STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted from 12/17/18 through 12/21/18. Immediate Jeopardy was identified at: CFR 483.25 at tag F 689 at a scope and severity (J). The F 689 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/03/18 and was removed on 12/20/18. An extended survey was conducted.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Sleep Apnea/Continuous Positive Airway Pressure (CPAP) and Behaviors for 2 of 23 residents reviewed for receiving special treatments and procedures (Resident #44 and Resident # 47). The findings included: 1. Resident # 44 was admitted to the facility on 09/04/17 with an admitting diagnosis of a Urinary Tract Infection. Other diagnosis included Sleep Apnea and Chronic Obstructive Pulmonary Disease.	F 641	On 12/20/18 resident number 44's Minimum Data Set (MDS) was updated by the MDS nurse to accurately reflect the resident's current diagnosis of Sleep Apnea. On 1/15/19, resident number 47's MDS was updated by the MDS nurse to accurately reflect the resident's current status related to behaviors. On 1/15/19 through 1/18/19, the MDS nurse and/or Nursing Supervisor performed quality improvement monitoring of the last 90 days of MDS assessments for accurately coding behaviors and Sleep Apnea and/or the usage of a C-pap. Any issues identified were addressed.	1/22/19

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

Electronically Signed | 01/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 1 A review of Resident # 44's history and physical dated 09/04/17 revealed she had a diagnosis of Sleep Apnea and currently on CPAP. A review of the annual MDS dated 08/31/18 revealed in section I that Sleep Apnea was not coded. A review of the annual MDS dated 08/31/18 revealed in section O that CPAP was not coded. A review of a physician's order dated 10/17/18 for CPAP to be put on every night for sleep apnea, on at bedtime and off in the AM. A quarterly MDS dated 10/25/18 revealed Resident # 44 was alert and oriented and had no behaviors coded. It was further revealed that she needed extensive assistance needing assist times 2 staff for bed mobility, locomotion off the unit. She needed extensive assistance with 1 staff for transfers, dressing and toileting. Supervision after set-up with eating and limited assistance times 1 staff for hygiene. A review of the quarterly MDS dated 10/25/18 revealed in section I that Sleep Apnea was not coded. 12/19/18 10:01 AM An interview with the Medical Director revealed his expectations are that all resident orders be followed. He further stated that if the nursing staff had any problems they should contact himself or his nurse practitioner for clarification or new orders. 12/19/18 04:09 PM An interview with the Director of Nursing revealed her expectations are that the	F 641	The MDS nurse was reeducated by the Regional MDS nurse on accurate coding of the MDS on 1/11/19. The Director of Nursing (DON) and/or Nursing Supervisor to perform quality improvement monitoring of the MDS's for accurate coding of behaviors and Sleep Apnea and/or C-pap two times a week for four weeks, then one time a week for eight weeks, then one time monthly for three months. The Administrator introduced the plan of correction to the Quality Assurance/Performance Improvement (QAPI) Committee on 1/15/19. The information from the audits will be reviewed for 6 months at the QAPI meetings. The Administrator is responsible for implementing this plan. The QAPI Committee members consist of but are not limited to the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Unit Manager, Social Services Director, Maintenance Director, Housekeeping Supervisor, Dietary Manager, MDS Nurse, Activities Director, and one direct care giver. Quality Improvement monitoring schedule will be modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 2	F 641		

nursing staff follow the physician's orders for all the residents.

12/20/18 08:40 AM An interview with Resident # 44 reported that she was admitted to the facility in 09/04/2017 with her CPAP, and order to use every night for Sleep Apnea.

2. Resident #47 was admitted to the facility on 10/25/18 with diagnoses that included depression.

Record review of a list of medical diagnoses that were current indicated Resident #47 had a diagnosis upon admission on 10/25/18 of "unspecified altered mental status."

Record review of nurse's notes dated for 10/25/18 revealed Resident #47 "won't use call light just screams out."

Record review of nurse's notes dated for 10/27/18 revealed Resident #47 "won't use call light just screams out."

Record review of the admission Minimum Data Set (MDS) dated 11/01/18 revealed Resident #47 had short and long-term memory problems. The MDS also revealed Resident #47 required limited to extensive assistance with most activities of daily living. The MDS further revealed Resident #47 had no mood or behavioral issues and no rejection of care.

