PRINTED: 09/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345477	B. WING _				C <b>17/2017</b>
	ROVIDER OR SUPPLIER  S AT SWEETEN CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE  3864 SWEETEN CREEK ROAD  ARDEN, NC 28704			<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	00			
F 309 SS=J	from 08/15/17 through Immediate Jeopardy (CFR 483.24, 483.25 aseverity (J) CFR 483.25 at tag F3 (J) CFR 483.70 at a scop The tags F309 and F3 Standard Quality of C Immediate Jeopardy I removed on 08/17/17 An extended survey (483.24, 483.25(k)(I) F FOR HIGHEST WELL 483.24 Quality of life Quality of life is a funcapplies to all care and residents. Each residents	was indentifed at: at tag F309 at a scope and 23 at a scope and severity be and severity (J). 323 constituted Sub are. began on 08/10/17 and was conducted. PROVIDE CARE/SERVICES BEING damental principle that discrvices provided to facility lent must receive and the	F3	09			9/15/17
APODATODY	services to attain or magneticable physical, magneticable physical, magneticable physical, magneticable physical, magneticable physical, magneticable physical physic	mental, and psychosocial with the resident's esment and plan of care.  endamental principle that and care provided to ed on the comprehensive elent, the facility must ensure treatment and care in		TITLE			(X6) DATE

Electronically Signed 09/08/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		345477	B. WING _		08/17/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704	, 00.1112011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 309	care plan, and the rebut not limited to the but not limited to the compression with profession the comprehensive pand the residents' go (I) Dialysis. The faci residents who requires services, consistent of practice, the compare plan, and the repreferences. This REQUIREMEN by:  Based on record reinterviews the facility staff to assess the reafter a fall in the faci moving and driving to f1 sampled resider accident.  Immediate Jeopardy Resident #4 was be appointment by a face #4's wheelchair fell I head hitting the floor #4 reported a heada who had assisted his wheelchair in the driver reported he lo #4's head to ensure The facility van driver wound care appoints.	thensive person-centered esidents' choices, including following:  Int.  Bure that pain management is so who require such services, essional standards of practice, person-centered care plan, bals and preferences.  It is must ensure that the dialysis receive such with professional standards perhensive person-centered esidents' goals and  This not met as evidenced esident for possible injury lity transport van and before the resident to the facility for 1 and (Resident #4) with a van  The began on 08/10/17 when the resident to a medical collity driver when Resident to the facility van ender the facility van. Resident che to the facility van driver minto an upright position in efacility van. The facility van oked at the back of Resident there was no visible injury. For any sitted the resident #4 to his ment. After Resident #4's		On 8/16/17, a Quality Assurance Performance Improvement Commeeting was held with the Exect Director, Regional Director of Cl Services, Regional Vice Presides Operations, Division Vice Presides Operations, Division Vice Presides Clinical Services, Vice President Safety, Division Director of Safe President of Clinical Education, Nursing Officer to determine the cause analysis and develop corresponding action plan to enaquality care is provided by quality personnel to meet the needs of resident.  Through Root Cause Analysis a on the findings for Resident #4, determined that the facility failed properly train designated non-meaning to the second of the sec	amittee utive inical ent of dent of ty, Vice and Chief root sure fied the
ORM CMS-256	#4's head to ensure The facility van drive	there was no visible injury. er assisted Resident #4 to his ment. After Resident #4's	1	on the findings for Resident #4, determined that the facility failed	it was I to

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		Ι,	c
		345477	B. WING				17/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	P AT OWEETEN ODEEK			38	864 SWEETEN CREEK ROAD		
THE UAK	S AT SWEETEN CREEK			Α	RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	transported back to the driver. The facility variaccident to the nurse to the facility. Immediate on 08/17/17 when the implemented an accession compliance. The face compliance at a lower (isolated with no actumore than minimal hard jeopardy) to complete monitoring systems prelated to training of the to respond in the every facility van.  The findings included Resident #4 was addrived 04/28/17 indicated 04/28/	nent, the resident was the facility by the facility van an driver reported the for Resident #4 upon return diate Jeopardy was removed the facility proved and the ptable credible allegation of dility remains out of the scope and severity of D that harm with potential for that is not immediate the education and ensure that it into place are effective facility van drivers and how tent of an accident in the  definitive to the facility 03/02/16. The Minimum Data Set (MDS) that defende with the series and the series of spina bifida and the sistance with transfers a wheelchair for mobility.  The on 08/15/17 at 10:44 AM the had a wound care to 0/17 that required the use of the sident #4 stated as they the over a bump his that and the hit his head on the stated the facility van that ack to an upright position in	F	309	licensed transport staff on proper procedure and response to resident incidents/accidents that may occur durit transport.  On 8/16/17, the Regional Director of Clinical Services provided education to current facility designated drivers, inclusive of the Maintenance Director, Maintenance Assistant, and Central Supply Coordinator who was providing transport for Resident #4 on 8/10/17. T training included the process for responding to resident incidents/accide during van transport by contacting 911 and the facility licensed nurse for medically related emergencies, and no moving or assessing the resident until licensed assistance arrives.  On 8/17/17 at 11:10 AM, the Regional Director of Clinical Services provided 1 reeducation to the licensed nurse carin for Resident #4 upon his return to the facility, on the importance of obtaining detailed information post incident/accid from the resident and/or witnesses to the event to ensure a comprehensive assessment can be completed includin but not limited to, neurological checks for residents who hit their head and an appropriate plan of care implemented.  Resident #4 will continue to be transported via the contracted transportation service related to	he ents t ent g ent ne	
	wheelchair fell backw the floor. Resident # driver assisted him b his wheelchair. Resi the facility van driver	vard and he hit his head on 4 stated the facility van			transported via the contracted		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	· ,	(X3) DATE SURVEY COMPLETED	
		345477	B. WING			C 8/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	2.2	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		6/11/2017	
TO UNE OF TH	TO VIDER OIL OUT I EIER				52		
THE OAKS	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD			
				ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 309	F 309 Continued From page 3		F 30	09			
	no iniury so Resident	#4 went on to his wound		The facility will ensure that p	rofessional		
		esident #4 stated no one at		licensed staff will assess res			
		ntment examined his head		possible injury in the event of			
		nent he was transported		accident in the facility transp			
	back to the facility. R	esident #4 stated the nurse		to moving and driving the res	sident back to		
		or injuries at the facility and		the facility.			
	he reported to the nur	rse that he had a headache.					
		e nurse gave him Tylenol for		On 8/16/17, the Regional Di			
		ent #4 denies any further		Clinical Services provided ed			
	pain or discomfort rela	ated to the fall.		current facility designated d			
	Donie e ee internieur	- 00/45/47 -+ 44:00 ABA		inclusive of the Maintenance			
		n 08/15/17 at 11:02 AM with		Maintenance Assistant, and			
	the facility van driver transporting Resident			Supply Coordinator. The training included the process for responding to resident			
	_	0/17 in the facility van. The		1			
		ed they were in the parking		falls and incidents/accidents during van transport by contacting 911 and the facility			
		I's appointment was and		licensed nurse, and not mov			
		imp and he heard a "thump"		assessing the resident until I	-		
	•	saw Resident #4 had fallen		assistance arrives. Newly hi			
	backward in his whee	lchair. The facility van		designated drivers will be ed	lucated upon		
		own straps had loosened		hire and bi-annually thereaft	er by the		
		eelchair to fall backwards		Maintenance Director.			
