PRINTED: 01/12/2018 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		MPLETED
		345477	B. WING			C 1 2/11/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704		127172017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	5	F 00	00		
F 567	extended to 12/11/13 survey day. Event II	eather, this survey was 7 with 12/09/17 missed as a D #FI9611. nent of Personal Funds	F 56	67		1/8/18
SS=B	CFR(s): 483.10(f)(10) §483.10(f)(10) The r manage his or her fit the right to know, in facility may impose a funds. (i) The facility must r deposit their persona resident chooses to the facility, upon writ resident, the facility r esident's funds and and account for the p deposited with the fa section. (ii) Deposit of Funds (A) In general: Excel 10)(ii)(B) of this section any residents' persona interest bearing a separate from any or accounts, and that or resident's funds to the accounts, there mus for each resident's s maintain a resident's exceed \$100 in a no interest-bearing acco (B) Residents whose The facility must dep funds in excess of \$2	esident has a right to nancial affairs. This includes advance, what charges a against a resident's personal not require residents to al funds with the facility. If a deposit personal funds with ten authorization of a must act as a fiduciary of the hold, safeguard, manage, personal funds of the resident acility, as specified in this				
ADODATODY		/SLIPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>	TITI E		(X6) DATE

Electronically Signed 01/04/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345477	B. WING		С	
		343477	D. WING		12/11/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD		
IIIE OAK	JAI OWLETEN ONLEN			ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 567	Continued From page	e 1	F 56	7		
	the facility's operating	accounts, and that credits				
	, , ,	resident's funds to that				
		ccounts, there must be a				
	` .	for each resident's share.)				
		ntain personal funds that do				
	-	noninterest bearing account,				
	interest-bearing acco	unt, or petty cash fund.				
	This REQUIREMENT is not met as evidenced					
		iews and interviews with		F tag 567 Trust Funds		
	residents and staff the facility failed to provide cognitively intact residents with access to			On 12/12/17, a Quality Assurance		
				Performance Improvement (QAPI)		
		he facility's business office		meeting was conducted by the Execu		
		led residents reviewed for		Director to complete a root cause ana	-	
	personal funds (Resid	dent #57 and Resident #80).		and to develop corresponding correct	ive	
	Finalinas in alualadı			action to ensure cognitively intact	a da	
	Findings included:			residents have access to personal fur after facility business hours. QAPI	ius	
	Deview of the informs	ation handbook included with		committee members in attendance		
		n packet revealed residents		included the Executive Director (QAP	4	
		sident trust account during		Coordinator), Director of Clinical Serv		
		office hours of 8:30 AM to		MDS nurse, Unit Manager, Dietary	1000,	
	5:00 PM, Monday thre			Manager, Social Worker, Activities		
				Director and Medical Director.		
	1. Resident #57 was	admitted to the facility on				
	03/14/16. A review o	f the quarterly Minimum		Through Root Cause Analysis and ba	sed	
	Data Set (MDS) date			on the findings for Resident #57 and	#80,	
	Resident #57 was co	gnitively intact.		it was determined that the facility faile	d to	
				ensure that a facility staff member wa	s	
	_	n 12/05/17 at 12:27 PM		assigned to provide access of person		
		she did not have access to		funds to cognitively intact residents at	iter	
	her personal funds ac	ccount on the weekends.		the facility business hours of	.	
		7/47		8:00AM-5:00PM Monday through Frid		
		7/17 at 8:30 AM with the		Residents have access of personal fu		
	Business Office Mana			after business hours including Reside	nts	
		n funds from their personal		#57 and #80		
		he posted business office		On 1/4/10 the Dusiness Office Man-		
		1:30 PM and added she or		On 1/4/18, the Business Office Manag	Jei	
	the Administrator Wer	e usually in the facility until		(BOM) completed a QA (quality		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345477	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343477	B: Willo _	STREET ADDRESS, CITY, STATE, ZIP CODE		2/11/2017	
NAME OF PI	ROVIDER OR SUPPLIER				Ξ		
THE OAK	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD			
•				ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 567	Continued From page	e 2	F 56	57			
	on the weekends, the the residents persona The BOM confirmed to Administrator or Rece	most days. The BOM stated a receptionist had access to al funds account if needed. that once she, the eptionist had left for the day ess to their personal funds if		assurance) monitoring of cogr residents who have personal the maintained by facility to ensure of funds after facility business during the evenings and week request to the nursing supervior on 12/27/17, the Regional Dir	unds e availability hours end upon sor.		
	Administrator confirm to their personal fund Receptionist had left Administrator stated s more thorough explai the Receptionist had	interview on 12/07/17 at 4:05 PM the ininistrator confirmed residents had no access heir personal funds once she, the BOM or ceptionist had left for the day. The ininistrator stated she should have provided a re thorough explanation so the residents knew Receptionist had access to their personal dis account on the weekend if needed.		Clinical Services provided eduthe Business Office Manager and Administrator on the facility possible ensuring resident personal fur available to cognitively intact rafter regularly scheduled busined Education was inclusive of possibusiness hours from 8:00AM-linstructions on accessing personal accessing personal education was inclusive of possibusiness hours from 8:00AM-linstructions on accessing personal education was inclusive of possibusiness hours from 8:00AM-linstructions on accessing personal education was inclusive to the provided education was included education was included education was inclusive to the provided education was included education was inclusive to the provided education was included education.	and blicy of nds are residents ness hours. sting of 5:00PM with		
	PM Resident #78 starn only get money out or business office hours had "never needed to the weekend but it wo could in case someth	Resident #78 added she o get money at night or on ould be nice to know you ing ever came up."		after hours during the evening weekend upon request to the supervisor, maintaining an up ledger balance and withdrawa providing cash funds in design safeguarded location for after accessibility. By 1/10/18, the Eprovided education to licensed	nursing dated trust I log and nated, BOM d nurse		
	02/04/16. A review o 11/10/17 revealed Re intact. During an interview o Resident #80 stated s her personal funds ac was unaware if other #80 added she could	admitted to the facility on f the quarterly MDS dated esident #80 was cognitively on 12/05/17 at 1:26 PM she was unable to access account on the weekends and staff had access. Resident only obtain funds from her at during business office		supervisors on the policy and of providing after hour availab funds to cognitively intact residence. On 1/4/18, a resident meeting was held and the BO additional education to resider attendance on the process for personal funds after hours. No BOM and nurse supervisor educated during orientation.	le personal dents upon council M provided nts in attaining ewly hired s to be		
	hours. An interview on 12/07	7/17 at 8:30 AM with the		Postings located at the busine and reception office doors will cognitively intact residents to	alert		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345477	B. WING				C 44/2047
NAME OF P	ROVIDER OR SUPPLIER	0-10-177	1	9	TREET ADDRESS, CITY, STATE, ZIP CODE	121	11/2017
TVAIVIL OF T	TOVIDER OR OUT FIELD				864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK				RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 567	Continued From page	e 3	F t	567			
F 567	BOM revealed reside their personal trust ac business office hours added she or the Adn the facility until 5:00 F. The BOM stated on the receptionist had accefunds account if need that once she, the Adhad left for the day retheir personal funds in their personal funds in their personal funds in their personal fund Receptionist had left Administrator stated smore thorough explain the Receptionist had funds account on the During a follow-up int AM Resident #80 statishe would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked personal funds after horder to get snacks from Resident #80 added statishes would have liked horder horder would have liked horder horder would have liked horder h	nts could obtain funds from account during the posted of 8:30 AM to 4:30 PM and ministrator were usually in PM to 6:00 PM most days. The weekends, the ss to the residents personal led. The BOM confirmed ministrator or Receptionist sidents had no access to f needed. 7/17 at 4:05 PM the led residents had no access so once she, the BOM or for the day. The she should have provided a mation so the residents knew access to their personal	F (567	personal funds from the nurse supervisafter 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 BON will reconcile the trust ledger and replenish funds weekly and as needed ensure resident personal funds are available during evenings and weekend. 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 perweek for 4 weeks then, 1 time per wee 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 effectivenes of the monitoring/observation tools for maintaining substantial compliance, an make changes to the corrective action necessary. The Quality Assurance Improvement Committee members	fl to ds.	
					_		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345477	B. WING _			12/1	1/2017
	ROVIDER OR SUPPLIER S AT SWEETEN CREEK			STREET ADDRESS, CITY, STA 3864 SWEETEN CREEK ROA			
				ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 567	Continued From page		F	Director, Director of Medical Director, Ph Social Services Dire Director, Maintenand Director, Minimum Director, Minimum Director, Minimum Director, and facility of and LPN/RN designs. The Executive Direct the implementation aplan. AOC date= 1/8/18	narmacy Consultant ector, Activities ce Director, Dietary Data Assessment ertified nurse aides ees.	or dis	
F 584 SS=D	CFR(s): 483.10(i)(1)-(§483.10(i) Safe Environment The resident has a rigoromfortable and home but not limited to receive the second s	onment. Int to a safe, clean, elike environment, including iving treatment and	F!	84		1	1/8/18
	homelike environmen use his or her persona possible. (i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall exthe protection of the ror theft. §483.10(i)(2) Housek	ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can rices safely and that the facility maximizes resident res not pose a safety risk. exercise reasonable care for resident's property from loss eeping and maintenance maintain a sanitary, orderly,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345477	B. WING			1	C 11/2017
	ROVIDER OR SUPPLIER S AT SWEETEN CREEK			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1864 SWEETEN CREEK ROAD ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	e 5	, F:	584			
	in good condition; §483.10(i)(4) Private						
	•	te and comfortable lighting					
	§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						
	sound levels. This REQUIREMENT by:	maintenance of comfortable is not met as evidenced					
	facility failed to store, personal hygiene iten	ns and staff interviews the dispose of and label ns and personal equipment bserved on the 300 hall.			On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executi Director to complete a root cause analy and to develop corresponding correctiv	/sis	
	Findings included:	Aho hadhasana haduusan			action to ensure personal hygiene item and personal equipment is stored,		
	rooms 314 and 316 a revealed 2 unlabeled toilet tank. One conta plastic container and label. The 2nd small the denture cup and a tub label. There was an unwash basin resting or				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 nurs Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director.	e,	
	towels inside sitting o	oped wash basin with wet n the floor of the bathroom an unlabeled urinal hanging			Through Root Cause Analysis and base on the findings for two resident bathroot between room #314 and #316 and root #313 and #315, it was determined that	ms n	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345477	B. WING		1:	C 2/11/2017	
NAME OF PI	ROVIDER OR SUPPLIER	L	-1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 1	2/11/2017	
				3864 SWEETEN CREEK ROAD			
THE OAK	S AT SWEETEN CREEK			ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 584	clear bags containing unwrapped and unlat top of the towel bar. c. Observations of the 314 and 316 at 12:21 small basins sitting o toothbrush in a plastitoothpaste all with no basin contained a de toothpaste with no lat rack was wash basin unwrapped. d. Observations of the 313 and 315 at 12:29 an unwrapped and un on the towel bar and same towel rack was catheter bag with a yellow substance. During an interview a Nursing Assistant (No	e bathroom between rooms 3 AM on 12/06/17 revealed 3 g unlabeled bed pans and 1 beled wash basin resting on 2 between rooms 1 PM on 12/11/17 revealed 2 in the toilet lid, 1 contained a c container, mouthwash, and 2 label and the 2nd small inture cup, mouthwash and 3 bel. Resting on the towel that was unlabeled and 2 between rooms 3 PM on 12/11/17 revealed inlabeled wash basin resting in a plastic bag tied to the 3 an unlabeled bed pan and a 3 ellow colored substance. On 3 was a plastic bag with an 3 on the toilet lid was an 3 beled catheter bag with a 3 through 315 on 12/11/17.	F 58	,	properly sonal uipment. operly bagged aned soiled and stored uipment for som #314 #315. Dector of oleted a QA of resident asure the abeling of resonal clean up anal space or of ded d nursing itoring and s and restorage, and hygiene		
	included protecting relitems and equipment catheter bag in the basis should have bee residents' personal habeled and placed in	esidents' personal hygiene . NA #4 explained the athroom between 313 and n discarded. NA #4 stated ygiene items should be n a zip-lock bag. NA # stated ubel, and wrap the personal		a safe, clean homelike environ Newly hired housekeeping and staff to be educated during orie Nursing staff to be responsible and bagging personal hygiene equipment in residents room	ment. I nursing entation. for labeling items and		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
			7 50.125 10			С	
		345477	B. WING			12/11/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
				3864 SWEETEN CREEK ROAD			
THE OAKS	S AT SWEETEN CREEK			ARDEN, NC 28704			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	(X5)		
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE	
F 584	Continued From page	2 7	F 58	4			
	equipment items in pl	astic bags. NA #4 also		admission and as items are ne	wly		
	indicated the persona	Il hygiene items would be		obtained labeling and proper s	torage		
	labeled and placed in	a zip-lock bags.		items to maintain a safe, clean	homelike		
				environment. Housekeeping ar			
	_	t 1:02 PM on 12/11/17,		staff will observe resident room	•		
	Nurse #3 revealed the			follow-up based on findings. So			
		stored in separate bags and		to be bagged and disposed of	-		
		o revealed the catheter bag		to dirty linen room for launderin	ng as		
	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			appropriate. The Director of			
				Housekeeping and/or facility Deliberation Heads to monitor resident room	-		
					115 101		
				compliance.			
		nal hygiene items, so the		The CNA Supervisor to comple	te quality		
		d to prevent residents from	assurance monitoring of five (5) resident				
		d not belong to them and to		bathrooms and bedrooms to er			
	prevent spreading info	-		proper storage, disposal of and			
				personal hygiene items and pe			
	During an interview a	t 1:24 PM on 12/11/17, the		equipment. Monitoring to be co			
	Administrator reveale	d her expectation was for		a frequency of 3 days per week	c for 4		
	staff to label and sepa	arately bag residents'		weeks then, 1 time per week for	or 8 weeks,		
	personal equipment a	and personal hygiene items		then monthly thereafter as dete	ermined by		
		be stored separately in a		the Quality Assurance Perform			
		e used catheter bag should		Improvement (QAPI) Committe			
	not have been on the			maintain compliance. Quality N	•		
		own away or correctly		schedule modified based on fir	idings.		
		ator also revealed her		The requite of the same life.			
		ersonal hygiene items to be		The results of the quality assur			
	prevent co-mingling re	zip-lock bags for storing to		monitoring to be reported to the Committee monthly by the Exe			
	prevent co-minging fo	esident items.		Director for twelve months .The			
				Committee to evaluate the effe			
				of the monitoring/observation to			
				maintaining substantial complia			
				make changes to the corrective			
				necessary. The Quality Assura			
				Improvement Committee memi			
				consist of, but not limited to, the			
				Director, Director of Clinical Se	rvices,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			71. 5012511			С	
		345477	B. WING _		12	2/11/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAK	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD ARDEN, NC 28704			
0/0/15	CHIMMADV CT.	ATEMENT OF DEFICIENCIES	ID.		ON	(V5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 636 SS=D	Continued From page Comprehensive Assection CFR(s): 483.20(b)(1)(1)	ssments & Timing	F 5	Medical Director, Pharmacy Consu Social Services Director, Activities Director, Maintenance Director, Die Director, Minimum Data Assessme Nurse, and facility certified nurse a and LPN/RN designees. The Executive Director is responsit the implementation and execution oplan. AOC date= 1/8/18	tary ot des le for	1/8/18	
SS=D	§483.20 Resident Ass The facility must cond a comprehensive, acc reproducible assessm functional capacity. §483.20(b) Comprehe §483.20(b)(1) Reside A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following: (i) Identification and d (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavio (vii) Psychological we	sessment duct initially and periodically curate, standardized nent of each resident's ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ement must include at least demographic information e. s.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345477	B. WING				C	
NAME OF P	ROVIDER OR SUPPLIER	343477	2	-	STREET ADDRESS, CITY, STATE, ZIP CODE	12	/11/2017	
					3864 SWEETEN CREEK ROAD			
THE OAK	S AT SWEETEN CREE	K			ARDEN, NC 28704			
(X4) ID	I .	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 636	Continued From pa	age 9	F	636				
	· ·	sis and health conditions.		000				
	(xi) Dental and nutr							
	(xii) Skin Conditions							
	(xiii) Activity pursuit							
	(xiv) Medications.							
		ents and procedures.						
	(xvi) Discharge plan							
	(xvii) Documentatio							
		ional assessment performed						
		riggered by the completion of						
	the Minimum Data							
	(xviii) Documentation	on of participation in						
	assessment. The a	assessment process must						
		rvation and communication						
		s well as communication with						
		ensed direct care staff						
	members on all shi	fts.						
	§483.20(b)(2) Whe	n required. Subject to the						
		ped in §413.343(b) of this						
		nust conduct a comprehensive						
		sident in accordance with the						
		ed in paragraphs (b)(2)(i)						
		section. The timeframes						
	-	343(b) of this chapter do not						
	apply to CAHs.							
		lar days after admission,						
	_	sions in which there is no						
	_	in the resident's physical or						
	1	For purposes of this section,						
	"readmission" means a return to the facility following a temporary absence for hospitalization							
	or therapeutic leave	-						
		ce every 12 months.						
	` '	NT is not met as evidenced						
by:		The first as syldenood						
	_	eviews and staff interviews the			On 12/12/17, a Quality Assurance			
		nplete Care Area Assessments			Performance Improvement (QAPI)			
	1	underlying causes and			meeting was conducted by the Evecut	iνρ		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(c	
		345477	B. WING			12/	11/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
THE OAK	AT OWEFTEN OBEEK			3	864 SWEETEN CREEK ROAD			
THE OAK	S AT SWEETEN CREEK			A	ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 636		e 10 or nutrition for 2 of 5 sampled 39 and Resident #78).	F	636	Director to complete a root cause analy and to develop corresponding corrective			
	Findings included:				action to ensure resident Care Area Assessments (CAA□s) for nutrition are comprehensive and complete to includ	e e		
	1. Resident #39 was admitted on 10/24/17 with diagnoses that included age-related debility, glaucoma, and depression.				the underlying causes and contributing factors . QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of			
	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.				Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director.			
					Through Root Cause Analysis and bas on the findings for Resident #39 and #it was determined that the facility failed 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 date 11/28/17 to ensure the CAA for nutrition was completed to include the underlyin causes and contributing factors. On 12/28/17, the MDS nurse completed a correction to Resident #78	78 to d d ed n		
	MDS Coordinator star completed by the Die MDS Coordinator rev dated 11/28/17 for Re	n 12/10/17 at 4:40 PM the ted nutrition CAAs were tary Manager (DM). The iewed the nutrition CAA esident #39 and confirmed it prehensive analysis of			Comprehensive MDS Assessment date 8/8/17 to ensure the CAA for nutrition v completed to include the underlying causes and contributing factors. On 12/31/17, the MDS nurse complete QA (quality assurance) monitoring of residents with Comprehensive	vas		