Record review of a care plan dated for 11/06/18 revealed the following: "the resident has a behavior problem (yelling out instead of using call bell)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 3 During an interview on 12/18/18 at 7:14 AM, Nurse Assistant (NA) #4 stated Resident #47 did holler out sometimes and he was able to use his call light but didn't. During an interview on 12/20/18 at 7:15 PM, Nurse #6 stated Resident #47 would scream out and say "hey, hey, hey" several times throughout the evening. Nurse #6 also stated she had been told by a day shift nurse (7AM - 7PM) that he hollered out during the day as well. Nurse #6 further stated they made sure the call light was within reach where Resident #47 could use it, but he wouldn't. Nurse #6 stated she felt like this was a behavior for him and he was doing better with this now than when he first came to the facility. During an interview on 12/21/18 at 4:28 PM, the Social Worker (SW) stated she completed sections C, D, E, and Q and on the comprehensive MDS she also completed section V. The SW reviewed her progress notes and reviewed notes for the lookback period for the admission MDS. The SW stated she thought when she looked at it she questioned if he was just asking for help versus this being a behavior. The SW stated she could not remember if she had talked to any staff about Resident #47. During an interview on 12/21/18 at 4:56 PM, the Director of Nursing stated her expectation was for the MDS coding to be accurate.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		1/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 4 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to invite a resident to participate in meetings to develop a plan of care for 1 of 1 sampled residents (Resident #78) reviewed for care plan participation. The findings included: Resident #78 was admitted to the facility on 02/08/18 with diagnoses that included depression and chronic pain. Record review of the significant change Minimum	F 657	A care plan meeting for resident number 78 was held on 12/19/18 by the Care Plan team which consisted of the Social Services Director and MDS Nurse. The Social Services Director and MDS nurse completed a Quality Assurance (QA) monitoring of residents care plan meetings on 1/15/19 with no additional incidents noted. On 1/11/19, the Regional MDS nurse provided education to the Social Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 5 Data Set (MDS) revealed Resident #78 was cognitively intact. The MDS also revealed Resident #78 required extensive assistance with most activities of daily living. During an interview on 12/17/18 at 4:31 PM, Resident #78 stated she was not being invited to participate in the development of her care plans. Record review of the Care Conference Record revealed Resident #78 had an admission care plan meeting on 02/26/18 and a quarterly care plan meeting on 05/26/18. There was a quarterly MDS completed on 09/14/18 and the following quarterly MDS completed on 11/23/18, with no documentation of a care plan meeting for either quarterly. During an interview on 12/19/18 at 9:25 PM, the Social Worker (SW) stated she kept copies of all the invitations of residents and responsible parties for care plan meetings. When the SW reviewed her file, she was unable to locate invitations for the last 2 care plan meetings for Resident #78. During an interview on 12/19/18 at 9:36 PM, the MDS Coordinator reviewed computer documentation for any notes regarding the past 2 care plan meetings for Resident #78. The MDS Coordinator also checked her file and could find no evidence the past 2 care plan meetings had occurred. The MDS Coordinator further stated the SW scheduled all the care plan meetings. During a second interview on 12/19/18 at 4:27 PM, the SW stated was not sure what had happened to prevent Resident #78 from being invited from her last 2 care plan meetings. The	F 657	Director and MDS Nurse on the importance of establishing a system of scheduling resident care plan meetings with documentation of invitation sent to resident, Power of Attorney (POA), or responsible party. The Director of Nursing to complete quality improvement monitoring for scheduling of resident care plan meetings. Monitoring to be completed two times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months. The Administrator introduced the plan of correction to the QAPI committee on 1/15/19. The Administrator is responsible for implementing this plan. The QAPI Committee members consist of, but are not limited to, the Administrator, Director of Nursing, Medical Director Staff Development Coordinator, Unit Manager, Social Services Director, Maintenance Director, Housekeeping Supervisor, Dietary Manager, Activities Director, MDS Nurse, and one direct caregiver. Quality Improvement Quality Monitoring schedule modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 6 SW stated she was responsible to send out letters to residents and responsible parties of upcoming care plan meetings. During an interview on 12/19/18 at 5:26 PM, the Director of Nursing (DON) stated her expectation was for residents to be invited to their care plan meetings and for staff to keep documentation to show this had been done. During an interview on 12/19/18 at 5:30 PM, the Administrator stated his expectation was for every resident and whoever they considered to be family to be invited to their care plan meeting. The Administrator also stated residents and family needed to be invited and documentation needed to be present to verify the meeting had occurred.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to provide nail care to 1 of 3 sampled residents dependent on staff for assistance with activities of daily living (Resident #74). The findings included: Resident #74 was admitted to the facility on 03/07/18 with diagnoses which included Alzheimer's disease, cognitive communication	F 677	Resident number 74's nails were cleaned 12/17/18 by the wound nurse at 3:59pm. Dependent residents nails were assessed by Licensed Nurse on 12/25/18 through 12/29/18 with nail care provided as needed. The Staff Development Coordinator (SDC), Nurse Supervisor, or Director of Nursing (DON) will reeducate Licensed	1/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 7 deficit, and dementia with behavioral disturbances. Review of the most recent Minimum Data Set (MDS) was a quarterly assessment dated 12/04/18 which included cognitive patterns were severely impaired and rejection of care occurred 1 to 3 days during the look back period. The resident required supervision with assistance from staff for personal hygiene and supervision with setup help for eating. The comprehensive care plan was revised on 12/20/18 and identified Resident #74 had difficulty with Activities of Daily Living (ADL) and a self-care performance deficit related to his diagnoses of dementia and limited mobility. The goal was to maintain the current level of function with ADL's through the next review date. The facility put in place interventions to maintain his goal which included resident prefers to grow a beard and refuses shaving and nail care, check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. The resident required skin inspection per protocol and as needed, observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. An observation made on 12/17/18 at 12:07 PM revealed Resident #74 had 2 open areas on his right lower extremity which he was actively picking causing the areas to bleed. His right hand had dark colored debris underneath all of the nails and some dark colored substance on tips of the thumb and index finger. The nails were approximately 0.25" long. During an observation on 12/17/18 at 12:26 PM,	F 677	Nurse/Certified Nursing Assistant regarding care of residents' nails on 1/3/19 through 1/23/19. The DON, SDC, or Nurse Supervisor will conduct Quality Improvement Quality Monitoring of all resident's nails two times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months. The results of the monitoring will be brought to the QA Committee monthly for six months. The DON introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 1/15/19. The Administrator is responsible for implementing this plan. The QAPI Committee members consist of, but are not limited to, the Administrator, DON, Medical Director, Staff Development Coordinator, Unit Manager, Social Services Director, Maintenance Director, Housekeeping Supervisor, Dietary Manager, Activities Director, MDS Nurse, and one direct caregiver. Quality Improvement monitoring schedule modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 8	F 677		

Resident #74's right hand continued to have dark colored debris under all the nails. Resident #74 was served a lunch tray in his room by NA #3 who didn't offer or encourage the resident to clean his hands before eating. He ate a piece of cornbread using his right hand. He grabbed a slice of ham with his right hand and continued to use both hands to eat.

An observation was made on 12/17/18 at 12:34 PM. Nurse #3 asked the resident if he needed anything and encouraged him to use his silverware, but he continued to use his hands to grab food and eat. Nurse #3 gave him a supplement shake but didn't offer to clean his hands, or encourage him to wash his hands. On 12/17/18 at 12:46 PM after Resident #74 had eaten approximately 75 percent of his food, the right hand no longer appeared to have dark colored debris underneath the nails or on the tips of his fingers.

Review of a nurse note read in part: On 12/17/18 at 1:34 PM, the nurse noted resident picking at legs and feet. The resident's fingers, fingernails, and wounds were cleaned. Educated the resident on the importance of keeping those areas clean to promote healing as well as infection related to open areas and blood under fingernails. The resident stated an understanding and the wound nurse was informed.