		still strapped securely in his					
		assisted him back into an		On 8/16/17, the MDS registe			
	. • .	facility van driver stated		began reeducation to license			
		he hit his head on the floor at the back of his head and		the post incident/accident princluding, but not limited to,			
		ess, bruising or bleeding.		resident assessment, vital si			
		stated he re-secured the		assessment, fall assessmen			
	•	nt #4 until they were parked		related accident), neurologic	•		
		him out of the facility van for		assessment (if unwitnessed			
		ent. After his medical		injury), notification to			
		nt #4 was transported back		physician/responsible party	and ongoing		
		facility van driver stated he		monitoring for changes in co			
	told the nurse for Res	sident #4 about the accident		hours and conducting a thore	ough		
		had hit his head. The		investigation to include witne			
	•	ed he was not sure what		statements as appropriate. N	-		
	happened after he tol	d the nurse.		nurses will be educated upor	•		
				Director of Clinical Services	or registered		

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				CIVID IN	<u>0. 0936-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		345477	B. WING _			08	3/17/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	O AT OWELTEN OBEEK			38	64 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			Al	RDEN, NC 28704		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 309	Continued From page	e 4	F 3	809			
		view on 08/15/17 at 1:10 PM			nurse designee.		
		ssessed Resident #4 on the			nuise designee.		
		he stated she had been told			The trained designated transportation		
		ver that Resident #4 had			staff will be equipped at all times with a		
	, ,	nair in the van. The nurse			cellular phone to contact licensed facili		
	stated that she went	to Resident #4 ' s room and			staff and emergency medical responde	-	
	assessed him and he	had no injuries and no pain.			in the event of resident incident/accident	nt	
	The nurse also stated	that she let the Family			during transport. The non-medically		
	Nurse Practitioner kn	ow and completed an			licensed transportation staff will not mo	ve	
		ort. The nurse stated that			or assess resident and will await		
		t #4 Tylenol for a headache			professional staff assistance to arrive to	)	
		o him having an injury from			complete a resident assessment and		
		ready had this available for			provide care as appropriate.		
	pain and headache a	nd requested it regularly.			The Executive Director and/or		
	During an interview o	n 08/15/17 at 1:47 PM with			Maintenance Director will complete qua	ality	
		ig (DON), she stated she			assurance monitoring of the facility	anty	
	had been notified tha				transport van for presence of an operal	ble	
		and went to his room on			cellular device to ensure that in the eve		
		him. The DON stated			of a van accident, a licensed profession		
		at he was okay and that he			will be contacted to complete a residen		
		ON stated she told the facility			assessment for possible injury prior to		
		his statement about what			being moved. Monitoring will be		
		t it to her. The DON stated			completed at a frequency of 5 days per	-	
	the facility van driver	turned in his statement the			week for a period of 12 weeks then, 3		
		he read it found out that			times per week for 3 months, then wee	-	
	Resident #4 had hit h	is head. The DON stated			thereafter as determined by the Quality	′	
		to see Resident #4 and he			Assurance Performance Improvement		
		ine, had no pain, and no			(QAPI) Committee.		
	• •	ent. The DON stated her			T1 10 50 10		
	I -	the facility van driver to			The results of the quality assurance		
	have called the facilit	y wnen the accident eone know what happened			monitoring will be reported to the QAPI		
		ined what medical treatment			Committee monthly by the Executive Director for twelve months and/or until		
	may be necessary.	inca what inculcal treathlefit			substantial compliance is obtained. Th	e	
	may be necessary.				QAPI Committee will evaluate the		
	During an interview o	n 08/16/17 at 3:35 PM with			effectiveness of the		
	_	ctitioner (FNP), she stated			monitoring/observation tools for		
		aware of the incident on			maintaining substantial compliance, an	d	

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		345477	B. WING			C <b>8/17/2017</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704	<u> </u>	0/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 309	head at that time. The assessed him on 08/1 stated he had bumper from the incident that On 08/16/17 at 8:44 informed of the Immer proved a credible alle 08/17/17 at 11:55 AN compliance indicated. To remove the immer and/or completed the On August 10th, 201 resident #4 was transphysician appointme a specialized modified diagnosis of Spina B On 8/10/17 at 8:45 A Resident #4, per the van experienced a but the parking lot of sch van driver looked bac wheelchair had tipper remaining secured in driver parked the var was still seated in his position, and immedi resident by visually of head for any bruising	a aware he had bumped his e FNP further stated she had 16/17 and Resident #4 and his head but had no injury to occurred on 08/10/17.  AM the Administrator was ediate Jeopardy. The facility regation of compliance on M. The allegation of I the following:  The allegation of I the following:  The facility has initiated a following:  The facility has initiated a following:  The approximately 8:30 AM, sported by facility staff to a not. Resident #4 does utilize and wheelchair due to ifida.  My during the transport of assigned the van driver, the tump during locomotion into eduled appointment. The cand noted the resident at the wheelchair. The van the wheelchair. The van the wheelchair, into an upright ately responded to the observing the back of the por cuts, and none were	F 30	,	ce ers Executive vices, sultant, es Dietary nent e Aides sponsible	
	that he hit his head of he fell. Resident did headache which did to facility. The van d	Hent stated to the van driver on the floor of the van when I have initial complaint of self-resolve prior to returning river did not contact the If or call 911 to inform them				

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' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345477	B. WING		08/17/2017		
	ROVIDER OR SUPPLIER	<b>(</b>	3	STREET ADDRESS, CITY, STATE, ZIP CODE 1864 SWEETEN CREEK ROAD ARDEN, NC 28704	1 00/1//2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION		
F 309	driver noticed the variaffixed to the front of were now loose and wheel chair and trar appointment.  On 8/10/17 at 11:00 facility and the van unurse assigned to Fin the van during trathat the resident hit nurse. The nurse a injuries noted, no condiscomfort. Vital Signedistered nurse that pressure 124/55, Pt. 18 per minute, and recorded utilizing do Background Appear form, Fall Risk Eval Progress Note.  On 8/10/17 at 12:15 assigned to residen tablet of Tylenol by needed orders for hid documented on the Record.  On 8/10/17 at 1:30 assigned to Residen practitioner with no treatment. Residen party. Resident co for changes in condineadache and none	and hit his head. The van an's floor straps that were of the resident's wheelchair did he secured the straps to the asported the resident onto his DAM, resident returned to the driver alerted the registered Resident #4 of the occurrence ansport, but did not inform her his head when he fell per the ssessed the resident with no	F 309				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,			(X3) DATE COMP	SURVEY
		345477	B. WING			1	C 17/2017
	ROVIDER OR SUPPLIER S AT SWEETEN CREEK			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE  864 SWEETEN CREEK ROAD  RDEN, NC 28704	1 06/	17/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	resident had struck his  The registered nurse be provided one to or Director of Clinical Se shift on obtaining deta incident/accident from witnesses to the ever comprehensive assess appropriate plan of caperforming neurologic who have hit their had telephone on August  On 8/16/17 at 10:15 A Performance Improve was held with the Exe Director of Clinical Se President of Operation of Clinical Services, Noivision Director of Sc Clinical Education, and determine the root cacorresponding action is provided by qualified needs of the resident  Through Root Cause 8/16/17 at 11:15 AM, facility failed to prope non-medically license procedure and respondincident/accident that  On 8/16/17 at 11:48 A evaluated Resident # He denies visual chair	t being notified that the s head during the incident.  assigned to Resident #4 will be education by the Regional ervices prior to her next work ailed information post in the resident and/or at to perform a sement to determine are. Education will include cal observation for residents ead. Education occurred via 17, 2017 at 11:10 AM.  AM, a Quality Assurance ement Committee meeting ecutive Director, Regional ervices, Regional Vice ins, Division Vice President of ad Chief Nursing Officer to use analysis and develop plan to ensure quality care and personnel to meet the company of the comp	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3864 SWEETEN CREEK ROAD  ARDEN, NC 28704		00/1//2017	
