obtaining resident labs as ordered. On 12/8/17, the licensed nurse notified the physician of the missed Valporic Acid level (VPA) , obtained STAT VPA level sample within normal limits, notified physician of results with no new orders received and completed incident report per policy. On 12/31/17, the Director of Clinical Services (DCS) completed a QA (quality	

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F 757	Continued From page 31 function test (LFT) on 11/28/17. A review of the lab results revealed on 11/28/17 a LFT was completed. The VPA was not in the chart and the facility was unable to provide the documentation to support the lab was collected. During an interview at 9:48 AM on 12/11/17, the MD revealed his expectations were for the VPA lab be collected and for the nurse to notify the physician of the lab results. During an interview at 10:04 AM on 12/11/17, Nurse #1 revealed she received the order on 11/14/17 to collect a VPA and LFT on 11/28/17 for Resident #73. Nurse #1 revealed she had correctly transcribed the labs to check in the communication book. Nurse #1 also revealed third shift was responsible for completing the lab requisition form used by the phlebotomist (a person who draws blood). A copy of the form revealed the LFT was checked, indicating blood was withdrawn from Resident #73 and the LFT was completed, but the VPA was not checked. Nurse #1 revealed she had not followed up on the labs, but the nurse who did receive the results must have compared them to the requisition copy and not the physician order and the VPA lab was missed. During an interview at 10:31 AM on 12/11/17, the Director of Nursing (DON) revealed her expectations were for the nurses to check and compare the lab results with the physician order and ensure all labs were correctly drawn.	F 757	assurance) monitoring of resident labs ordered 12/1/17-12/31/17 to validate resident lab values are collected as ordered. Follow-up lab draws and incident reports completed as indicated with no harm as a result of identified discrepancies. By 1/8/18, the Assistant Director of Clinical Services (DCS)provided education to licensed nurses on the facility policy and procedure for obtaining lab levels as ordered and to ensure appropriate monitoring to prevent the use of unnecessary medications. The licensed nurse receiving a lab order to be responsible for completing the lab requisition form and communicating lab order to be drawn in the Lab Book. The licensed nurse receiving the results of the ordered lab to be responsible for validating that the lab drawn correlates with the lab as ordered and results are communicated to the physician and response documented in the Lab Book and new orders processed as indicated. The Director of Clinical Services to review the Lab Book during Morning Clinical Meetings for compliance with obtaining and communicating lab levels and take corrective action as appropriate. Newly hired licensed nurses will be educated upon hire. The Director of Clinical Services or Licensed Nurse Supervisor to complete quality assurance monitoring of 3 random residents for compliance with obtaining lab levels as ordered. Monitoring to be	

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F 757	Continued From page 32	F 757	completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan. AOC Date: 1/8/18	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		1/8/18

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NAME OF PROVIDER OR SUPPLIER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 33 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide a hot and palatable breakfast meal for residents residing in the facility. The findings included: Due to multiple resident/complainant complaints, a breakfast tray was tested for palatability on 12/08/17. At 7:18 AM on 12/08/17 kitchen staff was observed plating breakfast foods and preparing trays for the residents that chose to eat breakfast in their rooms. The last tray cart designated for residents that ate in their rooms was prepared for hall 400. As the last resident tray was placed on the cart a test tray was requested. The test tray contained a plate of scrambled eggs, mechanical soft sausage covered with gravy, and toast that was covered with a plate cover. A covered bowl of grits was added to the test tray and placed by the covered plate along with a pad of butter. The test tray was placed on the 400 hall tray cart. The cart left the kitchen at 7:35 AM. The Dietary Manager (DM) was present for the preparation of the test tray and followed the cart to hall 400. At 7:37 AM staff began serving breakfast trays to the residents in their rooms. After all the breakfast trays were removed from the cart, the test tray was removed at 7:50 AM and taken to the nurses'	F 804	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure a hot and palatable breakfast meal for residents who reside in nthe facility. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings during a breakfast test tray of the 400 Hall, the facility failed to ensure a plate warming device was properly functioning to provide hot and palatable breakfast to facility residents. On 12/11/17, the Administrator submitted a requisition request to obtain a new plate warmer for the facility which was approved 12/28/17. While awaiting receipt of new warming appliance, the facility to ensure hot and palatable breakfast is provided to residents by warming plates through heated dish washing cycle as	