An interview was conducted on 12/17/18 at 3:04 PM. NA #3 explained she served Resident #74 his lunch tray in his room. She confirmed the resident usually ate with his hands and was also aware of him picking at his skin and stated, "It occurs every day all day." She didn't offer to wash his hands because the surveyor was in the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 9 She stated she should've offered to wash the resident's hands but didn't notice they were visibly soiled. During an interview conducted on 12/17/18 at 3:23 PM, the surveyor asked Nurse #3 if she had noted a dark colored substance on Resident #74's right hand and underneath his nails. Nurse #3 explained she had cleaned Resident #74's hands a couple of times throughout the shift, but he continued to pick at his wounds She was aware the nails needed to be cut and that was on her list of things to do. During an observation on 12/17/18 at 3:59 PM, the Wound Nurse offered to cut Resident #74's nails. He agreed and washed his hands himself and let the nurse cut his nails on both hands. Resident #74 cooperated and tolerated getting his nails trimmed with no noted behaviors or rejection of care. During an interview conducted on 12/21/18 at 6:05 PM, the Director of Nursing revealed it was her expectation staff would offer to clean or encourage Resident #74 to wash his hands before eating when visibly soiled.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		1/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to supervise a cognitively impaired resident with wandering behaviors from exiting the facility for 1 of 1 resident reviewed for accidents related to unsafe wandering/elopement (Resident #74). Immediate Jeopardy (IJ) began on 11/03/18 when Resident #74 was able to exit from the facility without the knowledge of staff. Resident #74 was found approximately 205 feet away from the main entrance door and approximately 85 feet from a stop sign exiting the facility parking which headed towards a long, steep hill and connected to the main highway. Immediate Jeopardy was removed on 12/20/18 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective to prevent accidents related to wandering/elopement. The findings included: Resident #74 was admitted to the facility on 03/07/18 with diagnoses which included Alzheimer's disease, cognitive communication deficit, and dementia with behavioral disturbance. The baseline care plan initiated 03/07/18 identified elopement and safety with the goal for Resident #74 to remain free of injury. Interventions included a wander risk assessment and to maintain safe environment.	F 689	100% of residents currently in the building were re-assessed by Nursing Administration to identify any further residents at risk for elopement on 12/19/2018. No further residents were identified as a new risk. Residents deemed at risk for elopement are added to the elopement binder and added to the facility clip board. Care plans of residents at risk were review/updated to reflect current resident needs by the Minimum Data Assessment Nurse on 12/19/2018. Care plans available through Point Click Care and Point of Care, appearing on the Kardex for the CNA's. Residents are assessed on admission, re admission, quarterly and/or significant change in condition by the licensed nurse. The Regional Director of Clinical Services in-serviced Nursing Administration on Event Management specific to elopements and root cause analysis on 12/19/2018. Licensed Nurses, Certified Nurse Aides, Dietary Staff, Housekeeping Staff, Therapy staff, Maintenance Director, Business Office, Human Resources, were educated on Wandering/Missing Person/Elopement and identifying behaviors of residents who might be exit seeking by Nursing Administration by 12/20/2018. This includes reporting to administration if a resident expresses the desire to leave the facilely and/or has new behaviors of exit seeking, and that residents identified at risk appear on the kardex. The facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 Review of an admission assessment dated 03/07/18 included the elopement/wander risk assessment. The assessment revealed Resident #74 was cognitively impaired, was independently mobile, and had the ability to exit the facility. There were no exit seeking behaviors identified, the resident did not wander oblivious to safety needs, had no history of elopement, and did not demonstrate poor decision making skills. Based on the information it was determined Resident #74 was not at risk for elopement. A Medical Doctor (MD) progress note revealed on 03/08/18 Resident #74 reported his goal was to return to home. Review of the nurse's documentation related to wandering read in part on 03/12/18 from 7:00 AM to 7:00 PM reported by other resident behavior of wandering throughout their room this morning. Staff monitored closely and resident voiced the need of wanting to go home. Was easily redirected by family phone calls. Further review of MD progress notes revealed on 03/16/18 the resident was seen per nursing request of persistent agitated behavior, had been going in and out of other patient rooms consistently day and night, and had not been sleeping. Continued to state, "Wants to go home", however cannot tell you where home was. The nurse's note dated 06/04/18 from 7:00 AM to 3:00 PM read in part resident wanders about unit and goes into other resident rooms and occasionally takes their belongings. Review of a quarterly Minimum Data Set (MDS)	F 689	does have an elopement policy and elopement is included in the emergency preparedness plan. Measures to ensure practice does not recur: The Regional Director of Clinical Services and/or Nursing Administration in-serviced Licensed Nurses, Certified Nurse Aides, Dietary Staff, Housekeeping Staff, Therapy staff, Maintenance Director, Business Office, Human Resources, 12/18/18-12/20/18 were educated on Wandering/Missing Person/Elopement and identifying behaviors of residents who might be exit seeking and where to locate the elopement binders, and to notify facility ED and/or DON if the behaviors are observed or if the resident verbalizes the intent to try and leave. The training will also be added to the facility orientation agenda for all new employees to be completed by the Nurse Educator or Director of Nursing. All new hires regardless of discipline are to be oriented/trained upon hire about elopement/wandering/missing resident policy and how to identify behaviors of a resident who may be exit seeking. This will include them reporting to leadership if a resident voices the desire to leave the facility. All Staff that were on vacation or FMLA will be in-serviced prior to returning to their work duties. Administrator will maintain a list of staff not in-serviced due to FMLA, vacation, etc. The elopement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 assessment dated 06/08/18 assessed cognitive patterns were severely impaired and wandering behaviors occurred 1 to 3 days during the look back period. For locomotion off the unit Resident #74 required supervision with 1 person and for locomotion on the unit required supervision with setup help by staff. Documentation of a Psychiatric evaluation done 06/13/18 read in part, wandering was problematic at times. Review of nurses' documentation related to wandering read in part: 06/18/18 at 11:30 AM resident has been wandering about facility and going into other resident rooms. 06/23/18 at 11:30 AM resident has been wandering in and out of other resident rooms. 10/19/18 at 11:54 PM resident continues to wander and needs re-directing at times. 10/28/18 at 1:52 AM resident self-propels up and down hall ways in wheelchair during shift. Resident redirected throughout the shift about taking items that does not belong to him. 11/01/18 at 3:42 PM resident up in wheelchair wandering in hallway. 11/01/18 at 10:05 PM resident spent most of shift rolling up and down hallway. 11/02/18 at 12:31 PM resident up in wheelchair wandering in hallway. An elopement incident report completed by the Unit Manager revealed the resident was found unattended outside on 11/03/18 at 9:25 AM. The report revealed Resident #74 was seen outside of the building by another nurse while taking her break. The description of what was observed read in part: resident was wheeling himself	F 689	binders are maintained by the Staff Development Coordinator as changes occur. Once a resident who had not previously been identified is assessed as identified, the clinical team will do an assessment, care plan, update clipboard and the Staff Development Coordinator will update the elopement binders. The facility will interview staff on identifying residents at risk, knowledge of behaviors that can identify someone as exit seeking and their knowledge of where to get current list of residents already identified. Interviews started 12/20/18 with a minimum of 10 staff members. Ten random staff members will be interviewed weekly two times a week for four weeks. The Staff Development Coordinator/Nursing Administration will be responsible for the interview process. The facility Maintenance Director and/or Staff Development will perform Wandering/Missing Person/Elopement drill every shift one time a week for four weeks, then monthly thereafter beginning on 12/19/18. Signs were posted on exit doors for visitors not to assist residents out of the building on 12/19/2018 by the MDS coordinator. This corrective action will be monitored by: Regional Director of Clinical Services will assist with on-site visits to review facility progress with obtaining and maintaining compliance with the plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 outside of the building towards the top of the hill in the driveway by another nurse while outside taking an employee break. No security alarm sounded. The physician was notified on 11/03/18 at 10:00 AM and family was notified 11/03/18 at 10:30 AM. A wander guard was placed and 15 minute checks were initiated. On 11/03/18 at 10:57 AM, Nurse #1 documented while outside on break at the back picnic table, she noted Resident #74 rolling toward the entrance of the building. Upon her investigation of the incident the resident stated, "He was going to the bottom of the hill to catch a cab." She was able to coerce the resident back into the building after approximately 10 minutes of negotiating. Resident #74 was deemed an elopement risk and a wander guard was placed and frequently monitoring for placement of the wander guard was initiated. Review of the elopement risk evaluation dated 11/03/18 identified potential risk factors as being cognitively impaired, independently mobile, poor decision-making skills, and had demonstrated exit seeking behaviors with the ability to exit the facility. Risk factors not identified included did not wander oblivious to safety needs with no history of elopement. Based on the assessments potential risk factors Resident #74 was determined to be at risk for elopement. During an interview conducted on 12/19/18 at 10:58 AM, Nurse #1 explained she was not assigned to Resident #74's care and didn't recall noticing him prior to the elopement. She identified the resident had a history of refusing care, had the ability to self-propel in a wheelchair, and would go around the facility. While on her break	F 689	correction a minimum of one time a week until substantial compliance is achieved starting 12/19/2018. Corporate staff will provide policies, procedures, education material as needed in order to assist the facility with acquiring and maintaining compliance. The facility QAPI committee had a meeting on 12/19/18 and were informed of the IJ being called and the plan to address the issue. The QAPI committee will monitor the progress of the plan. The QAPI committee will monitor staff interviews on identifying residents at risk, knowledge of behaviors that can identify someone as exit seeking and their knowledge of where to get current list of residents already identified. Elopement drill results will also be reviewed at the QAPI meeting. Results of the monitoring will be reported monthly to the QA Committee for six months. The date of removal of Immediate Jeopardy was 12/20/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

