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 05/03/2023

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 An unannounced complaint investigation survey was conducted from 05/02/23 through 05/03/23. Event ID# R25E11. The following intakes were investigated: NC00201272, NC00200810, NC00197830, NC00200210, NC00199521, NC00196521, NC00197211, AND NC00196559. 3 of 27 complaint allegations resulted in deficiency.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, last day of the observation period) for 2 of 4 residents reviewed for accidents (Residents #1 and #3). Findings included: 1. Resident #1 was admitted to the facility on 07/13/20. Review of Resident #1's medical record on 05/02/23 at 2:11 PM revealed a quarterly MDS assessment with an ARD of 04/11/23 that had a status of "in progress." During an interview on 05/02/23 at 3:50 PM, the	F 638	Resident #1 had Quarterly Minimum Data Set with Assessment Reference Date of 4/11/2023 completed on 5/6/2023 and Resident #3 had Quarterly Minimum Data Set with Assessment Reference Date of 4/15/2023 completed on 5/6/2023. Review by Regional Minimum Data Set Nurse conducted on 5/8/2023 of all Minimum Data Set assessments In Progress that were found to be not completed as scheduled were completed. Executive Director and Interdisciplinary team educated by Regional Minimum Data Set Coordinator on 5/24/2023 to check Minimum Data Set In Progress daily for assessments that need to be	5/30/23

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

Electronically Signed | 05/25/2023

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 05/03/2023

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 638	Continued From page 1 MDS Coordinator explained she was the only person in the MDS position with no one to cover for her when she was out of work and she just got behind on completing assessments. The MDS Coordinator confirmed Resident #1's quarterly MDS assessment dated 04/11/23 was not completed within the regulatory timeframe. During an interview on 05/03/23 at 4:53 PM, the Administrator stated she just found out there was an issue with MDS assessments not being completed within the regulatory timeframes. The Administrator explained had she known there was an issue, she and/or other regional staff could have assisted the MDS Coordinator with completing the MDS assessments. 2. Resident #3 was admitted to the facility on 11/23/22. Review of Resident #3's medical record on 05/02/23 at 9:59 AM revealed a quarterly MDS assessment with an ARD of 04/15/23 that had a status of "in progress." During an interview on 05/02/23 at 3:50 PM, the MDS Coordinator explained she was the only person in the MDS position with no one to cover for her when she was out of work and she just got behind on completing assessments. The MDS Coordinator confirmed Resident #3's quarterly MDS assessment dated 04/15/23 was not completed within the regulatory timeframe. During an interview on 05/03/23 at 4:53 PM, the Administrator stated she just found out there was an issue with MDS assessments not being completed within the regulatory timeframes. The Administrator explained had she known there was	F 638	completed. Executive Director and/or designee will check Minimum Data Set In Progress 5x/week x 4 weeks then 1x week x 4 weeks to ensure completion of Minimum Data Set timely. Regional Minimum Data Set Coordinator will review Minimum Data Set In Progress 2x/week x 4 weeks to ensure timely completion.The Executive Director and/or Designee will report the results of the quality monitoring tools to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. Date of Compliance 5/30/2023	

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 05/03/2023

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 638	Continued From page 2 an issue, she and/or other regional staff could have assisted the MDS Coordinator with completing the MDS assessments.	F 638		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment.	F 640		5/30/23

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 05/03/2023

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 640	Continued From page 3 (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and transmit an entry tracking record within 14 days of the admission date and a discharge - return anticipated MDS assessment within 14 days of the discharge date for 1 of 4 sampled residents reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on 07/13/20. Review of Resident #1's medical record on 05/02/23 at 2:09 PM revealed the last completed MDS assessment was a Medicare 5-day Prospective Payment System (PPS) dated 03/23/23. Further review revealed: a. A discharge - return anticipated MDS assessment dated 04/09/23 noted a status of "in progress."	F 640	Resident #1 had Quarterly Minimum Data Set Assessment with Assessment Reference Date of 4/11/2023 transmitted on 5/8/2023, Discharge Return Anticipated with Assessment Reference Date 4/9/2023 transmitted on 5/3/2023, and Entry with Assessment Reference Date 4/10/2023 transmitted on 5/3/2023. Regional Minimum Data Set Coordinator completed review of all assessments on 5/8/2023 that were In Progress and transmitted those. Regional Minimum Data Set Coordinator completed education with Executive Director on 5/24/2023 related to timely transmitting of all Minimum Data Set Assessments. Executive Director and/or designee will review Export Ready Minimum Data Set	