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F 309	today, calm and pleacough, congestion, dicomplaints."  On 8/16/17 at 12:30 If Clinical Services providesignated drivers, in Director, Maintenance Supply Coordinator with for Resident #4, who transport van. The trifor responding to residuring van transport. contacting 911 for me contacting facility lice non-emergent incider moving or assessing assistance arrives. The staff will be equipped 8/17/17 to contact lice emergency medical resident incident/acci Facility designated direducation on the princidents/accidents dibi-annually completed Director. Newly hirected receive education up thereafter on facility president incident/acci by the Maintenance If On 8/16/17 at 3:40 Preeducated licensed.	uises, or injury. He is alert sant and denies fever, yspnea, chest pain, or Gl  PM, the Regional Director of vided education to all facility inclusive of the Maintenance et Assistant, and Central vho was providing transport transport residents in the aining included the process ident incidents/accidents. The education included edically related emergencies, ansed nurse for ints/accidents, and not the resident until licensed the trained transportation with a cellular phone ensed facility staff or esponders in the event of dent during transport. The education staff will on hire and bi-annually process for responding to dents during van transport.  M the MDS nurse	F 30	09			
		ent assessment, vital signs, assessment (if fall related al assessment (if					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE COMP	SURVEY	
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	ROVIDER OR SUPPLIER S AT SWEETEN CREEK		-	S1 38	TREET ADDRESS, CITY, STATE, ZIP CODE  864 SWEETEN CREEK ROAD  RDEN, NC 28704	1 06/	17/2017
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F 323 SS=J	physician/responsible monitoring for change Licensed nurses will reducation is complete be educated upon hir. The Executive Directe implementing this crecompliance.  The credible allegation as evidenced by observing a where verification of re-educing post incident/accident facility designated drimedically related emelicensed nurse for not incidents/accidents, at the resident until licented and performation from the regarding gathering prinformation from the residents' who have the 483.25(d)(1)(2)(n)(1)-HAZARDS/SUPERVI	ead injury), notification to e party and ongoing es in condition for 72 hours. Not be permitted to work until ed. Newly hired nurses will ee.  Or will be responsible for dible allegation of each facility van elchair in the facility van, eation for licensed nurses on the procedure, education to all evers of contacting 911 for ergencies, contacting facility enemergent and not moving or assessing est assistance arrives, essigned to Resident #4 on the twas provided re-education east incident/accident esident and/or witnesses to be a comprehensive enine appropriate plan of care elogical observation for the interior head.  On FREE OF ACCIDENT SION/DEVICES		323			9/15/17

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3864 SWEETEN CREEK ROAD ARDEN, NC 28704		0/1//201/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 323	and assistance device  (n) - Bed Rails. The appropriate alternative bed rail. If a bed or somust ensure correct is maintenance of bed into the following element (1) Assess the resident from bed rails prior to (2) Review the risks at the resident or reside informed consent prior (3) Ensure that the beappropriate for the resident or resident for the resident for the resident for the resident for the facility and his wheelchair dithe facility to a medicibility and his wheelchair resulting thead. This is evident (Resident #4).  Immediate Jeopardy Resident #4 was being care appointment by Resident #4's wheelchair facility wheelchair facility appointment by Resident #4's wheelchair facility wheelchair facility	eives adequate supervision es to prevent accidents.  facility must attempt to use res prior to installing a side or side rail is used, the facility installation, use, and rails, including but not limited ents.  ent for risk of entrapment or installation.  and benefits of bed rails with ent representative and obtain or to installation.  ed's dimensions are sident's size and weight.  I is not met as evidenced  iews, resident, and staff failed to secure a resident uring van transportation from all appointment. The driver he parking lot and the d in his specialized in the resident hitting his tin 1 of 3 sampled residents  began on 08/10/17 when any transported to a wound a facility driver when chair fell backwards resulting	F 32	On 8/16/17, a Quality Assu Performance Improvement Comeeting was held with the Endirector, Regional Director of Services, Regional Vice Preciperations, Division Vice Preciperations, Division Director of Services, Vice Presing Safety, Division Director of Services, Vice Presing Clinical Services, Vice Presing Safety, Division Director of Services, Vice Presing Clinical Education Nursing Officer to determine cause analysis and develop corresponding action plan to residents are free from accidents are free from accidents are free from accidents are free from accidents.	Committee  xecutive  of Clinical sident of esident of dent of Safety, Vice on, and Chief the root		
	Resident #4 reported van driver who had a	efloor of the facility van.  a headache to the facility ssisted him into an upright chair in the facility van. The		Through Root Cause Analys on the findings for Resident determined that the facility fa	#4, it was		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					_	(	
		345477	B. WING			08/	17/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	AT OWELTEN ODERV			38	864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			Α	RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 323	Continued From page	e 11	F:	323			
	of Resident #4's head visible injury. The fact Resident #4 to his work called back to the fact Maintenance Assistant securing the wheelch wound care appoint transported back to the driver. The facility variated accident to the nurse to the facility. Immed on 08/17/17 PM when implemented an access compliance. The faci compliance at a lowe (isolated with no acturate more than minimal has jeopardy) to complete monitoring systems prelated to training of f	nt for further instructions on air. After Resident #4's lent, the resident was lent facility by the facility van in driver reported the for Resident #4 upon return liate Jeopardy was removed in the facility provided and eptable credible allegation of			1)identify non-traditional wheelchair equipment that may require additional alternate transport mechanisms or considerations and 2) provide an individualized care plan to meet the saft needs of each resident.  Resident #4 will continue to be transported via the contracted transportation service related to non-traditional, specialized wheelchair needs. Care plan updated as indicated  On 8/15/17-8/16/17, the Maintenance Director completed a review of current facility residents to identify any specialt or adaptive wheelchairs or durable medical equipment that may prevent th from transporting residents safely in a traditional wheelchair. Identified resider will be transported with a contracted transportation service that will ensure resident safety during medically related	rety y em nts	
	The findings included Upon review of the m inspection and mainte securement and occu a revision date of 02/	: anufacturer's instructions for enance for wheelchair upant restraint systems with 11, it was noted there were for securing a specialized			transports.  On 8/16/17, the MDS nurse updated th identified residents□ safety care plan to reflect the contracted transport needs related to the residents use of specializ and/or modified, non-traditional wheelchairs.	e O	
	wheelchair. Resident #4 was adm The significant chang dated 04/28/17 indica and oriented (BIMS o term memory problem Resident #4 had diag	nitted to the facility 03/02/16. e Minimum Data Set (MDS) ated Resident #4 was alert f 15) with no short or long as. The MDS also indicated anoses of chronic pain and thers and required extensive			On 8/15/17, the Maintenance Director provided education to facility designate drivers, inclusive of the Maintenance Assistant and Central Supply Coordina on the facility procedure for Loading an Unloading a Resident with a Wheelcha Lift on a Transport Van. Procedure	tor d	

PRINTED: 09/13/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDI	NG _		Ι,	С
		345477	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				38	864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			Α	RDEN, NC 28704		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	e 12	F	323			
	· -	fers along with the use of a		0_0	includes loading resident onto the lift,		
	wheelchair for mobilit				locking brakes while on the lift,		
	Wilecionali for mobili	.y.			transporting resident from lift into van,		
	During an interview o	n 08/15/17 at 10:44 AM			proper placement of resident within var	١.	
	Resident #4 stated he				securing the resident on the van,	•	
	appointment on 08/10	0/17 that required the use of			unloading the resident onto the lift, and		
		sident #4 stated as they			safely removing the resident from the v		
	were driving and wen	it over a bump his			Return demonstration was successfully	/	
	wheelchair fell backw			completed by each designated driver.			
		4 stated the facility van			Newly hired designated transport staff	will	
	driver assisted him back to an upright position in				be educated upon hire and bi-annually		
	his wheelchair.				thereafter with successful return		
	D	- 00/45/47 -t 44:00 AM:th			demonstration.		