in a designated employee area outside the facility she noted Resident #74 in the driveway leading to the parking lot. The resident was close to a large rock with the facility's name. She estimated it was approximately 10:00 AM when she seen the resident unattended outside and stated, "she just happened be there at the right time." After getting the resident back into the facility she informed the Unit Manager who completed an incident report.

On 12/19/18 at 11:52 AM, the Maintenance Director and the Administrator measured the distance from the main entrance door to the rock identified by Nurse #1 as where she had seen the resident outside and found it was 205 feet. A second measurement from the rock to the stop sign measured 85 feet. Going from the stop sign forward there was a long, steep hill which lead to the main highway.

During an interview conducted on 12/19/18 at 12:03 PM, Nurse Aide (NA) #1 recalled the elopement incident and explained she was assigned to provide direct care for the resident. She explained Resident #74 was already dressed when she first saw him but couldn't provide a description of the clothes he was wearing. She did recall seeing him roam the hallway multiple times prior to the elopement. She estimated it was around breakfast because third shift was gone and it was sunny outside. She recalled seeing Resident #74 approximately 20-30 minutes before hearing he had gotten out of the facility. She was not actively looking for him prior to the elopement, she had not been asked to look for him, and was not aware the resident was missing.

During an interview conducted on 12/19/18 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

1:01 PM, NA #2 explained she worked the day of the elopement and was assigned the split which included the hallway Resident #74 resided. She wasn't assigned to provide direct care for Resident #74 and didn't recall seeing the resident prior to the elopement. She wasn't aware of the elopement, was not asked to look for the resident, and did not know the resident was missing. She was asked to get a clean pair of pants for the resident because the pants he was wearing were dirty but couldn't provide a better description of what the resident was wearing.

During an interview conducted on 12/19/18 at 2:45 PM, Nurse #2 recalled the elopement and was assigned to provide his care. She was unaware the resident had left the building and no one had alerted her he was missing until after the incident. She could not recall when she last seen him prior to the elopement, but thought he was eating breakfast because other residents were still eating. She explained the resident had not previously tried to leave but would wander throughout the facility. She couldn't provide any information related to the clothes the resident was wearing the day he eloped.

During an interview conducted on 12/19/18 at 5:41 PM, the Director of Nursing (DON) explained she doesn't remember what time she was notified by the Unit Manager Resident #74 was found outside of the facility. She explained Nurse #1 brought the resident back into the facility, an elopement assessment was done, and a wander guard placed. She further explained an elopement assessment would be done for a resident who demonstrated exiting seeking behaviors. If the resident was at risk for elopement a wander guard would be placed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

the care plan updated. According to the DON, Resident #74 had never demonstrated any signs of trying leave the building or other exit seeking behaviors. She revealed signs for risk of elopement were beating on the door, trying to get out the door, packing bags, and personal items. She explained it had been discussed with staff how to identify signs of elopement and exit seeking behaviors. The resident was not identified as an elopement risk prior to the incident and therefore staff wouldn't have been looking for him. All he had previously done was wander around the facility and wasn't exit seeking. All staff know which residents to look out for and staff who have offices close to the main entrance know to look for residents' leaving the facility.

During an interview conducted on 12/19/18 at 5:41 PM, the Regional Director of Clinical Services explained all the doors either have magnetic locks or sounding alarms and the main entrance door had a wander guard alarm. After talking to the staff related to the elopement investigation it was determined Resident #74 was outside for a short period of time.

During an interview conducted on 12/19/18 at 5:50 PM, the Administrator revealed he was familiar with Resident #74 who never demonstrated signs of being at risk for elopement or exit seeking behaviors. He explained the resident rolls in the hallways and was never at the exit doors and never talked about going somewhere. The Administrator further explained the resident would stay close to his room and knew where his room was located. According to the Administrator there were no reasons/signs for staff to identify he was at risk for elopement and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

after the elopement the appropriate actions were taken.