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 05/03/2023

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 640	Continued From page 4 b. An entry tracking record dated 04/10/23 noted a status of "in progress." Review of the staff progress notes for Resident #1 revealed he was discharged to the hospital on 04/09/23 and readmitted to the facility on 04/10/23. During an interview on 05/02/23 at 3:50 PM, the MDS Coordinator explained she was the only person in the MDS position with no one to cover for her when she was out of work and she just got behind on completing assessments. The MDS Coordinator confirmed Resident #1's discharge - return anticipated MDS assessment dated 04/09/23 and the entry tracking record dated 04/10/23 were not completed or transmitted within the regulatory timeframe. During an interview on 05/03/23 at 4:53 PM, the Administrator stated she just found out there was an issue with MDS assessments not being completed and/or transmitted within the regulatory timeframes. The Administrator explained had she known there was an issue, she and/or other regional staff could have assisted the MDS Coordinator with completing the MDS assessments.	F 640	Assessments 5x a week x 4 weeks for timely transmission. Regional Minimum Data Set Coordinator will review 2x/week x 4weeks to ensure timely transmission.The Executive Director and/or Designee will report the results of the quality monitoring tools to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. Date of Compliance 5/30/2023	
F 689 SS=G	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	F 689		

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 05/03/2023

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 5 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident, staff, Nurse Practitioner and Medical Director interviews, the facility failed to safely transfer a resident from the bed to the wheelchair when one staff member used a mechanical lift resulting in the resident falling to the floor for 1 of 4 sampled residents reviewed for accidents (Resident #1). On 04/09/23, Resident #1 fell out of the sling attached to the mechanical lift landing on the floor on his back, hitting his head, sustaining an abrasion to the left elbow, and experiencing increased pain. Resident #1 was transported to the hospital for evaluation, diagnosed with an age-indeterminate (unable to determine if new or old) right L2 (second lumbar spinal vertebrae) transverse process fracture (bony projection on either side of the bones that make up the spinal column) and returned to the facility on 04/10/23. As a result, Resident #1 voiced feeling "fearful" of falling whenever staff transferred him using a mechanical lift. Findings included: Resident #1 was admitted to the facility on 07/13/20. His current diagnoses included spinal cord injury and chronic pain syndrome. A Transfer Mobility Status assessment dated 12/02/22 indicated Resident #1 required a mechanical lift with a full body sling. The quarterly Minimum Data Set (MDS) dated 03/23/23 revealed Resident #1 had intact cognition and required total assistance of two staff members with bed mobility and transfers.	F 689	Past noncompliance: no plan of correction required.	

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 05/03/2023

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 6	F 689		

Resident #1's Activity of Daily Living (ADL) care plan, last reviewed/revised 04/12/23, included an intervention initiated on 07/21/2020 that noted Resident #1 required a mechanical lift with full body sling and two-person assistance for all transfers.

During an observation and interview on 05/02/23 at 10:45 AM, Resident #1 was sitting up in his power wheelchair, covered with a blanket and displayed no signs of discomfort. Resident #1 stated he fell out of the mechanical lift during a transfer from his bed to his wheelchair on 04/09/23 and it was "the second time staff had dropped him from the mechanical lift", the first time occurring last year. Resident #1 stated typically there were two-staff members present when using the mechanical lift to transfer him but on 04/09/23, he stated Nurse Aide (NA) #3 couldn't find anyone to help her with the transfer so she used the mechanical lift by herself even after he had told her not to. Resident #1 recalled as NA #3 was assisting him out of bed, he was in the sling in the highest position on the mechanical lift when he fell out of the sling to the floor hitting his head and landing on his back. In addition, he also stated he had scraped his left elbow. Resident #1 could not recall how he came out of the sling but stated he was taken to the Emergency Department where he was diagnosed with a "brain bleed" and lumbar fracture. Resident #1 voiced he was now fearful of falling when staff transferred him using the mechanical lift.