	_	on 08/15/17 at 11:02 AM with			On 9/15/17 the Maintanance Director		
	the facility van driver transporting Residen				On 8/15/17, the Maintenance Director provided education to facility designate	d	
		0/17 in the facility van. The			drivers, inclusive of the Maintenance	u	
		ed they were in the parking			Assistant and Central Supply Coordina	tor	
		4's appointment was and			on the facility policy and procedure S-3		
		ump. The facility van driver			the Fleet Safety Program Motor Vehicle		
		ump" and looked back and			Safety, which describes the expectation		
		fallen backward in his			for transportation employees to operate		
	wheelchair. The facil	lity van driver stated the tie			company vehicles safely and prevent		
	-	sened which allowed the			accidents, including but not limited to,		
		kwards but Resident #4 was			training standards, accident reporting,		
		y in his wheelchair when he			vehicle inspections and maintenance a		
		o an upright position. The			general safety regulations. A Safe Driv	_	
		ed Resident #4 told him he			Quiz was completed by each designate		
		oor and had a headache.			drive with successful results. Newly hir		
		stated he looked at the			transportation staff will be educated up	UII	
		did not see any redness, The facility van driver stated			hire and bi-annually thereafter and complete a Safe Driving Quiz with		
		eelchair of Resident #4 by			successful results.		
		n straps then he assisted			adoctorial results.		
		van once they had parked			Non traditional wheelchairs will be		
		ntment. While Resident #4			evaluated by the Maintenance Director		
		ppointment the facility van			prior to transport to validate if the chair		
		ty and spoke with the			can safely be secured within the compa		
		nt for instructions to strap in			van or if alternate contracted	•	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	, ,	ATE SURVEY OMPLETED
		345477	B. WING			C <b>08/17/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	00/11/2011
				3864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK			ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 323	to the facility and the told the nurse for Res and that Resident #4 facility van driver stat training just over two the van and transportin-service or retrainin van driver also stated had transported Resihim the way he had be driver further stated he time of transport for Faxle on his wheelchair straps loosened durin wheelchair fell backwedenied having any action filter over the whany way during any to the Maintenance Assistation for the Maintenance Assistation for the what is sident #4's wheelch Maintenance Assistation for the van. The Maintend the facility van driver did the facility van driver	ely. After his medical and #4 was transported back facility van driver stated he sident #4 about the accident had hit his head. The ed he had completed years ago regarding driving ting residents but had no g since then. The facility if this was the first time he dent #4 and had secured been trained. The facility van the had been unaware at the Resident #4 that the rear ir allowed the wheels to spin was strapped down, so the first time he declehair or been injured in the head driven the facility had been the had the facility van driven with Resident #4 in his had been the stated the facility van him at the time of the call Resident #4 had taken place intenance Assistant stated he river he needed to get to the	F 33	transportation vendors may be to maintain safety.  On 8/17/17, the Executive Director, Maintenance Director, Massistant, Central Supply Coand to the Scheduler on the Unon-Facility Transportation loof the storage location and paupdating as necessary upon or newly identified non-facility equipment. Newly hired transstaff and schedulers will be eupon hire.  A master Non-Facility Transport master Non-Facility Transport master Non-Facility Transport master Non-Facility Transport be updated by the Maintenan as needed for changes. Drivereview the master Non-Facility Transport veriew the veriew the veriew that veri	rector ransportation Maintenance ordinator) use of the og, inclusive arameters for any changes ransport sportation ducated  ortation log and at the e appropriate t. The tation log will nce Director ers will ty the nurses  or to  Checklist st will be transport corts. Any be reported nediately and	
	strap it down. The M stated Resident #4 h	rame of his wheelchair to aintenance Assistant also ad something very different and it looked to be designed g wheelchair. The		alternate contracted transport to ensure residents□ safety a prevent accidents.  The Executive Director and/o	and to	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI		<del></del>	, ا	c
		345477	B. WING				17/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT SWEETEN CREEK			38	864 SWEETEN CREEK ROAD		
THE OAK	S AT SWELTEN CREEK			Α	RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	transported Resident had no problems with Maintenance Assistar an accident where so the wheelchair or bee any time he had drive During an interview of the Maintenance Director the Accident of the Believed that Resistrapped in correctly around in the van and loosened the tie down During the interview of Maintenance Director of the Maintenance Director of the State of	ant further stated he had #4 several weeks ago and his wheelchair. The nt also stated he had not had meone had flipped over in en injured in any way during en the facility van.  n 08/15/17 at 12:20 PM with ector, he stated the facility up until about 2 months ago. enance Assistant and the (facility van driver at the had been the 2 facility van e could be hired for that nance Director also stated dent #4's wheelchair was but because of the bouncing d the tension it may have	F	3323	Maintenance Director will complete quassurance monitoring of the Transport Van Securement Checklists, Daily Van Safety Checklists, and designated drive required training for completion to ensuresident safety during van transport. Monitoring will be completed at a frequency of 5 days per week for a per of 12 weeks then, 3 times per week for months, then weekly thereafter as determined by the Quality Assurance Performance Improvement (QAPI) Committee.  The results of the quality assurance monitoring will be reported to the QAPI Committee monthly by the Executive Director for twelve months and/or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, an make changes to the corrective action necessary. The Quality Assurance Improvement Committee members consist of, but not limited to, the Execu Director, Director of Clinical Services, Medical Director, Pharmacy Consultant	er ure iod 3	
	Administrator acknow were for the wheelch prior to use in the var because of the wheel On 08/16/17 at 8:44 informed of the Imme	n 08/17/17 at 4:37 PM, the vledged her expectations air to have been evaluated to transport the resident lichair's modified nature.  AM the Administrator was diate Jeopardy. The facility llegation of compliance on			Social Services Director, Activities Director, Maintenance Director, Dietary Director, Minimum Data Assessment Nurse, and facility Certified Nurse Aide and LPN/RN designees.  The Executive Director will be responsi for the implementation of this Plan of Correction.	s	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345477	B. WING				C 17/2017
	ROVIDER OR SUPPLIER  S AT SWEETEN CREEK			3	STREET ADDRESS, CITY, STATE, ZIP CODE 864 SWEETEN CREEK ROAD ARDEN, NC 28704	1 00/	17/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	and/or completed the On August 10th, 2017 Resident #4 was tran physician appointmer a specialized modified diagnosis of Spina Bi in a specialized/non-t secured in the van pe Loading and Unloadir (traditional) Wheelcha Procedure includes to locking brakes while or resident from lift into resident within van, s van, unloading the re safely removing the re traditional wheelchair Maintenance Director if the chair can safely company van or if alte transportation vendor maintain safety. A m. Transportation log wil and at the nurses' sta appropriate plan of ca master Non-Facility T updated by the Maint for changes. Drivers or Non-Facility Transpor nurses' station and w transport.  On 8/10/17 at 8:45 Al	It the following:  Itiacy, the facility has initiated following:  Itiacy, the facility has initiated following:  It approximately 8:30 AM, sported by facility staff to a set. Resident #4 does utilized wheelchair due to fida. Resident #4, who was raditional wheelchair, was ear the facility procedure for any a Resident with a sair Lift on a Transport Van. It is a the lift, transporting wan, proper placement of ecuring the resident on the sident onto the lift, and the sident from the van. Nonse will be evaluated by the exprise to transport to validate the secured within the ernate contracted as may be necessary to aster Non-Facility  I be maintained in the van the indicating the are for safe transport. The fransportation log will be enance Director as needed will review the master that in log posted at the ithin the van prior to  M, during the transport of	F	323			
	transport. On 8/10/17 at 8:45 Al						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	COMPLETED
		345477	B. WING		C 08/17/2017