During an interview conducted on 12/21/18 at 3:35 PM, the Staff Development/Infection Nurse explained she does the elopement risk assessment for residents already identified at risk for elopement and maintains those quarterly. She does weekly checks which include if the resident was evaluated on admission, quarterly, after being re-admitted, and if a significant change was noted. She explained the floor nurse or the MDS Nurse would do the quarterly assessments on all the residents and confirmed Resident #74 had no quarterly elopement assessments available in his chart and no elopement assessment had been done since admission on 03/07/18.

An interview conducted on 12/21/18 at 4:20 PM, the Unit Manager (UM) revealed Nurse #1 reported to her between 9:00 AM and 10:00 AM she had seen Resident #74 while on her break outside the facility. He was located in the driveway of the facility but had not made the turn towards the decline in the road. Nurse #1 returned the resident to the facility and the UM documented the incident report, notified the MD, and placed the information in elopement book. She denied Resident #74 had exit seeking behaviors prior to the elopement but had said he was trying to catch a cab.

An observation on 12/19/18 at 12:57 PM, Resident #74 was sitting in his wheelchair at the room entrance doorway of his room and was noted to propel himself throughout the hallway. He was wearing a wander guard bracelet on his left wrist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

An online website named Weather Underground was used to obtain the outside temperatures in the Asheville area. On 11/03/18 at 8:00 AM the temperature was 38 degrees Fahrenheit with no precipitation with wind speeds of 8 miles per hour (mph). At 10:00 AM the outside temperature was 43 degrees Fahrenheit with no precipitation with wind speeds of 10 mph.

The Administrator was notified of the immediate jeopardy on 12/19/18 at 6:10 PM.

On 12/20/18 at 2:24 PM, the facility provided the following Credible Allegation of Compliance:

Plan for Removal of Immediate Jeopardy:

Corrective action for areas affected: On 11/3/2018 at approximately 9:25 am resident #74 exited the building without staff knowledge. Resident #74 exited through the front door and proceeded into the parking lot. Resident # 74 had no injury related to elopement on 11/3/2018. Resident #74 had an elopement assessment completed on 11/3/2018 and a wander guard placed. Resident #74's picture and information was added to the elopement binders, and Clipboard. The elopement binders are located at the nurses' station and in the admissions office by the front door. The clipboard is at the nurses' station and the Interdisciplinary team also have the clipboard. Resident #74 was seen by the Nurse Practitioner on 11/5/18 for routine follow up, no changes in orders on that day. Once the wander guard was applied to resident #74 the front door will lock down if he tries to exit. The staff providing direct care to resident #74 was provided with education on reporting when a resident verbalizes they want to leave and if a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

resident begins to have exit seeking behaviors when they previously had not on 12/20/2018 by the Director of Nursing. The main front facility entrance and the therapy hall (100 hall) are wired for wander guard. All other facility doors have a magnetic locking system on them except the kitchen delivery door that residents do not have access too. Entrance into the kitchen is locked. The front door is visible from the nursing station but he had not had exiting seeking behavior prior so he didn't have a wander guard on or had been deemed at risk.

Other areas having the potential to be affected and corrective actions:

100% of residents currently in the building were re-assessed by Nursing Administration to identify any further residents at risk for elopement on 12/19/2018. No further residents were identified as a new risk. Residents deemed at risk for elopement are added to the elopement binder and added to the facility clip board. Care plans of residents at risk were review/updated to reflect current resident needs by the Minimum Data Assessment Nurse on 12/19/2018. Care plans available through Point Click Care and Point of Care, appearing on the Kardex for the CNA's. Residents are assessed on admission, re admission, quarterly and/or significant change in condition by the licensed nurse.

The Regional Director of Clinical Services in-serviced Nursing Administration on Event Management specific to elopements and root cause analysis on 12/19/2018. Licensed Nurses, Certified Nurse Aides, Dietary Staff, Housekeeping Staff, Therapy staff, Maintenance Director, Business Office, Human Resources,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

were educated on Wandering/Missing Person/Elopement and identifying behaviors of residents who might be exit seeking by Nursing Administration by 12/20/2018. This includes reporting to administration if a resident expresses the desire to leave the facilely and/or has new behaviors of exit seeking, and that residents identified at risk appear on the kardex. The facility does have an elopement policy and elopement is included in the emergency preparedness plan.

Measures to ensure practice does not recur:

The Regional Director of Clinical Services and/or Nursing Administration in-serviced Licensed Nurses, Certified Nurse Aides, Dietary Staff, Housekeeping Staff, Therapy staff, Maintenance Director, Business Office, Human Resources, 12/98/18-12/20/18 were educated on Wandering/Missing Person/Elopement and identifying behaviors of residents who might be exit seeking and where to locate the elopement binders, and to notify facility ED and/or DON if the behaviors are observed or if the resident verbalizes the intent to try and leave.

The training will also be added to the facility orientation agenda for all new employees to be completed by the Nurse Educator or Director of Nursing. All new hires regardless of discipline are to be oriented/trained upon hire about elopement/wandering/missing resident policy and how to identify behaviors of a resident who may be exit seeking. This will include them reporting to leadership if a resident voices the desire to leave the facility. All Staff that were on vacation or FMLA will be in-serviced prior to returning to their work duties. Administrator will maintain a list of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

staff not in-serviced due to FMLA, vacation, etc. The elopement binders are maintained by the Staff Development Coordinator as changes occur. Once a resident who had not previously been identified is assessed as identified, the clinical team will do an assessment, care plan, update clipboard and the Staff Development Coordinator will update the elopement binders.

The facility will interview staff on identifying residents at risk, knowledge of behaviors that can identify someone as exit seeking and their knowledge of where to get current list of residents already identified. Interviews started 12/20/18 with a minimum of 10 staff members. Ten random staff members will be interviewed weekly two times a week for four weeks. The Staff Development Coordinator/Nursing Administration will be responsible for the interview process.

The facility Maintenance Director and/or Staff Development will perform Wandering/Missing Person/Elopement drill every shift one time a week for four weeks, then monthly thereafter beginning on 12/19/18.

Signs were posted on exit doors for visitors not to assist residents out of the building on 12/19/2018 by the MDS coordinator.