During a telephone interview on 05/03/23 at 11:03 AM, NA #3 confirmed she attempted to transfer Resident #1 using a mechanical lift without

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 05/03/2023

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 7	F 689		

additional staff assistance on 04/09/23 and he had fallen to the floor during the transfer. NA #3 recalled she had asked other staff for assistance prior to attempting the transfer but they all told her "no" and she proceeded with transferring him independently because Resident #1 was yelling at her and pressuring her to get him up out of bed. She stated Resident #1 kept telling her that other staff "do it all the time" and even though she knew better than to transfer him without additional staff assistance she decided to go ahead and transfer him by herself since Resident #1 was getting so angry. NA #3 recalled once she had secured Resident #1 in the sling and lifted him above his bed, the mechanical lift controls stopped working properly and she couldn't get the mechanical lift to raise up or down. NA #3 stated Resident #1 was suspended above his bed and when she tried to move the sling manually, Resident #1 came out of the sling and dropped to the floor. NA #3 could not state for certain how Resident #1 was able to come out of the sling and stated the sling hooks "just came loose" from the mechanical lift and Resident #1 fell to the bed and then floor. NA #3 stated she immediately went and informed the nurse who came to assess Resident #1. NA #3 confirmed she was instructed to have two-persons during any mechanical lift transfers and stated, "I shouldn't have transferred him by myself and feel really bad that it happened."

A nurse progress note dated 04/09/23 and written by Nurse #1 read in part, called to resident's room by floor staff. Upon entry, Resident #1 was observed on the floor laying on his back next to his bed. Staff indicated he had fallen out of the mechanical lift. Resident #1 was noted with a small abrasion to his right arm and bleeding

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 05/03/2023

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 8	F 689		

noted around his suprapubic catheter site. Resident #1 complained of severe pain "all over." Emergency Medical Services (EMS) were called and arrived at the facility with the Fire Department who assisted Resident #1 off of the floor and onto the stretcher. Resident #1 left the facility at 12:00 PM with EMS.

An interview was conducted with Nurse #1 on 05/02/33 at 3:50 PM. Nurse #1 confirmed she was working at the facility on 04/09/23 as the Manager on Duty when she was notified Resident #1 was on the floor and immediately went to the room to assess the situation. Nurse #1 stated when she got to Resident #1's room, he was lying on the floor flat on his back, he was alert and complaining of severe pain. Nurse #1 added Resident #1 reported hitting his head when he fell to the floor but upon assessment, she felt no bumps or cuts to the back of his head and the only injury she noted was an abrasion to his left elbow. Nurse #1 stated Resident #1 was not moved and made as comfortable as possible until EMS and the Fire Department arrived to assist him up off the floor and transport him to the hospital for evaluation. Nurse #1 confirmed NA #3 reported transferring Resident #1 using the mechanical lift without additional staff assistance and stated mechanical lifts were supposed to be completed with two-person assistance. Nurse #1 stated when she had NA #3 reenact what she had done during the transfer, the only thing she could figure happened was that NA #3 didn't have the sling hooks attached correctly to the mechanical lift and when NA #3 lifted him, the strap came loose causing Resident #1 to fall out of the sling onto the floor.

During an interview on 05/03/23 at 3:44 PM, 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 05/03/2023

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 9	F 689		

Director of Nursing (DON) recalled being notified by Nurse #1 on 04/09/23 of Resident #1's fall during a mechanical lift transfer and came straight to the facility to assist in the investigation. The DON stated on 04/09/23, she started immediate re-education of nursing staff regarding mechanical lift transfers that included observations of nursing staff performing a mechanical lift transfer. The DON stated mechanical lifts should always be completed with two-person assistance for safety reasons and it was never appropriate for a staff member to attempt a mechanical lift transfer independently, they should always wait for additional staff assistance.