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NAME OF PROVIDER OR SUPPLIER THE OAKS AT SWEETEN CREEK THE OAKS AT SWEETEN CREEK ROAD ARCHAN, NO 2774 THE OAKS AT SWEETEN CREEK THE OAKS AT SWEETEN CREEK THE OAKS AT SWEETEN CREEK THE OAKS AT SWEETEN CREEK ROAD ARCHANGE NO CORRECTION THE OAKS AT SWEETEN CREEK THE OAKS AT SWEETEN CREEK ROAD ARCHANGE OF THE OAKS AND THE OAKS	STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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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 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								
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submission and make corrective recommendations as appropriate. 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 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		•	eutic diet and had no natural		-			
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 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		teeth.			-	-		
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 The Director of Clinical Services (DCS) and/or Assistant DCS to complete quality assurance monitoring of three (3) most recent resident Comprehensive MDS		.						
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 The Director of Clinical Services (DCS) and/or Assistant DCS to complete quality assurance monitoring of three (3) most recent resident Comprehensive MDS					recommendations as approp	oriate.		
therapeutic diet. The CAA did not include a and/or Assistant DCS to complete quality comprehensive individualized analysis of findings assurance monitoring of three (3) most that addressed why the triggered areas were a recent resident Comprehensive MDS					T. D. ((0):	· (DCC)		
comprehensive individualized analysis of findings assurance monitoring of three (3) most recent resident Comprehensive MDS								
that addressed why the triggered areas were a recent resident Comprehensive MDS								
		•	,		_	` '		
+ problem for Resident #76, contributing faciors of the season of the season of complete number 1					recent resident Comprehens Assessments for complete			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345477		B. WING		C 12/11/2017		
	ROVIDER OR SUPPLIER S AT SWEETEN CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704		2/11/2017
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 636	During an interview of MDS Coordinator revidated 08/08/17 for Recompleted by a DM with the facility. The Mithe nutrition CAA was added the analysis of mentioned Resident at the state of the the facility. During an interview of Director of Nursing state of the CAA to be considered.	n 12/10/17 at 1:44 PM the iewed the nutrition CAA esident #78 and stated it was who was no longer employed DS Coordinator confirmed a not comprehensive and	F 63	CAA sper RAI guidelines. Monibe completed at a frequency of 3 week for 4 weeks then, 1 time per for 8 weeks, then monthly theread determined by the Quality Assurate Performance Improvement (QAP Committee to maintain compliant Quality Monitoring schedule mode based on findings. The results of the quality assurate monitoring to be reported to the Committee monthly by the Execut Director for twelve months. The Committee to evaluate the effect of the monitoring/observation took maintaining substantial compliant make changes to the corrective an ecessary. The Quality Assurance Improvement Committee member consist of, but not limited to, the Director, Director of Clinical Services Director, Activities Director, Maintenance Director, Director, Maintenance Director, Director, Minimum Data Assessin Nurse, and facility certified nurse and LPN/RN designees. The Executive Director is respons the implementation and execution plan.	days per er week (after as ance ell) ce. (after ance ell)	
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy		F 64	AOC date= 1/8/18		1/8/18
						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	COMPLETED		
		345477	B. WING		C 12/11/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704	12/11/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 641	Continued From pag	e 13	F 64	1		
	resident's status. This REQUIREMEN' by:	st accurately reflect the T is not met as evidenced riew and staff interviews, the		On 12/12/17, a Quality Assurance		
	facility failed to accur Data Set (MDS) rega	rately code the Minimum arding antibiotics for 1 of 5 or unnecessary medications		Performance Improvement (QAPI) meeting was conducted by the Execu Director to complete a root cause and and to develop corresponding correct action to ensure the Minimum Data S	alysis tive	
	Findings included:			(MDS) is accurately coded the to refler residents use of antibiotics. QAPI	ect	
		Imitted on 09/14/16 with ded diabetes and depression.		committee members in attendance included the Executive Director (QAP Coordinator), Director of Clinical Serv		
	which read in part, "[to treat and prevent i	's order dated 10/12/17 Doxycycline (antibiotic used nfections) 100 milligrams		MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director.		
		s for left foot infection."		Through Root Cause Analysis and ba on the findings for #78, it was determ	ined	
	revealed Resident #7 displayed no rejectio Resident #78 receive during the 7 day assi	rly MDS dated 10/27/17 78 was cognitively intact and n of care. The MDS indicated ed insulin injections daily essment period. The MDS eident #78 received no		that the facility failed to ensure that all antibiotic order was captured in Section a quarterly MDS. On 12/31/17, the MDS nurse completed a correction to Resident #78 quarterly MDS Assess dated 10/27/17 to accurately reflect residents antibiotic use during the s (7)day assessment period.	on N e nent	
	MDS Coordinator staresident's physician of Administration Record Section N: Medication code medications and assessment period. reviewed Resident # she had received and	on 12/10/17 at 1:44 PM the ated she reviewed the orders and Medication of (MAR) when completing ons on the MDS in order to ministered during the 7 day The MDS Coordinator 78's MAR and acknowledged tibiotics during the 7 day		On 12/31/17, the MDS nurse complet QA (quality assurance) monitoring of residents with Minimum Data Set Assessments completed 12/1/17-12/3 to ensure accurate coding to Section related to antibiotic use. No additional discrepancies noted.	31/17 N I	
	assessment period for	or the MDS dated 10/27/17.		On 12/28/17, the Regional Director of	f	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345477	345477 B. WING			C 12/11/2017
	ROVIDER OR SUPPLIER S AT SWEETEN CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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	EIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 641	641 Continued From page 14		F 6	41		
	She confirmed Section 10/27/17 for Resider coded. During an interview of Director of Nursing s	on N on the MDS dated at #78 had been inaccurately on 12/10/17 at 3:50 PM the tated it was her expectation as to be accurately coded.		Clinical Services provided the MDS registered nurses importance of a thorough review to accurately code antibiotic use during the seassessment period for Mir Sets prior to submission p Assessment Instrument (Find MDS nurse is response completing resident MDS upon admission, quarterly with significant change in a condition to accurately refistatus and antibiotic use a Section N. Prior to submis resident MDS assessment nurse will revalidate coding Newly hired MDS licensed education during orientation. The Director of Clinical Seand/or Assistant DCS to consume a courate coding of Section use. Monitoring to be comfrequency of 3 days per withen, 1 time per week for 8 monthly thereafter as detequality Assurance Perforn Improvement (QAPI) Commaintain compliance. Quaschedule modified based of the results of the quality a monitoring to be reported for twelve monthly by the Director for twelve months Committee to evaluate the	s on the resident chart Section N for even (7) day nimum Data er the Resident RAI) guidelines. Sible for assessments annually and resident elect resident secoded in sion of a tat, the MDS g for accuracy. I nurses will be on. Privices (DCS) complete quality pree (3) most assemnts for a N for antibiotic pleted at a eek for 4 weeks a weeks, then emittee to ality Monitoring on findings. Assurance to the QAPI executive is The QAPI	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/11/2017	
		345477	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/11/2011	
THE 0 410			;	8864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 641	Continued From page	e 15	F 641	of the monitoring/observation tools for maintaining substantial compliance, an make changes to the corrective action necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Execu Director, Director of Clinical Services, Medical Director, Pharmacy Consultan 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 the plan.	as utive ut, y s	
F 658 SS=D	S483.21(b)(3) Comproduced The services provided as outlined by the commustic. (i) Meet professional of this REQUIREMENT by: Based on observation interviews, the facility had been left off the Endress and the Medic (MAR) resulting in miresidents reviewed for (Resident #5) and fail order as instructed by	ehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. is not met as evidenced ns, record review, and staff failed to note a medication December physician monthly ation Administration Record	F 658		ysis /e of s	