This corrective action will be monitored by: Regional Director of Clinical Services will assist with on-site visits to review facility progress with obtaining and maintaining compliance with the plan of correction a minimum of one time a week until substantial compliance is achieved starting 12/19/2018. Corporate staff will provide policies, procedures, education material as needed in order to assist the facility with acquiring and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22 maintaining compliance. The facility QAPI committee had a meeting on 12/19/18 and were informed of the IJ being called and the plan to address the issue. The QAPI committee will monitor the progress of the plan. The QAPI committee will monitor staff interviews on identifying residents at risk, knowledge of behaviors that can identify someone as exit seeking and their knowledge of where to get current list of residents already identified. Elopement drill results will also be reviewed at the QAPI meeting. The date of removal of Immediate Jeopardy was 12/20/2018. The credible allegation was verified on 12/21/18 11:26 AM as evidence by staff interviews. Staff education was initiated on 12/19/18 related to wandering/missing person/elopement and identifying behaviors of residents who might be exit seeking and who to notify if the behaviors were observed or if the resident verbalizes the intent to try and leave. Staff interviewed were able to described the procedure of locating a missing resident which included identification, who and when to notify, and delegating search areas to staff. Included in the training was how to recognize a resident demonstrating elopement behaviors and what to do when the behavior was recognized. Elopement binders were reviewed and location verified.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		1/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 23 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and physician interviews the facility failed to prevent catheter tubing and the bag from touching the floor for 1 of 2 sampled residents reviewed for urinary catheter (Resident #10).	F 690	Resident number 10's catheter tubing and bag was placed appropriately while sitting in wheelchair by Certified Nursing Assistant immediately on 12/18/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 24 The findings included: Resident #10 was admitted to the facility 09/21/18 with diagnoses which included neurogenic bladder and benign prostatic hyperplasia. A care plan was initiated on 09/22/18 which identified an indwelling catheter for a neurogenic bladder. The goal was to not demonstrate signs or symptoms of a urinary infection and to remain free from catheter-related trauma through the next review. Interventions included place the catheter bag and tubing below level of bladder and away from entrance room door. Monitor and document pain and discomfort, monitor, record, and report to Medical Doctor signs and symptoms of a urinary tract infection. Review of the most recent Minimum Data Set (MDS) was an admission assessment dated 09/28/18 which documented Resident #10 was cognitively intact and needed extensive assistance with personal hygiene and toilet use. The MDS did not rate urinary status due to an indwelling catheter and always incontinent of bowel. The Care Area Assessment of the MDS described Resident #10 with a self-care deficit who required extensive assist with activities of daily living. The resident was readmitted from the hospital with a catheter in place for a neurogenic bladder. During an observation on 12/18/18 at 8:54 AM, Resident #10 was sitting upright in a wheelchair with the catheter bag attached underneath the wheelchair frame. The catheter bag and tubing were directly touching the floor.	F 690	On 1/3/19, DON and/or RN Supervisor performed a Quality Improvement monitoring for all residents with catheters for proper placement. No other issues were identified. On 1/3/19 through 1/21/19, Staff Development Nurse, Nurse Supervisor, or DON provided reeducation to Licensed Nurse/Certified Nursing Assistants on appropriate catheter placement. Reeducation will be provided to all nursing staff, as well as to all newly hired nursing staff during initial orientation. The Director of Mursing and/or Nursing Supervisor to perform Quality Improvement monitoring of proper foley catheter bag and tubing placement to be completed two times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months. Results of the monitoring will be reported to the QA Committee monthly for six months. The DON introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 1/15/19. The Administrator is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of, but are not limited to, the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Unit Manager, Social Services Director, Maintenance Director, Housekeeping Supervisor, Dietary Manager, MDS Nurse, Activities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 25 An interview conducted on 12/19/18 at 9:54 AM, the Medical Doctor (MD) explained he expected staff providing catheter care and handling the bag to be aware of how to prevent potential contamination and not place the catheter bag directly on the floor. During an interview on 12/21/18 at 6:17 PM, the Director of Nursing revealed it was her expectation the catheter bag would not be placed on the floor.	F 690	Director, and one direct caregiver. Quality Improvement Quality Monitoring schedule modified based on findings.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		1/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 26 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and interviews with Medical Director (MD) and consultant pharmacist (CP), the facility failed to ensure physician's orders for as needed (PRN) psychotropic medication was time limited in duration and provided rationales for therapy exceeding 14 days for 1 of 6 sampled residents (Residents #39) reviewed for unnecessary medications. Findings included: Resident #39 was admitted to the facility on 07/14/17 with diagnoses which included anxiety, atrial fibrillation, and hypertension.	F 758	Licensed nurse notified the attending physician of resident number 39 on 12/19/18 and obtained order to discontinue PRN Ativan. On 1/16/19, Nurse Supervisor completed a Quality Assurance monitoring of residents physician orders for past 90 days to ensure PRN orders for Psychotropic drugs are limited to 14 days. Any issues identified were addressed. On 1/3/19 through 1/21/19, the Staff Development Coordinator, Nurse Supervisor, or Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 27 Review of the most recent Minimum Data Set (MDS) assessment dated 10/21/18 revealed Resident #39 was coded with mildly impaired cognition and required extensive assist with all Activities of Daily Livings (ADLs) except eating. The MDS indicated Resident #39 received an antianxiety medication for one day during the 7-day look back period. Review of Resident #39's physician's orders revealed an order of Ativan (anxiolytic medication) 0.5 milligram (mg), one tablet by mouth sublingually every 6 hours as needed for anxiety was ordered on 08/30/18. This active order had no stop date and the rationales for extended therapy beyond 14 days were not found in the resident's medical records. Review of Medication Administration Records (MARs) from 08/01/18 through 12/19/18 revealed Resident #39 did not receive the PRN Ativan since it was initiated on 08/30/18. Review of consultant pharmacist consultation report dated 10/29/18 indicated the CP had recommended to discontinue the PRN Ativan. The 10/29/18 CP report indicated if the PRN Ativan could not be discontinued at that time, the intended duration of therapy and the rationale for therapy extension must be provided by the physician and documented. During an interview conducted on 12/19/18 at 7:53 AM, the MD acknowledged that the PRN Ativan order which was written on 08/30/18 should be limited to 14 days unless rationales for extension was documented. He stated that the CP's recommendation had been in the "Doctor	F 758	provided education to licensed nurses regarding PRN orders for Psychotropic drugs, they are to be limited to 14 days unless the practitioner believes that the PRN order should be extended with rationale documented in the medical record. The Director of Nursing, Nurse Supervisor, Staff Development Coordinator to perform Quality Improvement Monitoring for psychotropic PRN orders for having a stop date of 14 days, two times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months. Results of monitoring will be brought to the QA Committee monthly for six months. The DON introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 1/15/19. The Administrator is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of, but are not limited to, the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Unit Manager, Social Services Director, Maintenance Director, Housekeeping Supervisor, Dietary Manager, MDS Nurse, Activities Director, and one direct caregiver. Quality Improvement Quality Monitoring schedule modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 28 Folder" since mid-November. It was his over-sight that the PRN Ativan was not being addressed in a timely manner. During a phone interview conducted on 12/19/18 at 1:00 PM, the CP stated that when she was doing the Medication Regimen Review (MRR) on 10/29/18, she noticed that Resident #39 had an active PRN Ativan order which had exceeded 14 days without a stop date. She had made recommendation either to discontinue the PRN Ativan or to provide a stop date and rationales for extended therapy. During an interview conducted on 12/19/18 at 4:23 PM, the Staff Development Coordinator stated that the Director of Nursing (DON) provided the CP's recommendation dated 10/29/18 to her on 11/14/18. She put the recommendation in the "Doctor Folder" on the same day. She stated she had no idea why this recommendation was not addressed until 12/19/18. During an interview conducted on 12/19/18 at 4:28 PM, the DON stated all CP's recommendations had to be addressed in a timely manner. It was her expectation for all the prescribers in the facility to follow the Centers for Medicare & Medicaid Services (CMS) PRN psychotropic medication regulations.	