During an interview on 05/03/03 at 8:03 AM, the Administrator revealed she was notified by Nurse #1 on 04/09/23 Resident #1 had fallen to the floor when NA #3 had attempted to transfer him using a mechanical lift without additional staff assistance. The Administrator recalled when she spoke with NA #3 about the incident, NA #3 reported she wasn't able to find anyone to help her with the transfer and felt Resident #1 was getting mad at her and pressuring her to transfer him out of bed, so she attempted the transfer without additional staff assistance. The Administrator stated it was facility protocol there were 2-persons present for all transfers using a mechanical lift and felt NA #3 had made a poor judgement call by not waiting for other staff to assist. The Administrator explained following the incident, NA #3 was immediately suspended pending an investigation, transfer assessments were completed on all residents, and residents' care plans/Kardex were updated. In addition, she stated all nursing staff completed mechanical lift competencies with return demonstration 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 05/03/2023

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	F 689		

were reeducated on mechanical lift procedure that included where to locate information regarding a resident's transfer status and to always have two-person assistance with all mechanical lift transfers.

An Emergency Department (ED) report dated 04/09/23 for Resident #1 read in part, "presents to the ED after being dropped essentially out of the lift at his skilled nursing facility. The patient apparently was lifted fairly high in his lift chair, he was dropped to the ground landing essentially on his back, he did strike his head but did not have loss of consciousness. The patient is complaining of considerable pain in the mid to upper back, some of which may be chronic. Physical exam: extremities show normal range of motion, no bony or joint deformity, no unilateral calf swelling or tenderness. Alert and oriented to person, place, time, and situation, upper extremities are strong bilaterally, lower extremities are immobile and he has diminished sensation below the knees bilaterally which is chronic. No step off (bones are not lined up properly which can be seen and felt by the examiner) or deformity to the back, considerable low thoracic and upper vertebral tenderness without step off or deformity. The patient's work-up is reviewed, his head Computed Tomography (CT; scan that uses x-rays to create pictures of the head) show possible focal subarachnoid hemorrhage (bleeding inside the brain) along the left frontal lobe without mass effect or evidence of territorial infarct (area of dead tissue resulting from inadequate blood supply) or mass-like lesion. The patient does not have a headache, he continues to complain primarily of back pain. For the most part , his back looks uninjured other than an

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 05/03/2023

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	F 689		

age-indeterminate right L2 transverse process fracture. Repeat head CT in four hours, if there is no change it may be related to either artifact (something artificial seen on an image but not actually present) or potential inconsequential (not significant) subarachnoid hemorrhage."

An ED report addendum dated 04/10/2023 for Resident #1 read in part, "He had a CT scan of the head that showed possible focal subarachnoid hemorrhage along the left frontal lobe. Otherwise, his trauma work up was negative for acute injuries. The repeat head CT which was completed at 5:40 PM noted the possible small subarachnoid hemorrhage adjacent to the left frontal lobe is less apparent, may be artifactual. No other evidence of intracranial abnormality."

During an interview on 05/03/23 at 11:59 AM, the facility's Interim Maintenance Director revealed the mechanical lift and sling used to transfer Resident #1 on 04/09/23 was immediately placed out of service until a thorough inspection was completed. On 04/13/23, he inspected the mechanical lift which included checking the boom (crane-like arm that uses hydraulics to lift up and down), legs (base of the mechanical lift) breaks, remote, and emergency stop button and all worked properly. He did a thorough check of the sling used during the transfer and there were no rips or tears and the sling hooks were intact. He then used the same sling to hook himself up to the mechanical lift, used the remote to raise himself up and down and everything worked properly. He also completed a thorough check of all the other mechanical lifts in the facility with no concerns identified. The Maintenance Director explained the mechanical lift used to transfer

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 05/03/2023

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	F 689		

Resident #1 had a hook that spiraled and curved inward and if the sling was attached properly, the weight of the person helped hold the sling and hooks in place and there was no way the sling could have come loose or slid off. The Maintenance Director stated when placing a resident in the sling, the straps should be crossed when attaching the sling hooks to the mechanical lift to secure the resident and ensure there were no exposed areas and his best guess, was that the sling was not attached properly which was how Resident #1 most likely slid out of the sling.

A Nurse Practitioner (NP) progress note dated 04/10/23 read in part, "Resident #1 seen today following a fall from mechanical lift on 04/09/23. Head CT initially showed a possible small subarachnoid hemorrhage adjacent to the left frontal lobe but with recheck it was less apparent and likely artifactual. Thoracic and lumbar CT showed an age indeterminate right L2 transverse process fracture. He returned to the facility this morning."

