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<td>F 282</td>
<td>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</td>
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The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
- Based on record review, observation and staff interviews, the facility failed to follow care plan interventions for fluid restriction for one (1) of one (1) dialysis residents. (Resident #48).

The findings included:

- Resident #48 was admitted to the facility on 05/08/06 and readmitted on 03/26/08 with diagnoses including late effect hemiplegia, late effect cardiovascular disease, cognitive deficit, pharyngeal dysphasia, hypertension, kyphosis, scoliosis, end stage renal disease and unavoidable weight loss due to hemodialysis.

  - Record review of the Minimum Data Set (MDS) dated 04/30/13 revealed Resident #48 had no hearing, speech and vision problems and was assessed with moderately impaired cognition. Resident #48 was assessed for most activities of daily living (ADL) as requiring extensive assistance with 2 person assist and a diet order for a therapeutic diet.

  - Record review of Resident #48's care plan dated 05/08/13 included a problem area of a renal diet and included an approach for a no added salt, low potassium diet and limit beverages to 240 cc each meal and 120 cc with each medication pass with no pitcher at bedside.

  - An interview was conducted on 08/15/13 at 3:25 PM with Resident #48. She stated her fluids had been restricted to 38 ounces each day. She stated the facility restricted her fluids although she would like more fluids. She reported she had to stay away from foods with high potassium, colas and chocolate.

  - The "Nurse Tech Information Kardex" (used by nurse aides to inform them of individual resident care needs) noted that Resident #48 should not have pitchers by the bedside.

  - Observation on 08/15/13 at 3:45 PM revealed Resident #48 had two water pitcher cups and two coffee cups in the room at the bedside.

  - On 08/15/13 at 3:46 PM Nurse #1 stated nurse aides monitor residents' fluid intake with meals and nurses monitor fluid intake with medications. Nurse #1 stated residents on fluid restrictions had not been allowed to have fluids at the bedside which was part of the care plan. Nurse #1 observed Resident #48 had fluid cups at the bedside and stated the cups should not have been in the room and that he was not aware the cups were in the room.

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

The above isolated deficiencies pose no actual harm to the residents.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CMS IDENTIFICATION NUMBER.
345477

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________________
B. WING ________________

(X3) DATE SURVEY COMPLETED
08/15/2013

NAME OF PROVIDER OR SUPPLIER
THE OAKS AT SWEETEN CREEK

STREET ADDRESS, CITY, STATE, ZIP CODE
3884 SWEETEN CREEK RD
ARDEN, NC 28704

(X4) ID PREFIX TAG
ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LOCAL IDENTIFYING INFORMATION)

F 164 SS=D 483.10(e), 483.75(I)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another health care institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observations and staff interviews, the facility failed to promote privacy during a shower by 1 of 1 residents observed during a shower.
(Resident #106)

F 164
This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and federal law.

1. Privacy was provided for resident #106 on 8/13/2013 by certified nurse assistant. Certified Nurse Assistant #3 was in-serviced by the Assistant Director of Clinical Services on privacy and providing privacy during ADL's and showers on 8/13/2013.

2. All residents have the potential to be affected by this citation. An audit was completed on 9/3/2013 of privacy and providing privacy during ADL's and showers by the Assistant Director of Clinical Services and/or Nursing Supervisor.

3. Licensed Nurses and Certified nurse assistants were in-serviced by the Assistant Director of Clinical services 8/16/2013-9/9/2013 on privacy and providing privacy during ADL's and showers.

4. The Director of Clinical Services and/or Nursing Manager will conduct Quality Improvement monitoring of privacy and providing privacy during ADL's and showers five times a week for two weeks, three times a week for two weeks, two times a week for two months, one time a week for three months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until 100% compliance is obtained.

9/3/13
TITI F
Director of Clinical Services
00 DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection for the resident. (See instructions.) Except for nursing homes, the findings stated above are disclosed 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

EVENT ID: TPGL11
Facility ID 023157

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The findings included:

Resident #106 was admitted to the facility 09/01/11 with diagnoses which included depression, Alzheimers and dementia with psychosis. The last Minimum Data Set assessment dated 05/18/13 assessed Resident #106 with severe cognitive impairment.

The current care plan for Resident #106 dated 05/22/13 included the following problem;
- Self care deficit. Inability to complete self care task independently, impaired decision making with poor safety awareness. Diagnosis of Alzheimers disease.
- Approaches to this care plan problem included, Promote dignity; converse with resident while providing care. Assure privacy.

On 08/13/13 at 9:34 AM while coming out of a room (located across from the shower room) Nurse Aide (NA) #3 was observed quickly opening the door of the shower room and exiting. The shower room door fully opened as NA #3 exited from the right and headed left, down the hall. As the door opened Resident #106 was observed fully unclothed, seated in a shower chair and, at the area just inside the door. In the moments the door remained opened (and Resident #106 realized she had been exposed to someone outside the shower room) the resident grabbed a towel and attempted to cover her upper body.