F 758		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		1/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 29 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the facility's 12/11/17 recertification and complaint survey. This failure related to one recited deficiency that was originally cited during the 12/11/17 recertification and complaint survey which was recited on the current recertification and complaint survey of 12/21/18. The recited deficiency was in the area of the provision of activities of daily living (ADL) care for dependent residents. The continued failure of the facility during two surveys of record in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: 1. F-677: ADL care provided for dependent residents. Based on observations, record review, and staff interviews the facility failed to provide nail care to 1 of 3 residents reviewed for ADL (Resident #74). During the recertification and complaint survey of 12/11/17 the facility was cited for failure to provide nail care to 1 of 5 residents reviewed for ADL (Resident #44). During an interview on 12/21/18 at 6:32 PM the	F 867	Resident number 74's nails were cleaned 12/17/18 by the wound nurse at 3:59pm. All residents nails were assessed by Licensed Nurse on 12/25/18 through 12/29/18 with nail care provided as needed. The Staff Development Coordinator, Nurse Supervisor, or Director of Nursing educated Licensed Nurse/Certified Nursing Assistant regarding care of resident's nails on 1/3/19 through 1/21/19. The Director of Nursing, Staff Development Coordinator, or Nurse Supervisor will conduct Quality Improvement monitoring of dependent resident's nails two times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months. Results of monitoring will be brought to QA Committee monthly for six months. The Regional Director of Clinical Services (RDCS) will attend the facility Quality Assurance Performance Improvement Committee meeting at a minimum of quarterly to evaluate the effectiveness of the program, the compliance of ongoing monitoring, and the revision to the plan of correction for citations as appropriate to maintain compliance. The RDCS will attend meetings in person or via phone for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 30 Administrator stated the QAA committee had been functional and the facility had a system in place to ensure all residents' ADL needs were met. After the last Federal survey, plan of correction was implemented and monitoring was ongoing until substantial compliance was achieved. The Administrator added the repeated areas of concern would be reviewed by the QAA committee for root cause analysis and a performance improvement plan would be developed to correct the deficiencies. If problems still exist, the monitoring would continue until it was corrected.	F 867	six months or until they deem substantial compliance is achieved for F677. The DON introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 1/15/19. The Administrator is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of, but are not limited to, the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Unit Manager, Social Services Director, Maintenance Director, Housekeeping Supervisor, Dietary Manager, MDS Nurse, Activities Director, and one direct caregiver. Quality Improvement Quality Monitoring schedule modified based on findings.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		1/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32 §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 observation, record review, and resident and staff interviews, the facility failed to store nebulizer equipment and C-pap mask properly for 3 of 5 residents reviewed for Infection Control (Resident # 2, # 67, and # 44). The findings included: 1. Resident # 2 was admitted to the facility on 12/10/18 with admitting diagnosis of Metabolic Encephalopathy and Acute Respiratory Failure with hypoxia. Other diagnosis included Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Chronic Kidney Disease (CKD), and Pulmonary Hypertension. Review of a quarterly Minimum Data Set (MDS) dated 12/10/18 revealed Resident #2 had no behaviors. Resident # 2 needed limited assistance of 1 person with bed mobility, transfers, walking in room, and toileting. He required supervision after set-up with eating. He further required extensive assist of 1 person for dressing and hygiene. Resident # 2 was occasionally incontinent of bladder and frequently incontinent of bowel. A care plan revealed Resident # 2 had behavior	F 880	On 12/21/18, resident numbers 2, 67, and 44's Nebulizer Mask was replaced and stored in a dated plastic covering by the licensed nurse. On 12/20/18, resident number 44's C-pap mask was washed and stored in dated plastic covering by licensed nurse. On 1/16/19, the Director of Nursing, and/or Nurse Supervisor performed a quality improvement monitoring of all residents with C-pap machines ensuring C-pap masks/nebulizer masks were properly stored. Any issues identified were addressed. On 1/3/19 through 1/21/19 all licensed nurses and CNA's were reeducated by the Staff Development Nurse and/or Director of Nursing on proper storage of C-pap masks/nebulizer masks when not in use. The Director of Nursing and/or Nurse Supervisor to perform Quality Improvement Monitoring for all residents on C-pap/nebulizer for proper storage of masks two times a week for four weeks, then one time a week for eight weeks, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33 problems which he did not take medications or treatments as ordered. He was also care planned for Altered Cardiovascular status related to CHF and CAD that revealed to give medications and treatments as ordered, assess for shortness of breath (SOB) and cyanosis, monitor vital signs, edema with weight changes, and to report any changes to lung sounds to nurse/doctor. Resident # 2 was also care planned for Fluid Overload or Potential for Fluid Volume Overload related to CHF, CKD, and Pulmonary hypertension that further revealed for nursing to administer medications as ordered and monitor side effects and effectiveness. A review of the physician's order revealed an order dated 09/06/18 for Albuterol Solution 0.5-2.5mg 3 millimeters to be inhaled via a nebulizer treatment 4 times a day for Acute Respiratory Failure with hypoxia. 12/17/18 10:45 AM A nebulizer machine in the room and the nebulizer mask is lying face down on bedside drawer not in a protective cover. 12/18/18 4:20 PM A nebulizer mask lying on top of bedside drawer without a protective covering. 12/19/18 08:45 AM A nebulizer mask lying on top of bedside drawer without a protective cover. 12/19/18 10:01 AM an interview with the Medical Director reported his expectations are that the nursing staff follow his orders, and if any problems he would expect the facility to contact him. Relating to the cleaning and changing of nebulizer mask and tubing he leaves it up to the protocol of the facility.	F 880	then one time monthly for three months. Results of the monitoring will be brought to the QA Committee monthly for six months. The DON introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 1/15/19. Information from the audits will be reviewed for 6 months at the QAPI meetings. The Administrator is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of, but are not limited to, the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Unit Manager, Social Services Director, Maintenance Director, Housekeeping Supervisor, Dietary Manager, MDS Nurse, Activities Director, and one direct caregiver. Quality Improvement Quality Monitoring schedule modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34	F 880		