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F 804	Continued From page 34 station. The cover was removed from the grits and the pad of butter was placed on the grits. The cover was removed from the plate and the food was tasted by the surveyor and the DM. The DM agreed the scrambled eggs, mechanical soft sausage with gravy, and the toast were cold and not palatable. The butter was observed melting on the grits. The grits were tasted and described as warm. At this time, the DM stated the food temperatures were obtained just before the kitchen staff began plating the food for breakfast trays. She provided the documented temperatures. The eggs were 176 degrees Fahrenheit (F) and the mechanical soft sausage was 197 degrees F. She explained she had been working at this facility for 3 months and was expected to test a tray each month for palpability. The DM was unable to provide documented results of the monthly test trays. She stated she was unaware of residents' complaints of cold food. On 12/08/17 at 8:13 AM, Resident #81 who resided on the 400 hall was interviewed. Resident #81 always ate meals in her room. She stated the scrambled eggs she was served this morning were cold and not appetizing. The resident added the grits were warm and were palatable but would have been better if they had been hot. An interview with the Administrator on 12/10/17 at 3:02 PM stated she expected the food served to the residents was warm and palatable.	F 804	needed and use plate insulators. By 1/8/18, the Administrator educated the Dietary Manager and cooks on the expectation of serving a hot and palatable breakfast to residents who reside in the facility. Plates to be heated in the plate warming appliance prior to meal service to ensure temperature is maintained from the kitchen to the resident for consumption. Dietary Manager and/or cook designee to continue to monitor compliance by completing and documenting a test tray for hot and palatable food a minimum of two (2) meals per week per policy. Newly hired Dietary Managers and cooks will be educated upon hire. Residents to be queried in Resident Council and during Customer Service rounds regarding food temps with follow up as indicated. The Administrator and/or designated supervisor to complete quality assurance monitoring by questionnaire to three (3) cognitively intact residents regarding hot and palatable meals and per test tray. Monitoring to be completed at a frequency of 3 meals per week for 4 weeks then, 1 meal per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI	

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F 804	Continued From page 35	F 804	Committee monthly by the Executive Director for twelve months The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan. AOC Date: 1/8/18	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		1/8/18

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F 842	Continued From page 36 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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F 842	Continued From page 37 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to maintain an accurate Treatment Administration Record (TAR) for checking the placement of a wanderguard (elopement prevention device) for 1 of 1 sampled resident (Resident #6) during 6 consecutive shifts after the device had been discontinued. Findings included: Resident #6 was admitted to the facility on 10/24/17 with diagnoses that included anxiety, depression and other symptoms and signs involving cognitive functions and awareness. Review of the admission Minimum Data Set (MDS) dated 11/01/17 revealed Resident #6 was cognitively intact and displayed no wandering behaviors. The MDS further indicated Resident #6 required supervision to limited staff assistance with activities of daily living. Review of Resident #6's medical record revealed a physician's order dated 11/13/17 which read in part, "wanderguard for exit seeking behaviors."	F 842	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure accurate Treatment Administration Records (TAR) are maintained for checking the placement of a wanderguard.. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #6, the facility failed to ensure licensed nurses accurately monitor wanderguards for placement each shift as ordered. On 12/11/17, the licensed nurse obtained an order for Resident #6 to discontinue the use a wanderguard and transcribed order onto the TAR.	