	ROVIDER OR SUPPLIER	(		STREET ADDRESS, CITY, STATE, ZIP CODE  3864 SWEETEN CREEK ROAD  ARDEN, NC 28704	1 00/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 323	parking lot of sched driver looked back a wheelchair had tipp remaining secured i driver parked the va an upright position, to the resident by vi the head for any bruvisualized. Resider headache which did to facility.  On 8/15/17 at 11:00 Director completed reverse demonstrat Loading and Unload Wheelchair Lift on a designated drivers, Assistant and Centr Maintenance Direct Quiz with successfu policy and procedur Program Motor Veh S-390 describes the transportation employehicles safely and but not limited to, trareporting, vehicle in and general safety in On 8/15/17 at 12:00 Team consisting of the Regional Director of Vice Presidents of C Maintenance Direct medically and non-rotansportation via the	during locomotion into the uled appointment. The van and noted the resident's ed backward with the resident in the wheelchair. The van in, tipped the wheelchair into and immediately responded sually observing the back of dising or cuts, and none were it did have initial complaint of self-resolve prior to returning.  AM, the Maintenance education and observed on of the facility procedure for ling a Resident with a Transport Van to facility inclusive of the Maintenance all Supply Coordinator. The for administered a Safe Driving I results, and reviewed facility es S-390 the Fleet Safety icle Safety. Facility policy is expectations for object to operate company prevent accidents, including aning standards, accident spections and maintenance regulations.  PM, the Interdisciplinary the Executive Director, inclinical Services, Regional Operations, and the or elected to conduct all	F 32	3	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345477	B. WING		C 08/17/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3864 SWEETEN CREEK ROAD  ARDEN, NC 28704	1 00/11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 323	and/or emergency re On 8/15/17 at 2:00 P began reviewing curr identify any specialty durable medical equi them from transportir wheelchair. Mainten audit 8/16/17 at 10 A be transported with a service that will ensu future medically relat the MDS nurse upda safety care plan to re needs due to speciali non-traditional wheel master Non-Facility T	t validation, and lar phone for post less to licensed facility staff sponders.  M the Maintenance Director lent facility residents to or adaptive wheelchairs or poment that may prevent leng safely in a traditional lence Director completed the light of transportation re resident safety during led transports. On 8/16/17 led the identified residents' flect the contracted transport led and/or modified, chair transport needs. A fransportation log will be	F 323		
	indicating the approp transport. The master Transportation log wi Maintenance Director Drivers will review the Transportation poster within the van prior to 2017 the Executive Drivers to the Maintenance Dransportation log inclocation and paramet necessary upon any non-facility transport be completed with the designated van drive Maintenance Assistant	Il be updated by the ras needed for changes. The master Non-Facility at the nurses station and particular transport. On August 16, prector provided education prector on the Non-Facility clusive of the storage ers for updating as changes or newly identified equipment. Education will be scheduler and other			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  3		DATE SURVEY COMPLETED
		345477	B. WING			C <b>08/17/2017</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3864 SWEETEN CREEK ROAD  ARDEN, NC 28704	<u> </u>	06/1//201/
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Performance Improwas held with the E Director of Clinical Services, President of Operat of Clinical Services, Division Director of Clinical Education, addermine the root of corresponding actions approvision is provided in the facility failed designated non-me on proper procedure incident/accident the and licensed nurse procedure 2) identifice equipment that may transport mechanism.	SAM, a Quality Assurance vement Committee meeting xecutive Director, Regional Services, Regional Vice ions, Division Vice President Vice President of Safety, Vice President of and Chief Nursing Officer to cause analysis and develop n plan to ensure appropriate ded to prevent accidents and	F 32	·		
	updated the Care P that he will be trans transportation service safety during future due to the resident modified wheelchair be evaluated quarte members of the Inter needed for any cha master Non-Facility	PM the Registered Nurse lan for Resident #4 to indicate ported via contracted ces that will ensure resident medically related transports utilization of specialized. Resident #4 will continue to erly by a Registered Nurse and erdisciplinary team and as nages to the care plan. A Transportation log will be an, at the nurses' station, and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED
		345477	B. WING		C 08/17/2017
	ROVIDER OR SUPPLIER	K		STREET ADDRESS, CITY, STATE, ZIP CODE  3864 SWEETEN CREEK ROAD  ARDEN, NC 28704	1 00/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 323	appropriate plan of master Non-Facility updated by the Mai for changes. Driver Non-Facility Transp nurses' station and transport.  Newly hired transport education from the hire and bi-annually safely loading and uprocess for respondincident/accidents of Safety Program Mo  The facility will provproperly respond to by ensuring appropicensed and licensed uring medically relationary at a transport incident licensed employee medical responders emergencies and will licensed nurse assi will properly assess post incident/accided.  The Executive Directimplementing this compliance.  The credible allegated as evidenced by obdiver securing and facility van, verificated. Transportation Log	care for safe transport. The Transportation log will be intenance Director as needed is will review the master ortation log posted at the within the van prior to ortation staff will receive Maintenance Director upon or thereafter on procedure for unloading a Resident, facility ding to resident during van transport, the Fleet tor Vehicle Safety.  Tide supervision to prevent and or resident incidents /accidents riate training to non- medically end nurses to maintain safety atted transport. In the event of /accident, the non-medically will contact emergency	F 32	3	

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345477	B. WING		C 08/17/2017
	ROVIDER OR SUPPLIER  S AT SWEETEN CREEK		•	STREET ADDRESS, CITY, STATE, ZIP CODE  3864 SWEETEN CREEK ROAD  ARDEN, NC 28704	, 00.111.2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 323 F 490 SS=J	after a return demons wheelchairs in the facility and all been retrained procedures for securi in the facility van and how to utilize the tranchecklist, and docum and on the daily vehick 483.70 EFFECTIVE ADMINISTRATION/R 483.70 Administration A facility must be admenables it to use its reefficiently to attain or practicable physical, well-being of each restricted processed on observation staff and Family Nursinterviews, the admin resident was afforded services during facility evident in 1 of 1 samplemented an accession of the facility o	Each driver was interviewed stration of securing the cility van and verified they d, had reviewed policies and ng residents in wheelchairs had reviewed and knew sport van securement ent in the transportation log cle inspection report.  ESIDENT WELL-BEING  1. Ininistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident.  1. Is not met as evidenced  1. In the transportation log cle inspection report.  It is not met as evidenced  1. In the transport in	F 49		e hief and

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NAME OF PROVIDER OR SUPPLIER THE OAKS AT SWEETEN CREEK    SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)    F 490		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		ATE SURVEY DMPLETED
NAME OF PROVIDER OR SUPPLIER  THE OAKS AT SWEETEN CREEK    CACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE   TAGE   SUMMARY STATEMENT OF DEFICIENCIES   TAGE   PROVIDER'S PLAN OF CORRECTION PREFIX   TAGE   PROVIDER'S PLAN OF CORRECTION PREFIX   TAGE   PROVIDER'S PLAN OF CORRECTION PREFIX   TAGE   PROVIDER'S PLAN OF CORRECTION PROPRIATE   DEFICIENCY			345477	B WING			C
SUMMARY STATEMENT OF DEFICIENCES   TAGE   SUMMARY STATEMENT OF DEFICIENCES   PREFIX   SUMMARY STATEMENT OF DEFICIENCES   PREFIX   PROVIDERS PLAN OF CORRECTION   PREFIX   REQUILATORY OR LSC (DENTIFYING INFORMATION)   PREFIX   TAGE   PROVIDERS PLAN OF CORRECTION   PREFIX   TAGE   PROVIDERS PLAN OF CORRECTION   PREFIX   PROVIDERS PLAN OF CORRECTION   PREFIX   TAGE   PROVIDERS PLAN OF CORRECTION   PROVIDERS PLAN OF CORRECTION   PROVIDERS PLAN OF	NAME OF D	DOVIDED OD SUDDUED	343477		CTDEET ADDRESS CITY STATE ZID COD	•	08/17/2017
CALID   SUMMARY STATEMENT OF DEFICIENCIES   REGULATORY OR I.S. IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION   PROVIDERS PLAN OF CORRECTION   PROFICE PLAN OF CORRECT	NAME OF PI	ROVIDER OR SUPPLIER			, , ,	/E	
SUMMARY STATEMENT OF DEFICIENCIES   PRECISE   PROPERTY PLAN OF CORRECTION	THE OAKS	S AT SWEETEN CREEK			3864 SWEETEN CREEK ROAD		
FASO  FASO  Continued From page 21  more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for residents transportation to appointments and other activities and to complete education and ensure monitoring systems put into place are effective related to training of facility van drivers and how to respond in the event of an accident in the facility van and re-education of licensed nursing staff.  1. Cross refer to F309: Based on record reviews, resident, and staff interviews the facility transport van and before moving and driving the resident to the facility or an and before moving and driving the resident to the facility to a medical appointment. The driver hit a speed bump in the parking lot and the resident tell backward in his specialized wheelchair resulting in the resident hitting his head. This is evident in 1 of 3 sampled residents (Resident #4).  The facility Administrator was informed of Immediate Jeopardy on 08/16/17 at 8.44 AM.		571. GWZZ1ZII GILZZII	•		ARDEN, NC 28704		