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AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3	(X3) DATE SURVEY COMPLETED C	
		345477	B. WING _		_	12/11/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				3864 SWEETEN CREEK RO	OAD		
THE OAK	S AT SWEETEN CREEK	(ARDEN, NC 28704			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S	S PLAN OF CORRECTION	(X5)	
PRÉFIX TAG			PREFIX TAG	CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
F 658	Continued From pag	ge 16	F6	58			
	reviewed for elopen	nent devices (Resident #6).		physician and trans			
	The findings include	54.		for the discontinuation	tration Record (TAR)		
	The infamge molade			prevention devices	•		
	1. Resident #5 was	admitted to the facility		members in attend			
		oses which included major			(QAPI Coordinator),		
	I	and diabetes mellitus. A			Services, MDS nurse,		
		Data Set (MDS) dated he resident's cognition was			tary Manager, Social Director and Medical		
		ided the resident with verbal		Director.	Director and Medical		
		ns directed toward others 1-3		Director.			
	days during the 7 da			Through Root Cau	se Analysis and based		
					a.) Resident #5, it was		
		nt #5's medical record		determined that the	-		
		n's order dated 10/13/17 for		_	ig monthly changeover		
		ams (mg) at bedtime for Further medical record		and record review	tnat the contracted properly transcribe an		
		resident had some weight		· ·	from the November		
	loss but had stabiliz				stration Record (MAR)		
				onto the December			
		1/17 thru 11/30/17 monthly		physician order wa	s not obtained for		
	· •	d MAR revealed an order for			e discontinuation of an		
	_	bedtime. The November		elopement prevent			
		se initials to indicate this			between nursing. On		
	medication was aun	ninistered every night.			orders were obtained discontinue the use of		
	A review of the 12/0	01/17 thru 12/31/17 monthly			eight stability and for		
		d MAR revealed there was no			continue the elopement		
	order for Remeron of			prevention device	due to Elopement		
				assessment indica	ting resident longer at		
		ecord review revealed no			rresponding care plans	i .	
	' '	as written during the month of		updated as approp	riate.		
	November 2017 to o	discontinue the Remeron.		O 40/04/47 H D	Nine at a mark Oliveia a l		
	Δn intervious was so	onducted with the Director of		On 12/31/17, the D Services (DCS) an			
		2/07/17 at 11:30 AM. The		completed a QA (q	_		
		meron 7.5 mg was not listed			ents⊟ physician orders		
		ecember 2017 monthly			I/17 to ensure accurate		
		r the December MAR but had			he January MAR for		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			، ا	С	
		345477	B. WING	B. WING			11/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAK	P AT OWELLEN OBEEK			38	864 SWEETEN CREEK ROAD			
THE UAK	S AT SWEETEN CREEK			Α	RDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	orders and Novembe unable to find a phys the Remeron. The D missed 6 doses of Re 12/06/17. The DON process of reconciling from the previous moorders to ensure the medications. She fur for each shift checker have found the Reme added the nurses just not on the December The DON stated she correct and for physical An interview was confamily Nurse Practitis 5:09 PM. The FNP sharm caused to the roof Remeron. The FN was used as an appearance over the past several order today to discontinued the proders and MARs was	er 2017 monthly physician or MAR. The DON was ician's order to discontinue ON confirmed Resident #5 emeron from 12/01/17 thru explained the facility's g monthly physician orders onth with the new month's resident was getting correct of the explained the hall nurse of the orders and should eron was missing. The DON to the most of the that the that the expected medications to be coan's orders to be followed. Inducted with the facility oner (FNP) on 12/07/17 at that she did not see any esident for missing 6 doses of the explained the Remeron exite stimulator for Resident of the sweight had stabilized months, she had written an tinue the Remeron.	F	658	medications and for elopement prevent devices on the TAR for implementation 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 appropriated and transcribed as appropriated 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 more review of medication orders for accurated 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 accurated transcription of physician orders month over month. The licensed nursing assessing a resident for the necessity of the control of the necessity of t	or n e. ng al		
	December monthly p After 3 phone calls, this issue. 2. Resident #6 was a 10/24/17 with diagno depression and other	de Remeron was left off the hysician orders and MAR. hey were still investigating dmitted to the facility on ses that included anxiety, symptoms and signs nctions and awareness.			discontinuation of an elopement prevention device will be responsible for obtaining and transcribing the order on the TAR as received by the physician. Third shift licensed nurses will serve as second check and be responsible for reviewing daily orders for accurate transcription and report discrepancies the physician and Director of Clinical Services as appropriate for corrective	to s a		