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F 842	Continued From page 38 Review of Resident #6's TAR for December 2017 revealed an undated order which read, "wanderguard for exit seeking behaviors, check placement every shift and check functioning every 11 PM to 7 AM shift." The TAR further indicated the order had been initialed as completed as indicated below: 7 AM to 3 PM shift on 12/04/17 and 12/05/17. 3 PM to 11 PM shift on 12/04/17 and 12/05/17. 11 PM to 7 AM shift on 12/05/17, 12/06/17 and 12/07/17. An observation of Resident #6 on 12/06/17 at 10:18 AM revealed she did not have a wanderguard in place. An observation and interview with Resident #6 on 12/06/17 at 3:30 PM revealed she did not have a wanderguard in place. Resident #6 confirmed that she had been wearing a wanderguard but the nurse had removed it "about one week ago" when she had left the facility for an appointment. An observation of Resident #6 on 12/07/17 at 12:08 PM revealed she did not have a wanderguard in place. During an interview on 12/07/17 at 12:18 PM Nurse #3 stated a wanderguard device was ordered for Resident #6 shortly after her admission due to her confusion and exit seeking behaviors. Nurse #3 added during a discussion with the Administrator and Director of Nursing (DON) on 12/01/17 it was decided to reassess Resident #6 for elopement risk since her confusion and exit seeking behaviors had improved. Nurse #3 confirmed she had removed	F 842	On 12/31/17, the DCS and RN Supervisor designee completed quality assurance monitoring of residents with current wanderguard orders for placement and accurate documentation on the Treatment Administration Record. No further discrepancies were identified. By 1/8/18, the Assistant Director of Clinical Services provided education to licensed nurses on the expectation of maintaining accurate medical records by monitoring for the placement of wanderguards be visual inspection and documenting findings as indicated on TAR. Newly hired licensed nurses to be educated during orientation. The DCS or Licensed Nurse designee to complete quality assurance of TARs for residents with wanderguard orders for accurate medical records. Monitoring to be completed at a frequency of 3 residents per week for 4 weeks then, 1 resident per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as	

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F 842	Continued From page 39 the wanderguard device from Resident #6 on 12/04/17 after it was determined the wanderguard device was no longer appropriate. Nurse #3 verified she had forgotten to write the order to discontinue the wanderguard device and acknowledged she had initialed Resident #6's TAR on 12/04/17 and 12/05/17 for wanderguard placement checks in error. During an interview on 12/07/17 at 12:40 PM the DON confirmed the wanderguard device was no longer appropriate for Resident #6 after she had been reassessed for elopement risk and was removed by Nurse #3 on 12/04/17. The DON added Nurse #3 had forgotten to write the order to discontinue the wanderguard device and confirmed the nursing staff had incorrectly documented placement checks were completed on Resident #6's TAR for 6 consecutive shifts after the device had been removed. The DON stated it was her expectation the TAR would be accurate. During an interview on 12/08/17 at 7:39 AM Nurse #4 confirmed she initialed Resident #6's TAR for wanderguard placement checks on 12/05/17, 12/06/17, and 12/07/17. Nurse #4 stated she was unaware it had been removed and discontinued.	F 842	necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan. AOC Date: 1/8/18	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 867		1/8/18

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F 867	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assurance Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in September of 2016. This was for a recited deficiency which was originally cited in August of 2016 on a complaint investigation and subsequently recited in November of 2017 on the current recertification survey. The deficiency was in the area of accidents hazards/supervision. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This tag is cross referred to: F689 483.25(d)(1)(2): Accident Hazards/Supervision: Based on observations, record review, and staff interviews, the facility failed to provide a smoking apron for 1 of 1 resident reviewed for smoking (Resident #44) and failed to provide a slip resistant pad on a wheelchair used as a fall prevention device for 1 of 2 residents reviewed for falls (Resident #12). The facility was recited for F 689 for failure to provide a resident deemed an unsafe smoker a smoking apron and failure to provide a slip resistant pad on a wheelchair. Originally the facility was cited at F323 483.25(d)(1)(2) (Accidents/Supervision) for failure to secure a resident and his wheelchair during van transportation causing the resident to fall and hit his head.	F 867	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure smoking aprons are worn by residents assessed as unsafe to smoke independently and slip resistant pads are placed in wheelchairs per safety care plan if indicated to prevent falls and maintain resident safety. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for a.) Resident #44, it was determined that the facility failed to ensure staff who supervise unsafe smokers comply with donning aprons on resident to prevent accidents and for b.) Resident #12, it was determined that the facility failed to ensure nursing staff monitor dycem for placement in residents wheelchair to prevent falls per safety care plan. Resident #44 will continue to don an apron while smoking and Resident #12 will continue to have dycem placed in wheelchair per their safety care plan. On 12/29/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis	