more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedure for residents transportation to appointments and other activities and to complete education and ensure monitoring systems put into place are effective related to training of facility van drivers and how to respond in the event of an accident in the facility van and re-education of licensed nursing staff.  1. Cross refer to F309: Based on record reviews, resident, and staff interviews the facility transport van and before moving and driving the resident to the facility for 1 of 1 sampled resident (Resident #4) with a van accident.  2. Cross refer to F323: Based on record reviews, resident, and staff interviews the facility failed to secure a resident and his wheelchair during van transportation from the facility to a medical appointment. The driver hit it a speed bump in the parking lot and the resident fell backward in hit specialized wheelchair resulting in the resident hitting his head. This is evident in 1 of 3 sampled residents (Resident #4).  The facility Administrator was informed of Immediate Jeopardy on 08/16/17 at 8:44 AM.	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
jeopardy) to allow the facility time to monitor and fully implement the new procedure for residents transportation to appointments and other activities and to complete education and ensure monitoring systems put into place are effective related to training of facility van drivers and how to respond in the event of an accident in the facility van and re-education of licensed nursing staff.  The findings included:  1. Cross refer to F309: Based on record reviews, resident, and staff interviews the facility failed to get professional staff to assess the resident to the facility for 1 of 1 sampled resident (Resident #4) with a van accident.  2. Cross refer to F323: Based on record reviews, resident, and staff interviews the facility failed to secure a resident and his wheelchair during van transportation from the facility to a medical appointment. The driver hit a speed bump in the parking lot and the resident in 1 of 3 sampled residents (Resident #4).  The facility Administrator was informed of Immediate Jeopardy on 08/16/17 at 8:44 AM.	F 490	Continued From pag	ne 21	F 49	00		
The facility Administrator was informed of for Resident #4 upon his return to the Immediate Jeopardy on 08/16/17 at 8:44 AM. facility, on the importance of obtaining	F 490	more than minimal hipopardy) to allow the fully implement the nutransportation to appactivities and to commonitoring systems is related to training of to respond in the evertacility van and re-ectivity van and be reviews, resident, ar failed to get profession resident for possible transport van and be resident to the facility (Resident #4) with a consideration of the resident, and staff in secure a resident and transportation from the appointment. The diparking lot and the respecialized wheelchalitting his head. This	arm that is not immediate e facility time to monitor and new procedure for residents pointments and other plete education and ensure put into place are effective facility van drivers and how ent of an accident in the ducation of licensed nursing  d:  09: Based on record nd staff interviews the facility onal staff to assess the injury after a fall in the facility efore moving and driving the y for 1 of 1 sampled resident van accident.  23: Based on record reviews, terviews the facility failed to d his wheelchair during van he facility to a medical river hit a speed bump in the esident fell backward in his air resulting in the resident s is evident in 1 of 3 sampled	F 49	properly train designated non licensed transport staff on proprocedure for response to resincident/accident that may octransport and licensed nurse post-incident/accident procedidentify non-traditional wheel equipment that may require a alternate transport mechanism considerations and 3) provide individualized care plan to meneeds of each resident.  On 8/16/17, the Regional Direction of the Maintenance Maintenance Assistant, and Courrent facility designated driinclusive of the Maintenance Maintenance Assistant, and Couply Coordinator who was transport for Resident #4 on 8 training included the process responding to resident incided during van transport by contained and the facility licensed nurse medically related emergencie moving or assessing the residicensed assistance arrives.	oper sident cur during dure 2) dehair additional or ms or ean eet the safety ector of ucation to ivers, Director, Central providing 8/10/17. The for ints/accidents acting 911 eros, and not dent until Regional	
The facility provided a credible allegation of compliance on 08/17/17 as follows:  On August 10th, 2017, at approximately 8:30 AM, Resident #4 was transported by facility staff to a		The facility provided compliance on 08/17 On August 10th, 201	on 08/16/17 at 8:44 AM.  a credible allegation of 7/17 as follows:  7, at approximately 8:30 AM,		for Resident #4 upon his return facility, on the importance of a detailed information post incide from the resident and/or witned event to ensure a comprehent assessment can be completed but not limited to, neurological	rn to the obtaining dent/accident esses to the sive of including, all checks for	

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OLIVILIV	O T OIT MEDIO, TILE &	WEDIO/ ND CEITTIOEC				<del></del>	<del>3. 0000 000 1</del>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	` ' /	SURVEY PLETED
			71. 501251	_			С
		345477	B. WING			l	/17/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	S AT SWEETEN CREEK			38	864 SWEETEN CREEK ROAD		
THE OAK	JAI OWLETEN GREEK			Α	RDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	e 22	, F	490			
	· -	nt. Resident #4 does utilize			appropriate plan of care implemented.		
	a specialized modifie				SPP SP SESSE Prom Cr San C map content		
		fida. Resident #4, who was			Resident #4 will continue to be		
	in a specialized/non-t	raditional wheelchair, was			transported via the contracted		
	secured in the van pe	er the facility procedure for			transportation service related to		
	Loading and Unloading				non-traditional, specialized wheelchair		
		air Lift on a Transport Van.			needs. Care plan updated as indicated		
		pading resident onto the lift,					
	locking brakes while on the lift, transporting				The facility will ensure that professiona	I	
	resident from lift into			licensed staff will assess residents for			
		ecuring the resident on the sident onto the lift, and			possible injury in the event of a fall or accident in the facility transport van pri	or	
	safely removing the re				to moving and driving the resident back		
		Ichairs will be evaluated by			the facility.	1 10	
		ector prior to transport to			and radimly.		
		an safely be secured within			On 8/15/17-8/16/17, the Maintenance		
	the company van or i				Director completed a review of current		
		rs may be necessary to			facility residents to identify any special	.у	
	maintain safety.				or adaptive wheelchairs or durable		
					medical equipment that may prevent th	em	
		M, during the transport of			from transporting residents safely in a		
		assigned the van driver, the			traditional wheelchair. Identified reside	nts	
		ump during locomotion into			will be transported with a contracted		
		eduled appointment. The			transportation service that will ensure		
		ck and noted the resident			resident safety during medically related	ı	
		d backward with the resident the wheelchair. The van			transports.		
	_	, tipped the wheelchair into			On 8/16/17, the MDS nurse updated th	Δ	
		nd immediately responded			identified residents safety care plan to		
		ually observing the back of			reflect the contracted transport needs	-	
		sing or cuts, and none were			related to the residents use of specializ	ed	
		did have initial complaint of			and/or modified, non-traditional		
		self-resolve prior to returning			wheelchairs.		
	to facility.	-					
	004047 1 44 66	ANA Desident#4			On 8/16/17, the Regional Director of		
		AM, Resident #4 returned to			Clinical Services provided education to		
	the facility and the va				current facility designated drivers,		
		gned to Resident #4 of the number during transport. The			inclusive of the Maintenance Director, Maintenance Assistant, and Central		
	Occurrence in the Val	rading transport. THE	1		mantonano Assistant, and Othila		1

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345477	B. WING			1	C <b>17/2017</b>
NAME OF PE	ROVIDER OR SUPPLIER	0.0	<u> </u>	9	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	17/2017
NAME OF T	COVIDER OR SOLT EIER						
THE OAKS	S AT SWEETEN CREEK				864 SWEETEN CREEK ROAD		
				Α	ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI: TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	e 23	F4	490			
	nurse assessed the r	esident with no injuries			Supply Coordinator. The training include	ded	
		of pain or discomfort. Vital			the process for responding to resident		
		by the registered nurse that			falls and incidents/accidents during val		
		od pressure 124/55, Pulse			transport by contacting 911 and the fac		
		e of 18 per minute, and pulse			licensed nurse and not moving or		
	oximetry of 99% and				assessing the resident until licensed		
		Situation Background			assistance arrives. Newly hired facility		
		iew, Fall Risk Evaluation,			designated drivers will be educated up		
	and Interdisciplinary	Progress Note.			hire and bi-annually thereafter by the Maintenance Director.		