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AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345477	B. WING			
NAME OF PE	ROVIDER OR SUPPLIER	0.0.1.1		STREET ADDRESS, CITY, STATE, ZIP CODE	14	2/11/2017
TAPAWIE OF TH	COVIDEIX OIX OOI I EIEIX					
THE OAKS	THE OAKS AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD ARDEN, NC 28704		
(X4) ID	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
F 658	Continued From page		F 65	8		
	(MDS) dated 11/01/13 cognitively intact and behaviors. The MDS	ion Minimum Data Set 7 revealed Resident #6 was displayed no wandering further indicated Resident on to limited staff assistance living.		action. The DCS and/or Unit Mareview physician orders during clinical meeting for accuracy. N licensed nurses will be educate hire.	daily ewly hired d upon	
	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."			The Director of Clinical Services and/or Assistant DCS to comple assurance monitoring of three (month resident MARs for accurate medication transcription and of current month resident TARs for elopement prevention device or Monitoring to be completed at a	ete quality 3) current ate three (3) r accurate rders.	
				of 3 days per week for 4 weeks time per week for 8 weeks, ther thereafter as determined by the Assurance Performance Improv	then, 1 n monthly Quality	
	Record (TAR) for Decundated order which	6's Treatment Administration cember 2017 revealed an read, "wanderguard for exit neck placement every shift		(QAPI) Committee to maintain compliance. Quality Monitoring modified based on findings.	schedule	
	and check functioning The TAR further indic	g every 11 PM to 7 AM shift." ated the order had been I for the 11 PM to 7 AM shift		The results of the quality assura monitoring to be reported to the Committee monthly by the Executive Director for twelve months .The Committee to evaluate the effective control of the committee to evaluate the effective control of the committee to evaluate the effective control of the cont	QAPI cutive QAPI	
	An observation of Re 10:18 AM revealed sh wanderguard in place			of the monitoring/observation to maintaining substantial complia make changes to the corrective necessary. The Quality Assurar	ools for ince, and action as	
	12/06/17 at 3:30 PM wanderguard in place that she had been we nurse had removed it she had left the facilit	nterview with Resident #6 on revealed she did not have a revealed she confirmed rating a wanderguard but the rabout one week ago" when y for an appointment.		Improvement Committee member consist of, but not limited to, the Director, Director of Clinical Ser Medical Director, Pharmacy Co Social Services Director, Activit Director, Maintenance Director, Director, Minimum Data Assess Nurse, and facility certified nurs	pers Executive rvices, nsultant, ies Dietary sment	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345477	B. WING _	B. WING			C / 11/2017
	ROVIDER OR SUPPLIER S AT SWEETEN CREEK			38	REET ADDRESS, CITY, STATE, ZIP CODE 64 SWEETEN CREEK ROAD RDEN, NC 28704	<u> 121</u>	711/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	12:08 PM revealed sh wanderguard in place During an interview of Nurse #3 stated a wa ordered for Resident admission due to her behaviors. Nurse #3 with the Administrator (DON) on 12/01/17 it Resident #6 for elope confusion and exit se improved. Nurse #3 of the wanderguard devite 12/04/17 after she had determined to no long device. Nurse #3 ver write the order to discontinuation.	ne did not have a . n 12/07/17 at 12:18 PM nderguard device was #6 shortly after her confusion and exit seeking added during a discussion and Director of Nursing was decided to reassess ment risk since her	F6	658	and LPN/RN designees. The Executive Director is responsible for the implementation and execution of the plan. AOC date= 1/8/18		
F 677 SS=D	DON confirmed the w longer appropriate for been reassessed for a #3 had forgotten to w The DON stated she order to be written wh had been removed fro ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain of personal and oral hyg	ent who is unable to carry iving receives the necessary good nutrition, grooming, and	F 6	377			1/8/18

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
						С	
		345477	B. WING			2/11/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE OAK	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD			
THE GARGAT GWEETEN GREEK				ARDEN, NC 28704			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From pag	e 20	F 67	7			
	Based on observation interviews the facility 1 of 5 residents revieilving (Resident #44). The findings included Resident #44 was act with diagnoses which dementia. A quarterly MDS date resident's cognition with the resident required for all activities of darequired limited staff. A care plan dated 10 #44 with a self-care plan goal specificate plan goal specificate appropriate scare. Interventions in staff regarding groom. An observation 12/08 Resident #44's finger an inch beyond her finand were observed each nail. An additional observation revealed the fingerna appearance and deb this observation Resident	ens, record review, and staff failed to provide nail care to ewed for activities of daily. d: d: d: d: d: d: d: d: d: d		On 12/12/17, a Quality Assura Performance Improvement (QA meeting was conducted by the Director to complete a root cau and to develop corresponding action to ensure residents depe assistance of staff with ADLs recare per their plan of care. QAF committee members in attenda included the Executive Director Coordinator), Director of Clinica MDS nurse, Unit Manager, Die Manager, Social Worker, Activi Director and Medical Director. Through Root Cause Analysis a on the findings for Resident #4d determined that the facility faile monitor that nursing staff obser cleanliness during scheduled s and daily hygiene care for deperesidents. On 12/7/17, NA #2 c filed Resident #44 nails. Nail caprovided by certified nursing as and monitored by for compliance. On 12/29/17, the Assistant DC Supervisor completed a QA (quassurance) monitoring of deperesidents to ensure nails were a trimmed and free from jagged e plan of care. Follow up/nail card as indicated by findings.	API) Executive se analysis corrective endent on eceive nail PI ance r (QAPI al Services, tary ities and based 4, it was ed to rved nails howers endent eleaned and are to be assistants ce. S and CNA uality ndent cleaned, edges per e provided		
		rsing Assistant (NA) #2 was at 2:55 PM. NA #2 stated		Clinical Services (ADCS) provided education to nurse aides and linurses on the policy for providing monitoring routine resident nail	censed ng and		

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NAME OF PI	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE		271172017	
				3864 SWEETEN CREEK ROAD			
THE OAKS AT SWEETEN CREEK			ARDEN, NC 28704				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 677	Continued From page	÷ 21	F 6	.77			
F 677	nail care which was difling the nails was pare. The NA confirmed he Resident #44 a show care was included in the replied he thought NA. An observation was confirmed debris was Resident #44's hands each nail with an emeremoved from undern fingernails. NA #2 state be caked food. NA #2 state and interview was confirmed was confirmed debris was Resident #44's hands each nail with an emeremoved from undern fingernails. NA #2 state caked food. NA #2 state was allable for interview. An interview was confirmed was confirmed years and the caked staff show every day for cleanling the caked staff show every day for cleanling the caked food was confirmed was con	escribed as cleaning and rt of the shower routine. and NA #1 had given er today. When asked if nail the shower procedure, he a #1 did nail care. onducted on 12/07/17 at Resident #44's nails asly observed. The NA under each nail on both of a. NA #2 began cleaning ery stick. Caked debris was eath each of Resident #44's ated the debris appeared to 2 was unaware Resident elean. NA #1 was not	F 6	Nursing staff to observe resident for length, smooth edges and cludring routine hygiene care and nail care as appropriate or per rechoice. Nail care to be provided documented per weekly bathing and as needed and/or requester resident. The licensed nurse supmonitor nail care by routine rand observations and by review of succession documentation for compliance. It hired nurse aides and licensed resident residents to ensure appropriate nail care per plan of per resident choice. Monitoring completed at a frequency of 3 dues for 4 weeks then, 1 time provide for 8 weeks, then monthly there determined by the Quality Assurperformance Improvement (QAI Committee to maintain compliant Quality Monitoring schedule mobased on findings. The results of the quality assurate monitoring to be reported to the Committee monthly by the Execution for twelve months. The Committee to evaluate the effect of the monitoring/observation to maintaining substantial compliant make changes to the corrective necessary. The Quality Assurant Improvement Committee memb	deanliness deanliness desident		
					ers		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED		
			7 50.25	A. BOILDING		С	
		345477	B. WING _	B. WING		12/11/2017	
	ROVIDER OR SUPPLIER S AT SWEETEN CREEK			STREET ADDRESS, CITY, STATE, ZIP C 3864 SWEETEN CREEK ROAD ARDEN, NC 28704	ODE		
(X4) ID PREFIX TAG			ID PREFIX TAG	((EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 677	Continued From page		F 6	Director, Director of Clinica Medical Director, Pharmacy Social Services Director, Ar Director, Maintenance Dire Director, Minimum Data As Nurse, and facility certified and LPN/RN designees. The Executive Director is re the implementation and exe plan. AOC Date: 1/8/18	y Consultant, ctivities ctor, Dietary sessment nurse aides esponsible for	4/0/40	
F 689 SS=D	CFR(s): 483.25(d)(1)(1)(1)(1)(1)(2)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	are that - sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced as, record review, and staff failed to provide a smoking ent reviewed for smoking illed to provide a slip eelchair used as a fall 1 of 2 residents reviewed 2).	F 6	On 12/12/17, a Quality Ass Performance Improvement meeting was conducted by Director to complete a root and to develop correspondi action to ensure smoking a by residents assessed as u smoke independently and s pads are placed in wheelch care plan if indicated to pre maintain resident safety. Quenembers in attendance inc	(QAPI) the Executive cause analysising corrective prons are work unsafe to slip resistant nairs per safety event falls and API committee	s n	