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F 867	Continued From page 41 During an interview on 12/11/17 at 2:28 PM, the Administrator stated she had been working at this facility for 4 months and had multiple Directors of Nursing. The Administrator added 12/15/17 would be her last day. A new Administrator and a new Director of Nursing were starting this week. She stated she hoped filling these positions permanently would bring stability to this facility.	F 867	and to develop corresponding corrective action to ensure the facility maintains an effective QAPI program to provide adequate supervision to prevent accidents. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for two repeat citations related to providing supervision to prevent accidents, it was determined the facility failed to broaden quality monitoring to include areas at risk outside of the specific areas of deficient practice. On 1/5/18, the DCS and designee completed a QA (quality assurance) monitoring of resident smokers to ensure residents assessed as unsafe to smoke independently don aprons for safety and residents with safety devices to prevent falls are in place per current plan of care. By 1/03/18,the licensed nurse completed an updated smoking assessment for residents who smoke to evaluate residents ability to safely smoke. A facility smoking agreement was signed and agreed to by each smoker to ensure understanding of company policies and procedures to maintain safety. The licensed nurse updated each care plan as appropriate for smoking for smoking and fall prevention to maintain the safety of residents.	

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F 867	Continued From page 42	F 867	By 1/8/18, the Assistant Director of Clinical Services (ADCS)provided education to nursing staff and department heads on the importance of monitoring unsafe smokers for donning aprons while smoking and ensuring safety devices are in place per residents□ plan of care to prevent falls. Newly hired nursing staff and department heads will be educated upon hire. The licensed nurse will be responsible for implementing nursing interventions and/or physician orders as indicated to prevent accidents. During supervised smoking for unsafe smokers, the designated staff smoking supervisor will ensure an apron is applied. The ongoing monitoring to ensure compliance with smoking aprons and continued placement of safety devices for fall preventions will be the responsibility of nursing staff throughout their shift and department head will make observations during daily mock survey rounds and follow-up as necessary. On 1/3/18, the Regional Director of Clinical Services provided education to the Interdisciplinary Team (IDT), including the Executive Director, Maintenance Director, Admissions Director and Coordinator, Medical Records, Social Services, Business Officer Manager, Director of Clinical Services, Minimum Data Set Director, Dietary Manager and Central Supply on Federal Regulation F867 and corporate's QAPI Committee Policy regarding the expectations of maintaining an ongoing Quality Assurance	

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F 867	Continued From page 43	F 867	and Performance Improvement (QAPI)program. The QAPI Committee consists of the Executive Director, Director of Clinical Services, Medical Director and at least 3 other members and meets at least monthly (Medical Director at least quarterly). Education also included the processes and procedures of implementing, reviewing and revising ongoing action plans for areas of deficiency that have been previously identified and broadening scope for potential areas at risk for cited areas,to attain and maintain substantial regulatory compliance and provide the highest level of care to residents. The Critical Element Pathway for preventing accidents per DHHS was reviewed by the IDT during QAPI committee meetings to prevent accidents and repeat citations for F689. The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. Newly hired IDT employees to be educated during orientation. The Director of Clinical Services or Licensed Nurse Supervisor to complete quality assurance monitoring of unsafe smokers while smoking for apron use and of 3 residents at risk for falls for placement of safety devices per plan of care. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance	