	On 8/10/17 at 12:15 I	PM, the registered nurse					
		#4 administered one 650mg			On 8/16/17, the MDS registered nurse		
	tablet of Tylenol by m	outh per physicians as			began reeducation to licensed nurses	on	
	needed orders for he	adache with positive results			the post incident/accident procedure		
	documented on the N	Medication Administration			including, but not limited to, the initial		
	Record.				resident assessment, vital signs, pain		
					assessment, fall assessment (if fall		
	On 8/10/17 at 1:30 P	M, the registered nurse			related accident), neurological		
		#4 notified the facility nurse			assessment (if unwitnessed fall or hea	d	
	•	ew orders received for			injury), notification to		
		#4 is his own responsible			physician/responsible party and ongoing	-	
	· ·	continued to be monitored in			monitoring for changes in condition for	72	
		or changes in condition. No			hours and conducting a thorough		
		eived and resident did			investigation to include witness		
		as needed 650 mg Tylenol			statements as appropriate. Newly hired		
	-	rdered for generalized pain.			nurses will be educated upon hire by the		
	_	were not documented per			Director of Clinical Services or register	ed	
		for residents who hit their			nurse designee.		
		e not being notified that the			The testine of destine at all terms of the testine		
	resident had struck h	is head during the incident.			The trained designated transportation	_	
	On 9/15/17 at 11:00	NM the Maintenance			staff will be equipped at all times with a		
	On 8/15/17 at 11:00 A	ducation and observed			cellular phone to contact licensed facili staff and emergency medical responde	-	
	-	n of the facility procedure for			in the event of resident incident/accide		
	Loading and Unloading	- ·			during transport. The non-medically	111	
		Transport Van to facility			licensed transportation staff will not mo	N/A	
		nclusive of the Maintenance			or assess resident and will await	,v <del>C</del>	
	_	I Supply Coordinator. The			professional staff assistance to arrive t	·O	
		r administered a Safe Driving			complete a resident assessment and	J	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345477	B. WING			C	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	8/17/2017	
NAME OF PROVIDER OR SUPPLIER							
THE OAKS AT SWEETEN CREEK				3864 SWEETEN CREEK ROAD			
				ARDEN, NC 28704			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 490	Continued From page	e 24	F 49	00			
		results, and reviewed facility S-390 the Fleet Safety		provide care as appropriate.			
		le Safety. Facility policy		On 8/15/17, the Maintenance [	Director		
	S-390 describes the			provided education to facility de			
		vees to operate company		drivers, inclusive of the Mainte	-		
		revent accidents, including		Assistant and Central Supply C			
		ning standards, accident		on the facility procedure for Lo			
	reporting, vehicle insp	pections and maintenance		Unloading a Resident with a W	/heelchair		
	and general safety re	gulations.		Lift on a Transport Van. Proced			
				includes loading resident onto			
		PM, the Interdisciplinary		locking brakes while on the lift,			
	Team consisting of th			transporting resident from lift in			
	Regional Director of Clinical Services, Regional			proper placement of resident w			
	Vice Presidents of Op	erations, and the elected to conduct all		securing the resident on the va			
	medically and non-me			unloading the resident onto the safely removing the resident from			
		contracted providers until		Return demonstration was suc			
	T	riate vehicle inspections,		completed by each designated	•		
	education, equipment			Newly hired designated transp			
	appropriation of cellul			be educated upon hire and bi-a			
		ess to licensed facility staff		thereafter with successful retur	-		
	and/or emergency res			demonstration.			
		M the Maintenance Director		On 8/15/17, the Maintenance I			
		ent facility residents to		provided education to facility d	-		
		or adaptive wheelchairs or		drivers, inclusive of the Mainte			
		oment that may prevent		Assistant and Central Supply C			
	•	g safely in a traditional		on the facility policy and proceed the Float Safety Program Mate			
		ance Director completed the  M. Identified residents will		the Fleet Safety Program Moto Safety, which describes the ex			
		contracted transportation		for transportation employees to	-		
	-	e resident safety during		company vehicles safely and p	•		
		ed transports. On 8/16/17		accidents, including but not lim			
		ed the identified residents '		training standards, accident re			
		flect the contracted transport		vehicle inspections and mainte			
	needs due to speciali	•		general safety regulations. A S			
	-	chair transport needs. A		Quiz was completed by each d			
	master Non-Facility T	ransportation log will be		driver with successful results.	-		
	maintained in the van	and at the nurses' station		transportation staff will be educ	cated upon		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	755.125.110		С				
		345477	B. WING				/17/2017
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	71772017
					864 SWEETEN CREEK ROAD		
THE OAK	S AT SWEETEN CREEK				RDEN, NC 28704		
				•	 		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	e 25	F	490			
		riate plan of care for safe			hire and bi-annually thereafter and		
	transport. The maste				complete a Safe Driving Quiz with		
	Transportation log wil				successful results.		
		r as needed for changes.					
	Drivers will review the				Non traditional wheelchairs will be		
		d at the nurses station and			evaluated by the Maintenance Director		
	within the van prior to				prior to transport to validate if the chair		
	•	·			can safely be secured within the compa		
	On 8/16/17 at 10:15 A			van or if alternate contracted			
	Performance Improve			transportation vendors may be necessa	ary		
	was held with the Executive Director, Regional				to maintain safety.		
	Director of Clinical Se						
	President of Operation			On 8/17/17, the Executive Director			
	· ·	Vice President of Safety,			completed education to the transportat		
		afety, Vice President of			staff (Maintenance Director, Maintenan		
		nd Chief Nursing Officer to			Assistant, Central Supply Coordinator)		
		use analysis and develop			and to the Scheduler on the use of the		
		plan to ensure appropriate			Non-Facility Transportation log, inclusion		
		ed to prevent accidents			of the storage location and parameters		
		t and residents' needs are			updating as necessary upon any chang	-	
	being met.				or newly identified non-facility transport		
	Through Boot Cours	Analysis, it was determined			equipment. Newly hired transportation staff and schedulers will be educated		
	that the facility failed	•			upon hire.		
		ically licensed transport staff					
		for response to resident			A master Non-Facility Transportation Id	oa	
		may occur during transport			will be maintained in the van and at the	-	
	and licensed nurse po			nurses□ station indicating the appropri	ate		
		non- traditional wheelchair			plan of care for safe transport. The		
	equipment that may r	equire additional or alternate			master Non-Facility Transportation log	will	
		s or considerations and 3)			be updated by the Maintenance Director		
	I -	zed care plan to meet the			as needed for changes. Drivers will		
	safety needs of each	resident.			review the master Non-Facility		
					Transportation log posted at the nurses	3 🗆	
		AM, the Nurse Practitioner			station and within the van prior to		
		4 who "denies any injury.			transport.		
		nges, headache, bump, loss					
		usea or pain from the fall.			A Transport Van Securement Checklist		
	Denies abrasions, bru			and Daily Van Safety Checklist will be			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245477	B. WING				С
		345477	D. WING _			08	3/17/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAKS AT SWEETEN CREEK				3	864 SWEETEN CREEK ROAD		
0,	5711 GTT	•		Δ	ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From pag	ge 26	F4	490			
		asant and denies fever,			completed by the designated transport	+	
		dyspnea, chest pain, or Gl			driver daily prior to van transports. Any		
	complaints."	dysprica, criest pairi, or or			safety concern identified will be reported		
	complaints.				to the Executive Director immediately		
	On 8/16/17 at 12:30	PM the Regional Director of			alternate contracted transportation utili		
	On 8/16/17 at 12:30 PM, the Regional Director of Clinical Services provided education to all facility				to ensure residents□ safety and to	200	
		esignated drivers, inclusive of the Maintenance			prevent accidents.		