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STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345477	B. WING			C	
NAME OF D	DOVIDED OD CLIDDLIED	343477		CTREET ADDRESS OITY STATE 71D CODE		2/11/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=		
THE OAKS	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD			
1112 07 111	5711 GWZZ 1211 GNZZIN			ARDEN, NC 28704			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	⊋ 23	F 68	9			
	Center will have safe designated smoking	area for residents. The ty equipment available in areas including: smoking rons, a fire extinguisher and closing ashtrays.		Executive Director (QAPI Cool Director of Clinical Services, Munit Manager, Dietary Manager Worker, Activities Director and Director.	IDS nurse, er, Social		
	impairment and anxie	ses which included cognitive ety.		Through Root Cause Analysis on the findings for a.) Residen determined that the facility fail staff who supervise unsafe sm	t #44, it was ed to ensure lokers		
An annual Minimum Data Set (MDS) 07/28/17 indicated Resident #44 was user. The MDS further indicated the cognition was moderately impaired, restensive staff assistance for all actives.		esident #44 was a tobacco er indicated the resident's ately impaired, required		comply with donning aprons of prevent accidents and for b.) F #12, it was determined that the failed to ensure nursing staff n dycem for placement in reside	Resident e facility nonitor		
	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.			wheelchair for fall manageme safety care plan. Resident #44 to don an apron while smoking Resident #12 to continue to ha placed in wheelchair per their	nt per I to continue g and ave dycem		
	the annual MDS desc to verbalize needs to staff assist with activi bilateral lower extrem mobility. The CAA fu with chronic back pai used a broda chair (a	ent (CAA) associated with cribed Resident #44 as able staff, required extensive ties of daily living related to nity weakness and impaired rther described the resident in impeding her mobility and a wheelchair with a high back position to provide comfort pain) for mobility.		plan. On 12/12/17, the ADCS and lice nurse designee completed a Completed a Complete assurance) monitoring of resides smokers to ensure residents a unsafe to smoke independent aprons for safety and resident devices for fall management apper current plan of care.	AA (quality lent Issessed as y don s with safety are in place		
	resident's cognition w MDS further describe extensive staff assistativing except eating w	ed 09/08/17 indicated the vas mildly impaired. The ed the resident required ance for all activities of daily which required limited staff S also indicated the resident remobility.		By 1/8/18, the Assistant Direct Clinical Services (ADCS)provideducation to nursing staff and heads on the importance of munsafe smokers for donning all smoking and ensuring fall mar safety devices are in place per plan of care. Newy hired nursi	ded department onitoring prons while nagement r residents□		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		C	
		345477	B. WING			l	_ 11/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	AT 014/55TEN 0055K			38	864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			Α	RDEN, NC 28704		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 689	Continued From page	e 24	F	689			
	. •				department heads to be educated during	na	
	A safe smoking evalu	uation dated 09/28/17			orientation .	-9	
	_	44 did not have fine motor			The licensed nurse to be responsible for	or	
	skills needed to secu	rely hold cigarettes. Needs			implementing nursing interventions and		
		by this statement. Review of			physician orders as indicated to prever		
		d revealed Resident #44 was			accidents. During supervised smoking	for	
	unable to safely light cigarettes with a lighter,				unsafe smokers, the designated staff		
	utilize an ashtray safely and properly and				smoking supervisor to ensure an apror	is	
	extinguish cigarettes safely and completely when				applied. The ongoing monitoring to ens	ure	
	finished smoking. Co			compliance with smoking aprons and			
	included resident was unable to balance self in				continued placement of safety devices		
		o light cigarette and properly			fall management to be the responsibili		
	-	aluation was signed by			of nursing staff throughout their shift ar		
	Nurse #2 who was no	ot available for interview.			department head will make observation	ıs	
	A	of the Constitute of the state of			during daily mock survey rounds and		
		safety-Smoking revised			follow-up as necessary.		
		esident #44 with a potential			The Director of Clinical Services or		
		g a smoker with poor safety e plan goal specified the			Licensed Nurse Supervisor to complete	<u> </u>	
		ose a threat to self/others or			quality assurance monitoring of unsafe		
		smoking. Interventions			smokers while smoking for apron use a		
		ng assessment quarterly and			of 3 residents at risk for falls for	ii id	
	provide smoking apro				placement of safety devices per plan of	f	
					care. Monitoring to be completed at a		
	An observation cond	ucted 12/06/17 at 4:15 PM			frequency of 3 days per week for 4 week	eks	
	revealed Resident #4	14 in the designated smoking			then, 1 time per week for 8 weeks, ther		
		neelchair positioned next to a			monthly thereafter as determined by th		
	round table. The res	ident was observed smoking			Quality Assurance Performance		
	_	dent was by a round table			Improvement (QAPI) Committee to		
		htray. The resident was			maintain compliance. Quality Monitorin	g	
	_	hes from the cigarette			schedule modified based on findings.		
		ith not all the ashes landing					
		dent #44 was not wearing a			The results of the quality assurance		
		ility staff that was supervising			monitoring to be reported to the QAPI		
		ting at another round table			Committee monthly by the Executive		
	and was approximately 6 feet away from				Director for twelve months The QAPI	_	
		esident's clothing did not			Committee to evaluate the effectivenes	8	
	demonstrate any sigr	ns of damage from smoking.			of the monitoring/observation tools for	d	
					maintaining substantial compliance, an	u	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OIVID IV	7. 0930-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						'	С
		345477	B. WING _			12/	11/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT SWEETEN CREEK			38	864 SWEETEN CREEK ROAD		
THE OAK	SAI SWEETEN CREEK			A	RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 689	12/07/17 at 11:20 AM assigned to supervise unsafe smokers for e time. When asked he safe smoker and who a sheet posted at the was divided into 2 se the names of residen The other section list deemed unsafe smok was noted on the uns no notation of which aprons. An observation on 12 NA #2 was supervisir smoking. The reside reclining wheelchair, blanket used on reside	rsing Assistant (NA) #5 on a revealed different NAs were a residents assessed as each designated smoking ow they knew who was a to was not, NA #5 referred to a nurses' station. The sheet actions. One section listed to deemed safe smokers. The red names of residents are residents required smoking are safe smoker list. There was residents required smoking are 1/07/17 at 4:48 PM revealed and Resident #44 while	F 6	689	make changes to the corrective action necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultan 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 the plan. AOC Date: 1/8/18	tive t,	
	the blanket. No smok An ashtray was positi and ashes were note When Resident #44 vicigarette, the resident butt in the ashtray. No removing the ashtray cigarette. At this time knew which residents NA #2 stated there we that required smoking provide names of tho An additional observation AM revealed the Bus was supervising the resmokers. Resident #	sing apron was observed. ioned on the resident's chest d in and around the ashtray. was finished with the t placed the lighted cigarette IA #2 was observed and extinguishing the e NA #2 was asked how he is required smoking aprons. ere a couple of residents g aprons but the NA did not					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		345477	B. WING			C 12/11/2017
	ROVIDER OR SUPPLIER S AT SWEETEN CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704	•	12/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	smoking apron. After had been lit and the r the MDS Coordinator area and provided a s #44. When asked where kept, the staff of contained residents' contained residents' contained residents' contained at the bottom that held the cigarette. During an interview of BOM explained if the take the residents designation concerning deemed safe or unsaffacility's morning meedid not provide a smobefore the resident's she knew the aprons box. The residents where wanted their cigarette apron on Resident #4 cigarette. An interview was con Administrator on 12/1 Administrator stated in residents that were dowern a smoking apropriate and provided a smoking apropriate and their cigarette.	Resident #44's cigarette esident had taken 2 puffs, came out to the smoking smoking apron for Resident here the smoking aprons bened the box that cigarettes. The aprons were of the box under the tray es. In 12/10/17 at 4:00 PM the NAs were busy, she would emed unsafe smokers out to he got most of her g which residents were fe smoker during the ching. The BOM added she king apron for Resident #44 cigarette was lit. She stated were kept in the smoking ere late going out and s lit. She forgot to put the 4 before lighting the ducted with the 0/17 at 3:27 PM. The t was her expectation for all emed unsafe smokers to he while smoking. The he smoking apron should	F	589		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345477	B. WING			C	
NAME OF B		343477	D: Willo		OTREET ARRESTO OITY OTATE ZIR CORE	12/	11/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS	S AT SWEETEN CREEK				3864 SWEETEN CREEK ROAD		
					ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	÷ 27	F	689			
	06/18/12 with the diag depression. Review of the physicia 11/01/17 through 11/3	admitted to the facility on gnoses of dementia and an treatment orders dated 80/17 read as place a dycem of the wheelchair for safety d on 04/30/17.					
	08/31/17 indicated Refalls due to cognitive is safety awareness and also indicated a wheel and Resident #12 had assessment. The CAA currently used were a	num Data Set (MDS) dated esident #12 was at risk for impairment with decreased il limited mobility. The CAA elchair was used for mobility id one fall since the last A included safety devices					
	Resident #12 fell in flo The quarterly MDS da Resident #12 was sev and needed extensive mobility and transfers assistance. The MDS	story revealed on 09/05/17 cor from the wheelchair. ated 11/26/17 indicated verely impaired cognitively e assistance with bed and was not steady without also indicated Resident #12 evious assessment with no					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345477	B. WING			C 12/11/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704	'	12/11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	included a focus on a potential for injury as awareness, confusio and comprehension. bed alarm and check function every day, o evaluate transfers and During an observation Resident #12 was less shoe strings while sit dycem pad was not a wheelchair. During an observation Resident #12 was less shoe strings while sit dycem pad was not a wheelchair. During an observation Resident #12 was less shoe strings while sit dycem pad was not a wheelchair. During an interview a Physical Therapy Assidycem was a sticky/t saran wrap and coulcand top of a wheelch the cushion and residuand top of a wheelch the cushion and residuand top of a wheelch the cushion and residuand top of the wheelchair for Residual Review of the undates.	d care plan dated 11/27/17 safety and falls with a evidenced by poor safety in, and poor communication. The interventions included a a placement every shift and occupational therapy to ad wheel chair mobility. In at 3:42 PM on 12/06/17, aning forward to grab at her ting in her wheelchair. The seen on the seat of the In at 4:11 PM on 12/06/17, aning forward to grab at her ting in her wheelchair. The seen on the seat of the at 10:41 AM on 12/07/17, the sistant (PTA) #1 explained a acky thin pad resembling d be placed on the bottom air cushion to help prevent dent from sliding forward. at 11:22 AM on 12/07/17, PTA was no dycem pad placed on esident #12.	F 6	39		
	pad.	ealed for safety use a dycem				
	puring an interview a	at 3:03 PM on 12/07/17, NA				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
						(c
		345477	B. WING _			12/	11/2017
	ROVIDER OR SUPPLIER S AT SWEETEN CREEK			3864	EET ADDRESS, CITY, STATE, ZIP CODE 4 SWEETEN CREEK ROAD DEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757 SS=D	#4 revealed Resident and she was respons wheelchair for the dyc did not put the dycem #4 also revealed she wheelchair for the dyc. A review of the revise revealed a dycem wa as an additional approprevention. During an interview a Director of Nurses revof the direct care staff guide and make sure working properly and make sure the device and if not to immediat Drug Regimen is Free CFR(s): 483.45(d)(1)-\$483.45(d) Unnecess Each resident's drug unnecessary drugs. Adrug when used-\$483.45(d)(1) In exceduplicate drug therapy \$483.45(d)(2) For exces \$483.45(d)(3) Without when used-\$483.45(d)(3) Without \$483.45(d)(3)	#12 was assigned to her ible for checking the cem pad and explained she pad on the wheelchair. NA had forgot to check the cem pad. d care plan dated 12/07/17 is added to the wheelchair pach to safety and fall t 8:17 AM on 12/08/17, the realed it was the expectation of to follow residents' care devices are in place and for nurses to check and is are in place and working rely place the device. It from Unnecessary Drugs (6) ary Drugs-General. It regimen must be free from An unnecessary drug is any ressive dose (including ty); or reserved the device of the		757			1/8/18