During an interview on 05/03/23 at 1:56 PM, the Nurse Practitioner (NP) revealed she was notified of Resident #1's fall during a transfer and when she reviewed Resident #1's hospital records, it was noted the L2 fracture was "age-indeterminate" which meant it could not be determined how or when the fracture occurred. In addition, the NP stated what initially appeared to be a subarachnoid hemorrhage to his left frontal lobe was actually artifactual. The NP explained when she evaluated Resident #1 on 04/10/23 he was already receiving scheduled and PRN (as needed) medications for chronic pain but was complaining of being sore all over and she didn't want to increase the current dosage

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 05/03/2023

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	F 689		

due to possible sedation but did adjust the scheduled times for his pain medications to be administered.

During a telephone interview on 05/03/23 at 4:03 PM, the Medical Director (MD) stated when he reviewed Resident #1's hospital records, the ED report noted the lumbar fracture was "age-indeterminate" which meant they couldn't tell how old it was or when it happened. The MD explained the fracture could have been the result of the fall on 04/09/23 or something that happened previously, there was just no way to know for sure. The MD stated when Resident #1 returned back to the facility, he was back to his baseline with no apparent residual effects as a result of the fall.

The facility provided the following Corrective Action Plan with a completion date of 04/10/23:

1. On 04/09/23, resident was being transferred from the bed to wheelchair by one Nurse Aide utilizing the mechanical lift. Upon interviewing the Nurse Aide, she stated that she was unable to get help and decided to transfer the resident herself due to being pressured by the resident. She stated that she did not feel comfortable but wanted to get the resident up. The Nurse Aide was able to demonstrate how she utilized the sling and how it was hooked up to the mechanical lift. She stated that once she raised the lift it was stuck and she began to pull on it. At that time the strap was under the resident's leg and slipped off the hook causing the resident to slide to the floor and landing on the legs of the lift, back down. The assigned nurse along with the nurse on duty assessed the resident and it was determined the resident would be sent to the ED for evaluation.

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 05/03/2023

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		

The resident was alert and oriented and able to answer all questions surrounding the incident. Resident stated he did hit his head and that his back was hurting. Nurses present did not move resident to complete a skin assessment on his back, due to resident complaining of pain. EMS in facility to take resident to hospital for evaluation. X-rays completed at ED did reveal "L2 fracture indeterminate age and CT scan revealed a "hemorrhage but could be artifactual." Resident remained in the ED overnight and returned to the facility on 04/10/23.

2. Nurse Aide involved was immediately suspended pending investigation and educated regarding use of mechanical lift and appropriate positioning of resident. Nurse Aide was also asked to do a return demonstration using the mechanical lift. Mechanical lift that was utilized was taken out of service until inspected by the Maintenance Director, sling that was used was also taken off hallway. Administrator and Director of Nursing met with the Nurse Aide on 04/10/23, written statement received, education provided, written corrective action completed, and mechanical lift competency completed with return demonstration.

3. Reeducation to nursing staff to include Nurse Aides, Nurses and Med Aides initiated on 04/09/23 by the Administrator and Director of Nursing. Education included proper use of the lift, positioning of the slings, and where to find information regarding how residents transfer and if mechanical lift, what sling size to use. All nursing staff will receive education prior to next scheduled shift. Education is ongoing for new hired and contracted staff.

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 05/03/2023

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		

a) Mechanical lift competencies completed on all Nurse Aides, Med Aides and Nurses before use of mechanical lifts.
b) Transfer assessments completed on 100% of all residents.
c) 100% audit of all slings in facility to ensure they were in good condition.
d) 100% audit of all care plans and Kardex to ensure correct information in place and updated as needed with new assessment information.
e) Director of Nursing or designee will complete random weekly observations of transfers for three (3) employees to ensure that appropriate transfer technique is being done using a mechanical lift three times a week for twelve weeks.

4. Results of random weekly observations will be discussed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting for three (3) months to sustain substantial compliance.

5. Allegation of Compliance Date: 04/10/23.

The Corrective Action plan was validated on 05/03/23 and concluded the facility had implemented an acceptable corrective action plan on 04/10/23. Interviews with nursing staff, including agency staff, revealed the facility had provided education and training on use of mechanical lift transfers that included requiring two-person assistance, where to locate information on resident transfer status and what size sling to use if mechanical lift needed. Staff interviewed all verbalized they were observed performing a mechanical lift transfer after receiving reeducation and prior to starting their next shift.