	Director, Maintenan						
	Supply Coordinator			The Executive Director and/or			
	for Resident #4, who transport residents in the				Maintenance Director will complete qu	ality	
	transport van. The training included the process				assurance monitoring of the facility		
	for responding to resident incidents/accidents				transport van for presence of an opera	ble	
	during van transport. The education included				cellular device to ensure that in the even		
	_	nedically related emergencies,			of a van accident, a licensed profession		
	contacting facility lic				will be contacted to complete a resider		
	_	ents/accidents, and not			assessment for possible injury prior to		
	- ·	g the resident until licensed			being moved, the Transport Van	_4.	
		The trained transportation d with a cellular phone			Securement Checklists, Daily Van Saf Checklists, and designated driver requ		
	1	censed facility staff or			training for completion to ensure reside		
		responders in the event of			safety during van transport.	JIIL	
		cident during transport.			salety during van transport.		
	Facility designated			Monitoring will be completed at a			
	reeducation on the			frequency of 5 days per week for a per	riod		
		during van transport			of 12 weeks then, 3 times per week for		
	bi-annually complete	ed by the Maintenance			months, then weekly thereafter as		
	Director. Newly hire	ed transportation staff will			determined by the Quality Assurance		
	receive education u	pon hire and bi-annually			Performance Improvement (QAPI)		
		process for responding to			Committee.		
	resident incident/accidents during van transport						
	by the Maintenance	Director.			The results of the quality assurance		
					monitoring will be reported to the QAP	I	
	On 8/16/17 at 1:00 PM the MDS nurse updated				Committee monthly by the Executive		
		esident #4 to indicate that he			Director for twelve months and/or until		
	•	ria contracted transportation			substantial compliance is obtained. The	ıe	
		sure resident safety during			QAPI Committee will evaluate the		
	_	ted transports due to the			effectiveness of the		
		f specialized modified nt #4 will continue to be			monitoring/observation tools for maintaining substantial compliance, ar	nd	
	wileciciali. Reside	III #7 WIII COIIIIIIUC IO DC			I maintaining substantial compliance, at	IU	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45.477	D WING				С
		345477	B. WING _			08/	/17/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAK	THE OAKS AT SWEETEN CREEK			3	864 SWEETEN CREEK ROAD		
IIIL OAK	JAI SWLLTEN CILLE	•		Δ	ARDEN, NC 28704		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRION DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From pag	ge 27	F 4	490			
		by a MDS nurse and			make changes to the corrective action	as	
		erdisciplinary team and as			necessary. The Quality Assurance	uo	
		nges to the care plan.			Improvement Committee members		
		.goo to tile out o pia			consist of, but not limited to, the Execu	ıtive	
	Newly hired transpo	ortation staff will receive			Director, Director of Clinical Services,		
	education upon hire			Medical Director, Pharmacy Consultar	ıt.		
	procedure for safely			Social Services Director, Activities			
	Resident, facility pro			Director, Maintenance Director, Dietar	y		
	resident incident/acc			Director, Minimum Data Assessment			
	the Fleet Safety Program Motor Vehicle Safety				Nurse, and facility Certified Nurse Aide	es es	
	completed by the Maintenance Director.				and LPN/RN designees.		
	On 8/16/17 at 3:40 I			The Executive Director will be respons	ible		
	reeducated licensed nurses on post				for the implementation of this Plan of		
	incident/accident procedure, including but not				Correction.		
	limited to, initial resi						
	Te	Ill assessment (if fall related					
	accident), neurologi	·					
		nead injury), notification to					
	physician/responsib						
	monitoring for chang						
		I not be permitted to work until					
	education is comple						
	be educated upon h	iie.					
	On 8/16/17 at 4:30 I	PM the District Director of					
		ducation to the Maintenance					
		ation and completion of the					
	Daily Vehicle Inspec	tion Report and Transport					
	Van Securement Checklist prior to initiating						
	transport of residents in the facility van.						
	Transportation staff will not be permitted to						
		until completion of this					
		red transportation staff will be					
	eaucated upon hire	and biannually thereafter.					
		PM the District Director of					
		visual van equipment					
	Inspection to identify	any potential safety hazards.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345477	B. WING		08/17/2017
NAME OF PROVIDER OR SUPPLIER  THE OAKS AT SWEETEN CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE  3864 SWEETEN CREEK ROAD  ARDEN, NC 28704	1 00/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 490	Continued From pag	e 28	F 49	90	
	No additional hazard Director of Maintena bi-annual van inspector provider inclusive of system.  The facility will provide properly respond to a by ensuring approprilicensed and licensed during medically reladesignated transport Vehicle Inspection R Securement Checklis of residents in the facility along with additional materials will be mai Maintenance Director Reference Manual a staff on van. In the eincident/accident, the employee will contact responders for life-th will contact the facility assistance. The licentassess resident and incident/accident profit of Clinical Sinformation post incidents acomprehensive assistance as appropriate plan of coperforming neurological sinformation post incidents and propriate plan of coperforming neurological sinformation post incidents and propriate plan of coperforming neurological sinformation post incidents and propriate plan of coperforming neurological sinformation post incidents and propriate plan of coperforming neurological sinformation post incidents and propriate plan of coperforming neurological sinformation post incidents and propriate plan of coperforming neurological sinformation post incidents and propriate plan of coperforming neurological sinformation post incidents and propriate plan of coperforming neurological sinformation pro	Is were identified. The Ince will ensure completion of Itions by a preferred service Ithe wheelchair securement  Ide supervision to prevent and Idesident incidents /accidents Idea training to non-medically Idea nurses to maintain safety Ited transport. The Idea will reference the Daily Idea peort and Transport Van Idea training to non-medically Idea transport in the propert of the property Idea to mendically licensed of the property Idea to mendically property Idea to mendical pro			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345477	B. WING			C 8/17/2017	
NAME OF PROVIDER OR SUPPLIER  THE OAKS AT SWEETEN CREEK				STREET ADDRESS, CITY, STATE, ZIP COD 3864 SWEETEN CREEK ROAD ARDEN, NC 28704		10/11/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 490	implementing this created and updated caspecialty wheelchairs facility van driver's st. 8/10/17, Transport Va Non-Facility Transport Log, Daily Vehicle Insteads of procedure with grown and updated caspecialty van driver's st. 8/10/17, Transport Va Non-Facility Transport Log, Daily Vehicle Insteads and updated Instead	or will be responsible for adible allegation of dility administration will not ere to established policies, and other specified ons for proper utilization of and resources in aufacturer guidelines to ed per resident's care. Failure to adhere to ria can and will result in to and including termination ernmental licensing boards  on was verified on 08/17/17 following: observations of er securing a wheelchair in eation of re-education for ost incident/accident to all facility designated enting facility licensed nurse for ints/accidents, and not the resident until licensed enting the nurse assigned entity of the accident was in regarding gathering post remation from the resident	F 49				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345477	B. WING		C 08/17/2017	
NAME OF PROVIDER OR SUPPLIER  THE OAKS AT SWEETEN CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE  3864 SWEETEN CREEK ROAD  ARDEN, NC 28704	00/17/2017	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
Assessment Flow Shee Fall Investigation and D SBAR (Situation, Backg	n Condition, Neurological t, Fall Risk Evaluation, ocumentation Checklist, iround, Assessment, Response Action Plan and	F 490			