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345477	B. WING		C 12/11/2017
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	12/11/2011
THE OAK	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD	
THE OAK	S AI SWEETEN CREEK			ARDEN, NC 28704	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 757	Continued From page	e 30	F 757	7	
	consequences which reduced or discontinu	indicate the dose should be ued; or			
		mbinations of the reasons (d)(1) through (5) of this			
	section. This REQUIREMENT	「 is not met as evidenced			
	by:				
		iew, physician, and staff		On 12/12/17, a Quality Assurance	
	interviews the facility	llecting a lab value as		Performance Improvement (QAPI) meeting was conducted by the Execut	ive
		cian for 1 of 5 sampled		Director to complete a root cause ana	
		or unnecessary medications		and to develop corresponding correcti	•
	(Resident #73).			action to ensure diagnostic labs levels	
	,			obtained as ordered to provide proper	
	Findings included:			monitoring of medications and to prev unnecessary medication use. QAPI	ent
		mitted to the facility on		committee members in attendance	
	12/27/16 with the dia	~		included the Executive Director (QAPI	
		nd failure to thrive. The		Coordinator), Director of Clinical Servi	ces,
		a Set (MDS) dated 11/30/17		MDS nurse, Unit Manager, Dietary	
	_	nitive impairment with		Manager, Social Worker, Activities	
		rected towards others for 1 symptoms of feeling down,		Director and Medical Director.	
	_	eless for 1 day during the		Through Root Cause Analysis and base	has
	assessment look bac			on the findings for Resident #73, it wa	
	accessification bac	in portod.		determined that the facility failed to en	
	A review of the revise	ed care plan dated 11/30/17		an effective and consistent	
		npaired behaviors related to		communication process for obtaining	
	cognitive loss and an			resident labs as ordered. On 12/8/17,	the
	violence towards other	ers and scratching. The		licensed nurse notified the physician of	
	interventions included	d collect labs as ordered and		the missed Valporic Acid level (VPA),	
	report the results to p	hysician.		obtained STAT VPA level sample within	
				normal limits, notified physician of res	ults
		cian orders revealed on		with no new orders received and	
		s written to monitor the use		completed incident report per policy.	
		r the diagnosis of dementia.			
		MD) wrote an order to		On 12/31/17, the Director of Clinical	
	collect a valproic acio	l level (VPA) and liver		Services (DCS) completed a QA (qua	lity

	OF DEFICIENCIES CORRECTION			E SURVEY MPLETED			
		345477	B. WING			C 12/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.0		STREET ADDRESS, CITY, STATE, ZIP C		2/11/2017	
TVAIVIL OF T	NOVIDER OR OUT FEEL			3864 SWEETEN CREEK ROAD	ODE		
THE OAK	S AT SWEETEN CREE	K					
				ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 757	Continued From pa	ge 31	F 7	57			
	function test (LFT)	on 11/28/17.		assurance) monitoring of re ordered 12/1/17-12/31/17 to			
	LFT was completed chart and the facility	results revealed on 11/28/17 a I. The VPA was not in the y was unable to provide the upport the lab was collected.		resident lab values are colle ordered. Follow-up lab drav reports completed as indica harm as a result of identifie	ected as ws and incident ated with no		
	MD revealed his ex	at 9:48 AM on 12/11/17, the pectations were for the VPA d for the nurse to notify the results.		By 1/8/18, the Assistant Dir Clinical Services (DCS)pro- education to licensed nurse	vided es on the facility		
	Nurse #1 revealed a 11/14/17 to collect a Resident #73. Nurse correctly transcribed communication boothird shift was responsive requisition form use person who draws a revealed the LFT was withdrawn from was completed, but Nurse #1 revealed a labs, but the nurse must have compare and not the physicia missed.	at 10:04 AM on 12/11/17, she received the order on a VPA and LFT on 11/28/17 for se #1 revealed she had d the labs to check in the lok. Nurse #1 also revealed onsible for completing the labed by the phlebotomist (a blood). A copy of the form as checked, indicating blood in Resident #73 and the LFT is the VPA was not checked, she had not followed up on the who did receive the results and order and the VPA lab was that 10:31 AM on 12/11/17, the (DON) revealed her		policy and procedure for ob- levels as ordered and to en appropriate monitoring to p of unnecessary medication nurse receiving a lab order responsible for completing requisition form and commonder to be drawn in the La licensed nurse receiving the ordered lab to be responsible validating that the lab draw with the lab as ordered and communicated to the physi response documented in the and new orders processed The Director of Clinical Ser the Lab Book during Mornin Meetings for compliance wi and communicating lab leve corrective action as approp	revent the use s. The licensed r to be the lab unicating lab ab Book. The e results of the ble for ran correlates d results are cian and he Lab Book as indicated. Vices to reviewing Clinical ith obtaining els and take briate. Newly		
	expectations were f	(DON) revealed her for the nurses to check and sults with the physician order were correctly drawn.		hired licensed nurses will b upon hire. The Director of Clinical Ser Licensed Nurse Supervisor quality assurance monitorir residents for compliance will lab levels as ordered. Moni	vices or to complete ng of 3 random ith obtaining		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345477	B. WING		С
NAME OF PR	ROVIDER OR SUPPLIER	345477		STREET ADDRESS, CITY, STATE, ZIP CODE	12/11/2017
	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD	
				ARDEN, NC 28704	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 757	Continued From page	e 32	F 75	completed at a frequency of 3 days perweek for 4 weeks then, 1 time per week for 8 weeks, then monthly thereafter a 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 effectivene of the monitoring/observation tools for maintaining substantial compliance, at make changes to the corrective action necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Exect Director, Director of Clinical Services, Medical Director, Pharmacy Consultar Social Services Director, Activities Director, Maintenance Director, Dietar Director, Minimum Data Assessment Nurse, and facility certified nurse aider and LPN/RN designees. The Executive Director is responsible the implementation and execution of the plan. AOC Date: 1/8/18	ss and as utive ant,
F 804 SS=E		ar, Palatable/Prefer Temp (2)	F 80		1/8/18
	§483.60(d) Food and Each resident received	drink es and the facility provides-			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345477	B. WING		C 12/11/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704	1 12/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 804	Continued From page	e 33	F 80	04	
		repared by methods that ue, flavor, and appearance;			
	attractive, and at a sattemperature. This REQUIREMENT by: Based on observation facility failed to provide breakfast meal for restacility. The findings included Due to multiple reside a breakfast tray was 12/08/17. At 7:18 AM on 12/08/observed plating breattrays for the residents in their rooms. The later trays for the residents in their rooms.	is not met as evidenced in and record review, the de a hot and palatable sidents residing in the l: ent/complainant complaints, tested for palatability on 17 kitchen staff was akfast foods and preparing is that chose to eat breakfast ast tray cart designated for		On 12/12/17, a Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause at and to develop corresponding correlaction to ensure a hot and palatable breakfast meal for residents who renthe facility. QAPI committee membrattendance included the Executive Director (QAPI Coordinator), Director Clinical Services, MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Med Director.	nalysis ective eside in pers in
	hall 400. As the last the cart a test tray was contained a plate of soft sausage covered was covered with a pof grits was added to the covered plate alotest tray was placed cart left the kitchen at Manager (DM) was possible test tray and folloom 7:37 AM staff began residents in their roor trays were removed for soft soft sausages.	heir rooms was prepared for resident tray was placed on as requested. The test tray scrambled eggs, mechanical with gravy, and toast that late cover. A covered bowl the test tray and placed by ng with a pad of butter. The on the 400 hall tray cart. The tr.35 AM. The Dietary resent for the preparation of wed the cart to hall 400. At serving breakfast trays to the ms. After all the breakfast from the cart, the test tray AM and taken to the nurses'		Through Root Cause Analysis and to on the findings during a breakfast to of the 400 Hall, the facility failed to a plate warming device was properl functioning to provide hot and palate breakfast to facility residents. On 12/11/17, the Administrator subra requisition request to obtain a new warmer for the facility which was approved 12/28/17. While awaiting of new warming appliance, the facility ensure hot and palatable breakfast provided to residents by warming plathrough heated dish washing cycle.	est tray ensure ly able mitted v plate receipt ity to is lates