12/19/18 03:19 PM A nebulizer mask and tubing laying on the floor not attached to the nebulizer machine.

12/19/18 04:09 PM An interview with the Director of Nursing (DON) reported her expectations are tubing and masks are changed once a week, and nebulizer mask put in a protective cover.

12/19/18 04:15 PM An interview with Infection Control RN, reported that nebulizer tubing and mask are changed weekly on Sunday nights. She further revealed that C-pap hose and mask are washed once a week.

2/20/18 08:24 AM A nebulizer mask and tubing remain on the floor.

12/20/18 04:25 PM No nebulizer mask located in room, and the mask that was on the floor is gone.

12/21/18 08:45 AM No nebulizer mask in room. A review of the Medication Administration Report (MAR) revealed a nebulizer treatment was signed off for 4 treatments the day before and for 1 treatment today.

2. Resident # 67 was re-admitted to the facility on 12/06/18 with a diagnosis of Aspiration Pneumonia. Other diagnosis included End Stage Renal Disease on dialysis, dyspnea, CHF and Hypoxia.

A review of a MDS dated 12/15/18 revealed Resident #67 had no behaviors noted during the assessment period. The MDS further revealed that he needed extensive assistance with assist times 1 with bed mobility, transfers, dressing, toileting and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35	F 880		

personal hygiene. Resident # 67 needed supervision with 1-person assistance with locomotion off the unit and supervision after set-up with eating. It further revealed he was always continent of bowel and bladder.

A care plan revealed Resident # 67 needed oxygen therapy and breathing treatments related to CHF, anxiety, dyspnea (SOB) and a history of pneumonia.

A review of the physician's order dated 12/06/18 revealed DuoNeb treatments twice a day via a nebulizer.

12/17/18 08:53 AM A nebulizer mask on the floor without a covering.

12/17/18 05:08 PM A nebulizer mask lying on top of drawer without a protective covering.

12/18/18 08:35 AM A nebulizer mask lying on resident mattress at head of bed without a protective covering.

12/18/18 4:10 PM A nebulizer mask lying on top of bedside drawer without a protective covering.

12/19/18 06:45 AM A nebulizer mask lying on the side of the bed, not being used and not in a protective cover. Resident # 67 lying in bed with eyes closed.

12/19/18 10:01 AM an interview with the Medical Director reported his expectations are that the nursing staff follow his orders, and if any problems he would expect the facility to contact him. Relating to the cleaning and changing of nebulizer mask and tubing he leaves it up to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36	F 880		

protocol of the facility.

12/19/18 03:40 PM A nebulizer mask on top of drawer with no protective cover.

12/19/18 04:09 PM An interview with the Director of Nursing (DON) reported her expectations are tubing and masks are changed once a week, and nebulizer mask put in a protective cover.

12/19/18 04:15 PM An interview with Infection Control RN, reported that nebulizer tubing and mask are changed weekly on Sunday nights. She further revealed that C-pap hose and mask are washed once a week.

12/20/18 08:31 AM A nebulizer mask lying on top of drawer not in a protective cover.

3. Resident # 44 was admitted to the facility on 09/04/17 with an admitting diagnosis of a Urinary Tract Infection. Other diagnosis included Sleep Apnea and Chronic Obstructive Pulmonary Disease.

A quarterly MDS dated 10/25/18 revealed Resident # 44 was alert and oriented and had no behaviors coded. It was further revealed that she needed extensive assistance needing assist times 2 staff for bed mobility, locomotion off the unit. She needed extensive assistance with 1 staff for transfers, dressing and toileting. Supervision after set-up with eating and limited assistance times 1 staff for hygiene.

A review of a physician's order dated 10/17/18 for CPAP on every night for sleep apnea, on at bedtime and off in the AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37	F 880		

12/17/18 09:49 AM A C-pap mask was sitting on top of machine with no protective cover.

12/17/18 05:09 PM No cover for C-pap mask, sitting on top of machine

12/18/18 8:45 AM A C-pap mask sitting on top of machine without a protective covering.

12/18/18 4:12 PM The mask for C-pap was lying on top of C-pap machine without a protective covering

12/19/18 06:48 AM A C-pap mask lying on top of C-pap machine without a protective covering. Resident lying in bed with eyes closed without C-pap being used.

12/19/18 10:01 AM an interview with the Medical Director reported his expectations are that the nursing staff follow his orders, and if any problems he would expect the facility to contact him. Relating to the cleaning and changing of nebulizer mask and tubing he leaves it up to the protocol of the facility.

12/19/18 03:40 PM A nebulizer mask on top of drawer with no protective cover.

12/19/18 04:09 PM An interview with the Director of Nursing (DON) reported her expectations are tubing and masks are changed once a week, and nebulizer mask put in a protective cover.

12/19/18 04:15 PM An interview with Infection Control RN, reported that nebulizer tubing and mask are changed weekly on Sunday nights. She further revealed that C-pap hose and mask are washed once a week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 12/19/18 03:42 PM Resident # 44 reports she does not wear the C-pap every night because no one will wash mask. C-pap mask lying on top of machine. 12/20/18 08:40 AM Resident # 44 reports that the C-pap mask and chamber was set-up last night and she used it because it was washed with soap and water and air-dried.	F 880		