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 05/03/2023

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 Review of the monitoring tools of mechanical lift transfers that began on 04/12/23 were completed weekly as outlined in the corrective action plan with no concerns identified.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring,	F 867		5/30/23

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 05/03/2023

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 17	F 867		

including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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 05/03/2023

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 18 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F 867		

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 05/03/2023

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 19 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 the interventions that the committee put into place following the recertification and complaint investigation survey completed on 06/24/22. This was for a repeat deficiency in the area of free of infection control that was originally cited on 06/24/22 during a recertification and complaint investigation survey and subsequently recited during a complaint investigation survey on 05/03/23. This continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F880: Based on observations, record review, and interviews the facility failed to implement infection control for hand hygiene when 2 of 2 facility staff (Nurse Aide #1 and Nurse Aide #2) did not remove their gloves and perform hand hygiene after providing incontinence care for 1 of 1 resident observed for incontinence care (Resident #2). During the recertification and complaint investigation survey of 06/24/22, the facility failed to establish and implement infection control policies to reduce the risk of growth and spread of Legionella in the building water systems that had the potential to affect 83 of 83 residents. The facilty also failed to implement infection control	F 867	Ad Hoc Quality Assurance Performance Improvement Meeting held on 5/25/2023 with the Executive Director, Medical Director, Director of Nursing, and Interdisciplinary Team to include F880 and F689 and any further areas of concern as stated by surveyors upon exit. Regional Director of Clinical Services re-educated Executive Director on 5/25/2023 on the components of this regulation and quality assurance monitoring related to Infection Control and Accidents/Incidents to ensure identification of potential problems. Quality Assurance Performance Improvement Meeting to be conducted monthly and as needed to review Quality Assurance with F 880 and F 689. Present at the meetings will be the Executive Director, Director of Nursing, Medical Director, and Interdisciplinary Team. The Executive Director and/or designee will conduct a quality review of QAPI to ensure quality assurance monitoring of facility processes related to Infection Control and Accident/Incidents 1x week x 4 weeks, then every 2 weeks x 2 months then as indicated. The findings of these quality monitoring tools will be reported to the Quality Assurance Performance Improvement Committee monthly and changes made as needed.	

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 05/03/2023

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 20 procedures when the Staff Development Coordinator and Nurse Aide failed to perform hand washing after the removal of gloves during wound care and following a resident transfer for 2 of 2 sampled residents. During an interview on 05/03/23 at 8:03 AM, the Administrator revealed she was not employed at the facility in June 2022 during but had read the CMS 2567 to familiarize herself with the results of the recertification and complaint investigation survey and understood there was a similar incident that had occurred with Resident #1 last year. The Administrator stated staff were educated on proper procedure related to using mechanical lifts with an emphasis on the importance of always having two-person assist with mechanical lift transfers and felt the Nurse Aide had made a poor judgement call by not following facility protocol and waiting on other staff to assist.	F 867	Date of Compliance 5/30/2023	
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:	F 880		5/30/23

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 05/03/2023

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 21 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be 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	F 880		

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 05/03/2023

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 22 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to implement infection control for hand hygiene when 2 of 2 facility staff (Nurse Aide #1 and Nurse Aide #2) did not remove their gloves and perform hand hygiene after providing incontinence care for 1 of 1 resident observed for incontinence care (Resident #2). Findings included: Review of the facility's policy titled "Handwashing/Hand Hygiene" last revised August 2019 read in part as follows: "This facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: after contact with blood or bodily fluids and after removing gloves."	F 880	Resident # 2 is still a resident at the facility and suffered no harm as a result of the staff member not washing hands after doffing dirty gloves. Nurse Aide #1 and Nurse Aide #2 were reeducated on Hand Hygiene/Perineal Care on 5/18/2023. On 5/3/2023 through 5/30/2023 the Director of Nursing and/or designee performed Quality Improvement Monitoring for staff to include: Licensed Nurses, Medication Aides, and Certified Nursing Assistants to ensure proper Handwashing/Hand Hygiene performed by completion of Hand Hygiene Competency and Perineal Care Competency. The Root Cause Analysis was completed by the Regional Director of Clinical Services, Executive Director, and the Director of Nursing on 5/18/2023. To prevent this from recurring the Director of Nursing/or designee will re-educate nursing staff to include: Licensed Nurses, Medication Aides, and Certified Nursing Assistants on hand hygiene with special	