On 09/13/13 at 10:30 AM NA #3 stated it was her first day working independently as she was just recently hired. NA #3 stated she had completed all training, including shadowing other nursing assistants to observe care. NA #3 stated she did...
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<td>F 164</td>
<td>463.15(a)</td>
<td>DIGNITY AND RESPECT OF INDIVIDUALITY</td>
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give Resident #106 a shower that morning. NA #3 stated she did not realize Resident #106 had been exposed when she came out of the shower room and she forgot to pull the shower curtain.

On 08/15/13 at 4:14 PM the Assistant Director of Nursing stated residents should never be exposed and, when providing showers, the privacy curtain should be pulled or, at a minimum, a resident should be covered.

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on record review, observations, resident interview and staff interviews the facility failed to treat 1 of 6 sampled residents with dignity and respect by leaving a resident wet during the breakfast meal.

(Resident # 127)

The findings included:

Resident #127 was admitted to the facility on 04/30/13 and readmitted on 08/23/13 with diagnoses including oral pharyngeal dysphasia, peritonitis of abdominal cavity, muscle weakness, and depression.

The initial Minimum Data Set (MDS) dated 05/07/13 indicated resident #127 was severely
Continued From page 3
cognitively impaired. Resident #127 was
assessed for most activities of daily living (ADL)
as requiring extensive assistance with 2 plus
person assist. Record review of nurses notes
dated 08/14/13 revealed Resident #127 was
incontinent of bowel and bladder.

A review of Resident #127's care plan dated
05/01/13 included a problem of self care deficit
and an inability to complete self care task
independently.

On 08/15/13 at 8:29 AM Resident #127 was
observed in his room, with the door opened,
sitting on the edge of the bed in a very wet and
soaked sheet with his breakfast tray in front of
him on the overbed table. He stated, "I am
soaking wet and my breakfast is a mess." The
nurse on the hall was passing medications close
to the resident's room and a nurse aide was not
visible on the hall. Resident #127 remained in a
wet condition for about 20 minutes and when he
was changed he was able to eat his breakfast.

On 08/15/13 at 9:43 AM Resident #127 was
interviewed. He stated he had been very upset
that staff had delivered his breakfast tray and had
not cleaned him up. He was not sure how long
he had remained wet and expressed he could
have been wet since the early morning shift.

An interview was conducted on 08/15/13 at 9:50
AM with Nurse Aide (NA) #1. He stated he had
been assigned to deliver and set up breakfast
trays on 300 hall where Resident #127 resided.
He said another nurse aide was supposed to be
available to answer call bells during meal times.
NA #1 reported he had delivered Resident #127's
tray and the resident told him he was wet and

This plan of correction does not
constitute an admission or agreement by
the provider of the truth of the facts
alleged or conclusions set forth in this
Statement of Deficiencies. This Plan of
Correction is prepared solely because it
is required by state and federal law.

1. Incontinence care was provided to
resident #127 on 8/15/2013 by certified
nurse assistant. Certified nurse assistant
#3 was in-serviced by the Assistant
Director of Clinical Services on
providing assistance during meals,
dignity and incontinent care when
needed.

2. All residents have the potential to be
affected by this citation. An audit was
completed on 9/3/2013 of dignity and
residents requiring toileting assistance
during meal times by the Assistant
Director of Clinical Services and/or
Nursing Supervisor.

3. Licensed Nurses and Certified nurse
assistants were in-serviced by the
Assistant Director of Clinical services
8/16/2013-9/9/2013 on dignity and
providing toileting assistance during
meals.
4. The Director of Clinical Services and/or Nursing Manager will conduct Quality Improvement monitoring of dignity and providing toileting assistance during meals times five times a week for two weeks, three times a week for two weeks, two times a week for two months, one time a week for three months. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until 100% compliance is obtained.

5. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Activities Director, Medical Director, Social Services, Maintenance Director, Minimum Data Assessment Nurse.

On 08/15/13 at 10:11 AM the ADON stated during meal times one nurse aide had been assigned to
Continued From page 5

a hall to deliver meal trays and pick them up and another nurse aide had been assigned to answer call bells for all 5 halls. The ADON said NA #1 had reported Resident #127 was in a mess and that when he finished delivering trays he would provide incontinence care. The ADON revealed she headed down 300 hall toward Resident #127's room and was called by Human Resources staff to come to her office so she said she never made it to Resident #127's room to check on him or find out if he had received the care he needed. The ADON reported she was not sure which nurse aide was assigned to answer call bells during the breakfast meal. The ADON said the Unit Manager had assigned nurse aides during meal times. The ADON revealed her expectation was to locate a nurse aide or nurse to provide immediate assistance with incontinence care and not leave a resident wet. The ADON said in-services had been provided to staff in the last six months on dignity issues related to providing care.

An interview was conducted on 08/15/13 at 11:06 AM with the Director of Nursing (DON) She stated that during meal times, one nurse aide had been assigned to deliver and pick up meal trays and another nurse aide had responsibility to answer call bells for all 5 halls. The DON revealed if a resident had voiced or rang a call bell for incontinence assistance, he expectation would be that the nurse aide should stop passing or picking up trays, alert the nurse on the hall, and get assistance to provide the care. The DON said in-services had been provided on dignity issues in orientation classes with new employees and ongoing covering a variety of dignity issues.