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F 867	Continued From page 44	F 867	Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Regional Director of Clinical Services and/or the Regional Vice President of Operations will attend the facility QAPI meeting at a minimum of quarterly to evaluate the effectiveness of the program and compliance with the ongoing monitoring and revision to the plan of correction as appropriate to maintain compliance. Reeducation, use of outside resources and/or disciplinary action will be implemented as necessary to reduce the risk of repeat citations. The Executive Director is responsible for the implementation and execution of this	

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NAME OF PROVIDER OR SUPPLIER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 45	F 867	plan. AOC Date: 1/8/18	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		1/8/18

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F 880	Continued From page 46 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to wash hands after providing personal care for 1 of 2 residents observed for incontinence care (Resident #21). The findings included:	F 880	On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure proper infection control	

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F 880	Continued From page 47 A review of a facility policy revised 08/29/17 regarding Hand Hygiene specified the purpose of this policy was to reduce the spread of germs in the healthcare setting. Hand hygiene should be performed before and after patient care, before initiating a clean procedure, and after glove removal. An observation was conducted on 12/05/17 at 10:52 AM of Nursing Assistant (NA) #1 and NA #3 providing incontinence care for Resident #21 after the resident asked to be changed because of being wet. NA #1 stabilized the resident and assisted with turning while NA #3 provided the care while utilizing the correct technique. When the NAs completed care for Resident #21, NA #3 removed her gloves and washed her hands while NA #1 gathered the soiled linen and placed it in a bag. NA #1 was observed removing her left glove while she held the bag with her gloved right hand. She opened the room door and was observed placing the bag of soiled linen in a covered hamper in the hallway. NA #1 removed her right glove and placed it in the hamper. NA #1 did not wash her hands. She was observed removing a clean bed pad from the clean linen cart located in the hallway and was proceeding to another resident's room. An interview was conducted with NA #1 at 11:00 AM before she entered the next resident's room. When asked if she was going to wash her hands, she replied after she got into the next resident's room. During this interview, NA #1 was holding the clean linen she had retrieved from the clean linen cart. An interview was conducted with the Director of	F 880	practices of handwashing before, during and after providing direct patient care. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and based on the findings for Resident #21, the facility failed to ensure a nurse aide washed her hands prior to providing incontinence care. On 12/11/17, the Assistant Director of Clinical Services provided 1:1 reeducation to NA #1 on following infection control precautions by washing hands with hand sanitizer or warm soap and water before, during and after incontinence care to prevent the spread of communicable infections. On 12/11/17, the DCS completed quality assurance (QA) monitoring of staff providing personal care to ensure proper handwashing practice. No additional concerns were identified. By 1/8/18, the Assistant Director of Clinical Services provided education to direct care staff on preventing the spread of infections by proper handwashing between patient incontinence care. Newly hired direct care staff will be educated during orientation. Direct care staff will wash hands with warm soap and water before, after and between patients□	

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F 880	Continued From page 48 Nursing (DON) on 12/10/17 at 1:34 PM. The DON stated she expected hands were washed after providing resident care and before going to the next resident or removing linen from the clean linen cart.	F 880	incontinence care as appropriate. On an ongoing basis, the ADCS or Licensed designee will complete quality assurance (QA) monitoring of handwashing for three (3) direct care staff during incontinence care for proper infection control practice. Monitoring to be completed at a frequency of 3 days per week for 4 weeks then, 1 day per week for 8 weeks, then monthly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedule modified based on findings. The results of the quality assurance monitoring to be reported to the QAPI Committee monthly by the Executive Director for twelve months The QAPI Committee to evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility certified nurse aides and LPN/RN designees. The Executive Director is responsible for the implementation and execution of this plan.	

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F 880	Continued From page 49	F 880	AOC Date: 1/8/18	