OL. TILIT	C . C	WEDIO/ ND CEITTICE				<u> </u>	2. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			7 50.25	_		,	С
		345477	B. WING				/11/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT SWEETEN CREEK			38	864 SWEETEN CREEK ROAD		
THE OAK	JAI SWELTEN CREEK			Α	RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804	and the pad of butter. The cover was remove food was tasted by the DM agreed the scrams ausage with gravy, a not palatable. The butter on the grits. The grits as warm. At this time temperatures were of kitchen staff began plut trays. She provided to temperatures. The effahrenheit (F) and the was 197 degrees F. working at this facility expected to test a transpected to test a transpected to test a transpected to the monthly was unaware of reside food. On 12/08/17 at 8:13 / resided on the 400 has Resident #81 always stated the scrambled morning were cold ar resident added the grapalatable but would held been hot. An interview with the	s removed from the grits was placed on the grits. The seed from the plate and the bold eggs, mechanical soft and the toast were cold and after was observed melting were tasted and described the DM stated the food obtained just before the ating the food for breakfast the documented ggs were 176 degrees emechanical soft sausage She explained she had been for 3 months and was yeach month for palpability. The oprovide documented seed trays. She stated she ents' complaints of cold for the state of the seed from the seed	F	804	needed and use plate insulators. By 1/8/18, the Administrator educated to Dietary Manager and cooks on the expectation of serving a hot and palata breakfast to residents who reside in the facility. Plates to be heated in the plate warming appliance prior to meal service ensure temperature is maintained from the kitchen to the resident for consumption. Dietary Manager and/or cook designed 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. New hired Dietary Managers and cooks will educated upon hire. Residents to be queried in Resident Council and during Customer Service rounds regarding for temps with follow up as indicated. The Administrator and/or designated supervisor to complete quality assurant monitoring by questionnaire to three (3 cognitively intact residents regarding he and palatable meals and per test tray. Monitoring to be completed at a freque of 3 meals per week for 4 weeks then, meal per week for 8 weeks, then month thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee to maintain compliance. Quality Monitoring schedu modified based on findings.	ble e e to of vly be od ce) ot ncy 1 nly	
					The results of the quality assurance monitoring to be reported to the QAPI		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345477	B. WING			C 12/11/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		12/11/2017
THE OAK	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 804	Continued From page	35	F 80	Committee monthly by the Exect Director for twelve months The Committee to evaluate the effect of the monitoring/observation too maintaining substantial complian make changes to the corrective anecessary. The Quality Assurant Improvement Committee member consist of, but not limited to, the Director, Director of Clinical Serv Medical Director, Pharmacy Consocial Services Director, Activities Director, Maintenance Director, Director, Minimum Data Assess Nurse, and facility certified nurse and LPN/RN designees. The Executive Director is responsible.	QAPI tiveness bls for nce, and action as ce ers Executive vices, nsultant, es Dietary ment e aides	
F 842 SS=B	CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not re resident-identifiable to (ii) The facility may re resident-identifiable to accordance with a col agrees not to use or of except to the extent th to do so. §483.70(i) Medical rec §483.70(i)(1) In according	483.70(i)(1)-(5) at-identifiable information. elease information that is to the public. lease information that is an agent only in intract under which the agent lisclose the information he facility itself is permitted	F 84	AOC Date: 1/8/18 42		1/8/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345477	B. WING			C 2/11/2017	
	ROVIDER OR SUPPLIER S AT SWEETEN CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704		12/11/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 842	must maintain medicathat are- (i) Complete; (ii) Accurately docum (iii) Readily accessibl (iv) Systematically on §483.70(i)(2) The face all information contain regardless of the form records, except wher (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pa operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purp purposes, research p medical examiners, fi a serious threat to he by and in compliance §483.70(i)(3) The face record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement	ented; e; and ganized illity must keep confidential ned in the resident's records, n or storage method of the n release is- or their resident permitted by applicable law; yment, or health care ted by and in compliance i; activities, reporting of abuse, violence, health oversight I administrative proceedings, poses, organ donation purposes, or to coroners, uneral directors, and to avert ealth or safety as permitted with 45 CFR 164.512. illity must safeguard medical gainst loss, destruction, or I records must be retained required by State law; or need date of discharge when ent in State law; or ars after a resident reaches	F 84:				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345477	B. WING			12/	11/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	2 AT 0WEETEN OBEEK			38	864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			Α	RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page §483.70(i)(5) The med (i) Sufficient informate (ii) A record of the reservity of the comprehension provided; (iv) The results of any and resident review of determinations conductive (v) Physician's, nurse professional's progred (vi) Laboratory, radio services reports as restricted from the comprehension of the comprehension	e 37 edical record must containion to identify the resident; sident's assessments; ive plan of care and services by preadmission screening evaluations and fucted by the State; ets, and other licensed is notes; and logy and other diagnostic equired under §483.50. To is not met as evidenced ons, record reviews and staff failed to maintain an administration Record (TAR) ement of a wanderguard on device) for 1 of 1 sampled 60 during 6 consecutive shifts		342		ve /sis re of	
	Review of the admiss (MDS) dated 11/01/1 cognitively intact and behaviors. The MDS	sion Minimum Data Set 7 revealed Resident #6 was displayed no wandering further indicated Resident ion to limited staff assistance			Director. Through Root Cause Analysis and base on the findings for Resident #6, the fact failed to ensure licensed nurses accurately monitor wanderguards for placement each shift as ordered. On 12/11/17, the licensed nurse obtained as	ility	
	a physician's order d	#6's medical record revealed ated 11/13/17 which read in person exit seeking behaviors."			order for Resident #6 to discontinue the use a wanderguard and transcribed orden onto the TAR.	е	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345477	B. WING		C 12/11/2017
NAME OF PI	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE	12/11/2017
				3864 SWEETEN CREEK ROAD	
THE OAK	S AT SWEETEN CREEK			ARDEN, NC 28704	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	
F 842	Continued From pag	e 38	F 842	2	
	Review of Resident #	#6's TAR for December 2017		On 12/31/17, the DCS and RN Supe	ervisor
	revealed an undated	order which read,		designee completed quality assuran	ice
	"wanderguard for exi	t seeking behaviors, check		monitoring of residents with current	
	placement every shif	t and check functioning		wanderguard orders for placement a	and
		shift." The TAR further		accurate documentation on the Trea	ıtment
	indicated the order h			Administration Record. No further	
	completed as indicate			discrepancies were identified.	
		nift on 12/04/17 and 12/05/17.		By 1/8/18, the Assistant Director of	- 1-
	12/05/17.	shift on 12/04/17 and		Clinical Services provided education	
		shift on 12/05/17, 12/06/17		licensed nurses on the expectation of maintaining accurate medical record	
	and 12/07/17.	mile 011 12/00/17, 12/00/17		monitoring for the placement of	13 by
	ana 12/01/11.			wanderguards be visual inspection a	and
	An observation of Re	esident #6 on 12/06/17 at		documenting findings as indicated o	
	10:18 AM revealed s	he did not have a		TAR. Newly hired licensed nurses to	
	wanderguard in place	е.		educated during orientation.	
		nterview with Resident #6 on		The DCS or Licensed Nurse design	
		revealed she did not have a		complete quality assurance of TARs	
		e. Resident #6 confirmed		residents with wanderguard orders f	
		earing a wanderguard but the		accurate medical records. Monitorin	g to
		t "about one week ago" when		be completed at a frequency of 3 residents per week for 4 weeks ther	
	She had left the facili	ty for an appointment.		resident per week for 8 weeks, then	
	An observation of Re	esident #6 on 12/07/17 at		monthly thereafter as determined by	
	12:08 PM revealed s			Quality Assurance Performance	
	wanderguard in place			Improvement (QAPI) Committee to	
	, 9			maintain compliance. Quality Monito	oring
	During an interview of	on 12/07/17 at 12:18 PM		schedule modified based on finding	
	_	anderguard device was			
	ordered for Resident			The results of the quality assurance	
		confusion and exit seeking		monitoring to be reported to the QA	
		added during a discussion		Committee monthly by the Executive	
		r and Director of Nursing		Director for twelve months The QA	
		was decided to reassess		Committee to evaluate the effective	
	Resident #6 for elope			of the monitoring/observation tools f	
	confusion and exit se			maintaining substantial compliance,	
	ımprovea. Nurse #3	confirmed she had removed		make changes to the corrective active	on as

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	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345477	B. WING			C
	ROVIDER OR SUPPLIER	343477	B. Wille	STREET ADDRESS, CITY, STATE, ZIP C 3864 SWEETEN CREEK ROAD ARDEN, NC 28704	ODE	12/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)		
F 842	the wanderguard dev 12/04/17 after it was device was no longer verified she had forgo discontinue the wand acknowledged she had TAR on 12/04/17 and placement checks in During an interview on DON confirmed the wlonger appropriate for been reassessed for removed by Nurse #3 added Nurse #3 had to discontinue the wa confirmed the nursing documented placement on Resident #6's TAR after the device had be stated it was her experience was accurate. During an interview on Nurse #4 confirmed stated it was her experience was unawant discontinued. QAPI/QAA Improvem CFR(s): 483.75(g)(2):	ice from Resident #6 on determined the wanderguard appropriate. Nurse #3 often to write the order to erguard device and ad initialed Resident #6's 12/05/17 for wanderguard error. In 12/07/17 at 12:40 PM the vanderguard device was not resident #6 after she had elopement risk and was a on 12/04/17. The DON forgotten to write the order inderguard device and gestaff had incorrectly ent checks were completed at for 6 consecutive shifts been removed. The DON ectation the TAR would be in 12/08/17 at 7:39 AM whe initialed Resident #6's a placement checks on ind 12/07/17. Nurse #4 are it had been removed ent Activities	F8	necessary. The Quality Ass Improvement Committee in consist of, but not limited to Director, Director of Clinical Medical Director, Pharmac Social Services Director, A Director, Maintenance Director, Minimum Data Ass Nurse, and facility certified and LPN/RN designees. The Executive Director is in the implementation and explan. AOC Date: 1/8/18	nembers o, the Execu- al Services, by Consultant activities ector, Dietary esessment nurse aides	t, , or

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		TE SURVEY MPLETED
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		345477	B. WING		1	2/11/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	CODE	
				3864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEP	•		ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 867	Continued From page	ge 40	F 86	57		
	- '	IT is not met as evidenced				
	by:	The field as evidenced				
	'	ions, record review, and staff		On 12/12/17, a Quality Ass	surance	
		ty's Quality Assurance		Performance Improvement		
		vement (QAPI) Committee		meeting was conducted by		
	failed to maintain im	plemented procedures and		Director to complete a root	cause analysis	
	monitor these interv	rentions that the committee		and to develop correspond	ing corrective	
	put into place in Sep	otember of 2016. This was for		action to ensure smoking a	prons are worn	
a recited deficiency which was originally cited in			by residents assessed as u			
		a complaint investigation and		smoke independently and	•	
	subsequently recited in November of 2017 on the current recertification survey. The deficiency was			pads are placed in wheelch	•	
				care plan if indicated to pre		
		ents hazards/supervision. The		maintain resident safety. Q		
		the facility during two federal		members in attendance inc		
		now a pattern of the facility's n effective QAPI program.		Executive Director (QAPI C	· · · · · · · · · · · · · · · · · · ·	
	IIIability to sustaill a	in ellective QAF1 program.		Director of Clinical Service: Unit Manager, Dietary Man		
	Findings included:			Worker, Activities Director	-	
	i indings included.			Director.	and Medical	
	This tag is cross ref	erred to:		Bir Cotor:		
	(ag 10 0.000 10.			Through Root Cause Analy	sis and based	
	F689 483.25(d)(1)(2): Accident		on the findings for a.) Resid		
	1	n: Based on observations,		determined that the facility		
		staff interviews, the facility		staff who supervise unsafe		
	failed to provide a s	moking apron for 1 of 1		comply with donning apron	s on resident to	
	resident reviewed for	or smoking (Resident #44)		prevent accidents and for b	o.) Resident	
		e a slip resistant pad on a		#12, it was determined that	t the facility	
		a fall prevention device for 1		failed to ensure nursing sta		
	of 2 residents reviev	wed for falls (Resident #12).		dycem for placement in res		
				wheelchair to prevent falls	•	
		ted for F 689 for failure to		plan. Resident #44 will con		
		leemed an unsafe smoker a		apron while smoking and R		
		failure to provide a slip		will continue to have dycen	•	
	•	vheelchair. Originally the		wheelchair per their safety	care pian.	
		F323 483.25(d)(1)(2)		On 12/20/17 a Ovality Ass	curance	
	resident and his wh	sion) for failure to secure a		On 12/29/17, a Quality Ass Performance Improvement		
		ing the resident to fall and hit		meeting was conducted by		
	his head.	ing the resident to fall and fill		Director to complete a root		