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 05/03/2023

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 23 1. A continuous observation of Nurse Aide (NA) #1 on 05/02/23 from 10:30 AM through 10:37 AM revealed NA #1 provided incontinence care to Resident #2. With gloved hands, NA #1 cleaned urine with a resident care wipe, removed the wet brief and care wipes and placed them in the trash can, placed a clean brief under Resident #2, secured the brief tabs, pulled Resident #2's gown down, sat the container of resident care wipes on the air conditioner, and pulled up Resident #2's bed cover. NA #1 picked up the trash bag containing the wet brief, removed her left glove and placed it in the trash bag, pushed Resident #2's overbed table closer to the bed with her left hand, opened the room door with her left hand, and placed the trash bag in a trash can in the hallway. NA #1 did not remove her gloves and perform hand hygiene after removing urine and before touching Resident #2's clean brief, gown, container of resident care wipes, bed cover, overbed table, and door handle. An interview with NA #1 on 05/02/23 at 10:38 AM revealed she had been trained to remove her gloves and perform hand hygiene after providing incontinence care and she did not when she provided incontinence care for Resident #2 on 05/02/23 because she just didn't think about it. An interview with the Director of Nursing (DON) on 05/03/23 at 3:51 PM revealed NA #1 should have removed her gloves and performed hand hygiene after performing incontinence care and before touching other items in Resident #2's room. An interview with the Administrator on 05/03/23 at 4:52 PM revealed gloves should be removed and hand hygiene should be performed after providing	F 880	focus on gloves should be removed/discarded and hand hygiene should be performed after providing incontinence care. Hand hygiene and new gloves should be applied before touching clean brief. The education will be completed by the Director of Nursing/or designee by 5/30/2023. Any nursing staff that cannot be reached within the initial reeducation time frame, will not take an assignment until they have received this reeducation. Agency nursing staff and newly hired nursing staff will have this education during their orientation. To monitor and maintain ongoing compliance, The Director of Nursing/Assistant Director of Nursing or designee will conduct random Quality observation of nursing staff to ensure staff are washing hands after doffing gloves. Beginning on 5/30/23 The Director of Nursing and/or designee will conduct Quality improvement monitoring by observing 5 random employees to ensure they wash their hands after doffing gloves when going from dirty to clean while providing patient care. These monitor tools will be completed 3 x weekly x 12 weeks, then as needed to ensure compliance. The Executive Director and Director of Nursing will report the results of the quality monitoring tools to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. Correction action will be 5/30/2023	

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 05/03/2023

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 24	F 880		

incontinence care.

2. A continuous observation of Nurse Aide (NA) #2 on 05/03/23 from 8:59 AM through 9:04 AM revealed NA #2 provided incontinence care to Resident #2. With gloved hands, NA #2 cleaned urine and stool with a resident care wipe, removed the soiled brief and care wipes and placed them in the trash can, placed a clean brief under Resident #2, secured the brief tabs, removed her gloves and placed them in the trash can. NA #2 handed Resident #2 the bed control, removed the trash bag containing the soiled brief from the trash can and sat the bag on the floor, washed her hands, and removed the trash bag from the room. NA #2 did not remove her gloves and perform hand hygiene after removing urine and stool and before touching Resident #2's clean brief and the bed control.

An interview with NA #2 on 05/03/23 at 9:05 AM revealed she had been trained to remove her gloves and perform hand hygiene after providing incontinence care and it was an oversight that she did not when providing care to Resident #2 on 05/03/23.

An interview with the Director of Nursing (DON) on 05/03/23 at 3:51 PM revealed NA #2 should have removed her gloves and performed hand hygiene after performing incontinence care and before touching other items in Resident #2's room.

An interview with the Administrator on 05/03/23 at 4:52 PM revealed gloves should be removed and hand hygiene should be performed after providing incontinence care.