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
							0
		345477	B. WING			12/	11/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT SWEETEN CREEK			38	64 SWEETEN CREEK ROAD		
THE OAK	O AT OWLLTEN ONLLIN			AF	RDEN, NC 28704		
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Administrator stated s facility for 4 months a Nursing. The Admini- would be her last day new Director of Nursi She stated she hoped	n 12/11/17 at 2:28 PM, the she had been working at this nd had multiple Directors of strator added 12/15/17 A new Administrator and a ng were starting this week. If illing these positions ring stability to this facility.	F	867	and to develop corresponding corrective action to ensure the facility maintains a 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 base on the findings for two repeat citations related to providing supervision to prevaccidents, 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 arresidents with safety devices to preven falls are in place per current plan of car By 1/03/18, the licensed nurse complete an updated smoking assessment for residents who smoke to evaluate residents ability to safely smoke. A fact 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 appropriate for smoking for smoking ar fall prevention to maintain the safety of residents.	n f ed ent / re ed tillity	

PRINTED: 01/12/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT SWEETEN CREEK				8864 SWEETEN CREEK ROAD		
				1	ARDEN, NC 28704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345477	B. WING _		12/11/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE OAK	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD	
07	5711			ARDEN, NC 28704	
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F 867	Continued From page	÷ 43	F 86	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 broade scope for potential areas at risk for cit areas,to attain and maintain substanti regulatory compliance and provide the highest level of care to residents. The Critical Element Pathway for preventir accidents per DHHS was reviewed by IDT during QAPI committee meetings prevent accidents and repeat citations F689. The QAPI Committee to evalua the effectiveness of the monitoring/observation tools for maintaining substantial compliance, a make changes to the corrective action necessary. Newly hired IDT employe be educated during orientation. The Director of Clinical Services or Licensed Nurse Supervisor to comple quality assurance monitoring of unsafi smokers while smoking for apron use of 3 residents at risk for falls for placement of safety devices per plan care. Monitoring to be completed at a frequency of 3 days per week for 4 we then, 1 time per week for 8 weeks, the monthly thereafter as determined by ti Quality Assurance Performance	s ening ed all e

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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F 867	Continued From page	e 44	F 8	In me so T me con con me in con con con con con con con con con co	improvement (QAPI) Committee to naintain compliance. Quality Monitorin chedule 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 naintaining substantial compliance, and hake changes to the corrective action recessary. The Quality Assurance emprovement Committee members onsist of, but not limited to, the Executive processory. The Quality Assurance emprovement Committee members onsist of, but not limited to, the Executive process. Medical Director, Pharmacy Consultant social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Plurse, and facility certified nurse aides and LPN/RN designees. The Regional Director of Clinical Service and/or the Regional Vice President of Deparations will attend the facility QAPI meeting at a minimum of quarterly to evaluate the effectiveness of the program of compliance with the ongoing monitoring and revision to the plan of correction as appropriate to maintain ompliance. Reeducation, use of outside esources and/or disciplinary action will mplemented as necessary to reduce the sk of repeat citations.	es das tive t,	
					he Executive Director is responsible for implementation and execution of the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345477	B. WING				C / 11/2017
NAME OF PROVIDE	ER OR SUPPLIER			38	TREET ADDRESS, CITY, STATE, ZIP CODE 864 SWEETEN CREEK ROAD RDEN, NC 28704		
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	ction Prevention & R(s): 483.80(a)(1)(F	880	AOC Date: 1/8/18		1/8/18
The infect desi com dever dise \$480 program a mi \$480 proven arra conce acce \$480 proce but a conce infect pers	ction prevention a gned to provide a gned to provide a gned to provide a affortable environmelopment and trareases and infection param. facility must estal control program (animum, the follow in the facility in the follow in the facility in	blish and maintain an and control program a safe, sanitary and bent and to help prevent the asmission of communicable ans. brevention and control blish an infection prevention and PCP) that must include, at a ving elements: If the for preventing, identifying, and controlling infections seases for all residents, bors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following and ards; standards, policies, and bogram, which must include, lance designed to identify ble diseases or can spread to other					

NAME OF PROVIDER OR SUPPLIER THE OARS AT SWEETEN CREEK THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE ARON NO CONSTRUCTION SHOULD BE CROSS-REFERENCED TO HE APPROPRIATE THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE ARON NO CROSS-REFERENCED TO HE APPROPRIATE THE OARS AT SWEETEN CREEK ROAD ARON, NO 28740 THE ARON NO CROSS-REFERENCED TO HE APPROPRIATE THE ARON NO CROSS-REFERENCED TO HE APPROPRIATE		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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THE OAKS AT SWEETER CREEK CAN DISUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY AUST BE PRECEDED BY FULL PREFIX CACH DEFICIENCY AUST BE PRECEDED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONMETTING THE PRECEDED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTRED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE CONCESTED BY FULL CACH CORRECTIVE ACTION SHOULD BY FULL CACH CACH CACH CACH CACH CACH CACH CA	NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	11/2017
RRIEN, NC. 29704 SUMMARY STATEMENT OF DETICIENCIES PRECULATORY OR US CIDENTIFYING INFORMATION) PRIEFIX TAG CONTINUED FROM PROPERTY OR US CIDENTIFYING INFORMATION) 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:	THE OAK	S AT SWEETEN CDEEK		3864 SWEETEN CREE		864 SWEETEN CREEK ROAD		
FREETY TAG REDULATORY OR LSC IDENTIFYING INFORMATION) 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 is 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:	THE OAK	S AT SWEETEN CREEK			A	ARDEN, NC 28704		
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: The findings included:	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI			COMPLETION
	F 880	reported; (iii) Standard and tranto be followed to previous followed to previous foresident; including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employed disease or infected slacontact with residents contact will transmit to (vi) The hand hygiene by staff involved in disease of the following forester for the following following for the following fol	nsmission-based precautions rent spread of infections; plation should be used for a state to limited to: attended to a state of the isolation, infectious agent or organism. It the isolation should be the ble for the resident under the sunder which the facility sees with a communicable kin lesions from direct or their food, if direct the disease; and procedures to be followed rect resident contact. The for recording incidents acility's IPCP and the en by the facility. The store, process, and to prevent the spread of the view. The store is not met as evidenced and it is not met as evidenced and it is not met as evidenced and it is not met as evidents ence care (Resident #21).	F	880	Performance Improvement (QAPI) meeting was conducted by the Executi Director to complete a root cause analy and to develop corresponding correctiv	/sis re	
ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Fl9611 Facility ID: 923157 If continuation sheet Page 47 of 50		-						

PRINTED: 01/12/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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F 880	regarding Hand Hyging this policy was to recome the healthcare setting performed before an initiating a clean progremoval. An observation was a 10:52 AM of Nursing providing incontinent the resident asked to being wet. NA #1 states assisted with turning care while utilizing the NAs completed of removed her gloves NA #1 gathered the stag. NA #1 was obsimile she held the basing was her hands. She opened the room placing the bag of so hamper in the hallway glove and placed it in wash her hands. She clean bed pad from the hallway and was resident's room. An interview was cor AM before she enter When asked if she washe replied after she room. During this into the clean linen she halling the clean linen she halling and the clean linen she halling the c	policy revised 08/29/17 ene specified the purpose of luce the spread of germs in g. Hand hygiene should be d after patient care, before redure, and after glove conducted on 12/05/17 at Assistant (NA) #1 and NA #3 receare for Resident #21 after be changed because of abilized the resident and while NA #3 provided the recorrect technique. When rare for Resident #21, NA #3 and washed her hands while soiled linen and placed it in a reved removing her left glove ag with her gloved right hand. In door and was observed illed linen in a covered y. NA #1 removed her right in the hamper. NA #1 did not rewas observed removing a he clean linen cart located in proceeding to another Inducted with NA #1 at 11:00 red the next resident's room. The resident's room and retrieved from the clean reducted with the Director of	F 880	practices of handwashing before, diand after providing direct patient ca QAPI committee members in attendincluded the Executive Director (QAC Coordinator), Director of Clinical Set MDS nurse, Unit Manager, Dietary Manager, Social Worker, Activities Director and Medical Director. Through Root Cause Analysis and I 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 Clinical Services provided 1:1 reeds to NA #1 on following infection cont precautions by washing hands with sanitizer or warm soap and water to during and after incontinence care to prevent the spread of communicable infections. On 12/11/17, the DCS completed quassurance (QA) monitoring of staff providing personal care to ensure phandwashing practice. No additional concerns were identified. By 1/8/18, the Assistant Director of Clinical Services provided education direct care staff on preventing the sof infections by proper handwashing between patient incontinence care. hired direct care staff will be educated during orientation. Direct care staff wash hands with warm soap and washefore, after and between patients.	re. dance API ervices, pased e date date date date date date date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704			
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F 880	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 88	incontinence care as appropriate. On an ongoing basis, the ADCS of Licensed designee will complete quassurance (QA) monitoring of handwashing for three (3) direct care during incontinence care for properinfection control practice. Monitoring completed at a frequency of 3 days week for 4 weeks then, 1 day per variety weeks, then monthly thereafter and determined by the Quality Assurant Performance Improvement (QAPI) Committee to maintain compliance Quality Monitoring schedule modificated on findings. The results of the quality assurance monitoring to be reported to the Qay Committee monthly by the Execution Director for twelve months. The Qay Committee to evaluate the effective of the monitoring/observation tools maintaining substantial compliance make changes to the corrective accommittee to evaluate the effective of the monitoring observation tools maintaining substantial compliance make changes to the corrective accommittee to evaluate the effective of the monitoring observation tools maintaining substantial compliance make changes to the corrective accommittee to evaluate the effective of the monitoring observation tools maintaining substantial compliance make changes to the corrective accommittee members consist of, but not limited to, the Expirector, Director, Director, Pharmacy Consumptions of Clinical Services Director, Maintenance Director, D	uality are staff or ong to be so per week for as acce deceded. API ve tAPI eness as for e, and the stion as as acceutive the ses, cultant, etary ent aides		

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				ARDEN, NC 28704			
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