STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/27/24 through 05/01/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# GV1M11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/27/25 through 05/01/25. Event ID# GV1M11. The following intakes were investigated: NC00228766, NC00228311, NC00228113, NC00228111, NC00228109, NC00227915, NC00227658, NC00226577, NC00225867, NC00223078, NC00221678, NC00221348, NC00220508, NC00220455, NC00220464, NC00220284, NC00218801, NC00218155, NC00217008, and NC00215460. 13 of the 47 complaint allegations resulted in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 553		6/11/25

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

Electronically Signed | 05/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 1 plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to reschedule and hold a care plan meeting that was previously cancelled and invite the resident to participate in the care planning process for 1 of 1 sampled resident (Resident #43). Findings included: Resident #43 was admitted to the facility on 09/27/23. Review of a Care Conference Record dated 12/02/24 revealed a quarterly care plan meeting was held with Resident #43 in attendance. The quarterly Minimum Data Set (MDS) assessment dated 12/13/24 revealed Resident	F 553	1. The Care Plan Meeting for Resident #43 was completed on 5/2/2025. 2. The Care Plan meetings held in the last 90 days were reviewed for timeliness by the Social Worker on 5/14/2025 with no additional discrepancies noted. 3. On 5/28/25 the Executive Director provided education to the Care Plan Team, that consists of: The Director of Nursing and/or the Assistant Director of Nursing or Unit Manager, the Social Worker, the Minimum Data Set Nurse, the Food Services Director, and the Rehabilitation Program Manager on stressing the importance of ensuring the Residents Care Plan meetings are held	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 2 #43 had intact cognition. Review of a Social Worker (SW) progress note dated 03/11/25 revealed Resident #43 was currently in the hospital and his care plan meeting would be rescheduled upon his return to the facility. Review of a physician progress note dated 03/17/25 revealed Resident #43 was seen for a post-hospitalization visit following his hospital stay on 03/08/25 through 03/14/25. Review of Resident #43's electronic medical record revealed no documentation that a care plan meeting was held or Resident #43 was invited to attend a care plan meeting following his return from the hospital on 03/14/25. During an interview on 04/28/25 at 9:50 AM, Resident #43 stated he had attended care plan meetings in the past but could not recall attending one this year (2025). Resident #43 stated he was usually notified of upcoming care plan meetings and expressed that he wanted to participate in the care plan meetings so he could communicate and provide input about his care. During an interview on 04/30/25 at 12:15 PM, the SW revealed she was the one responsible for keeping track of the schedule for care plan meetings and invited alert and oriented residents to attend when a care plan meeting was due. The SW confirmed the care plan meeting scheduled for Resident #43 in March 2025 was cancelled due to him being in the hospital. The SW explained she had planned on rescheduling the care plan meeting once Resident #43 returned from the hospital but she "dropped the	F 553	within the Resident Assessment Instrument guidelines. Emphasis was placed on timely rescheduling for Residents who are not residing in the facility during the scheduled time frame. The education packet will be included in new hire orientation for any of the newly hired positions of the Care Plan Team including: The Director of Nursing and/or the Assistant Director of Nursing or Unit Manager, the Social Worker, the MDS nurse, the Food Services Director, and the Rehabilitation Program Manager. This education will be provided by the Executive Director, the Director of Nursing, or the Assistant Director of Nursing. The Care Plan schedule corrective action will be monitored by the Executive Director weekly for 12 weeks. The monitors will be presented to the Quality Assurance Performance Improvement Committee each month. 4. The Executive Director presented the monitoring plan to the Quality Assurance Performance Improvement Committee on5/2/2025. The Quality Assurance Committee will review the monitoring plan monthly for 3 months and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 3 ball" and the meeting was never rescheduled. During an interview on 05/01/25 at 5:37 PM, the Administrator explained the SW was very good at keeping track of the care plan meeting schedule and Resident #43's care plan not getting rescheduled following his hospital stay was an oversight. The Administrator stated she would have expected for the SW to make a follow-up note to reschedule Resident #43's care plan meeting when he returned from the hospital and a care plan meeting held with Resident #43.	F 553	5. 6/11/2025	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to assess residents for the ability to self-administer medications for 1 of 1 resident reviewed for self-administering medications (Resident #59). The findings included: Resident #59 was admitted on 7/4/23 with diagnosis that included type 2 diabetes and gastroesophageal reflux disease. Resident #59 had a physician's order for calcium carbonate antacid 2 tablets every 6 hours as needed for gastroesophageal reflex disease ordered 10/9/24.	F 554	1. Resident #59 had a self-administration medication assessment completed on 5/27/25 as this resident expressed the desire to have some over the counter medications available to her, locked up at her bedside. 2. All cognitively intact residents were interviewed by the Social Worker and/or the Executive Director on 5/27/25 to determine if they had the desire to self-administer medications and to ensure they were aware that they could not keep over the counter medications in their rooms. Those residents who expressed that they wanted to self-administer some, or all their medications were assessed for	6/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 4	F 554		

Resident #59's quarterly minimum data set (MDS) assessment dated 2/18/25 coded her as cognitively intact.

A review of Resident #59's care plan dated 3/7/25 revealed no care plan for self-administration of medication.

A review of Resident #59's medical record found no assessment for self-administration of medication.

An observation in Resident #59's room on 4/28/25 at 10:58 AM found a partially used bottle of liquid bismuth, a bottle of chewable antacids, and an unopened box of [topical treatment for the mouth and gums that may be used to relieve pain] on her bedside table. The resident stated she had the medications for a long time and would take them when her stomach was hurting. Resident #59 said she had the medications ordered and delivered to her.

On 4/28/25 at 2:19 PM an observation with Nurse #2 in Resident #59's room found the medications remained at bedside. Resident #59 stated to Nurse #2 she had always had the medications and that she bought them from a store. Nurse #2 told the resident she was not allowed to keep the medications in her room or take them without a nurse giving them to her to take.

On 4/28/25 at 2:19 PM Resident #59's assigned Nurse #2 was interviewed. Nurse #2 stated she had administered Resident #59's medication that morning and had not noticed any medications in Resident #59's room. Nurse #2 said Resident #59 was not assessed to take her own medications and should not have any the ability to self-administer medications.

3. On 5/10/25, the Executive Director educated the Director of Nursing on the importance of assessing cognitively intact residents for the ability to self-administer medications. The policy and procedure for this was also reviewed with the Director of Nursing. The Director of Nursing educated the licensed nurses, including nurse managers regarding assessing cognitively intact resident for the ability to self-administer medications to include reviewing the facilitys policy and procedure from 5/19/25 through 5/28/25. Any Licensed Nurses who were unavailable during the education period will have the education prior to their next shift. This facility does not use agency staff.This education will be provided to any newly hired nurses, to include nurse managers during their orientation process by the Director of Nursing, the Assistant Director of Nursing and/or a Nurse Manager. A quality monitor was implemented on 5/29/25 to ensure that all newly admitted residents that are deemed cognitively intact are interviewed to determine their preference for self-medication administration. If the resident expressed a desire to self-medicate some or all of their medication, then a licensed nurse will proceed with a self-medication administration This monitor will be completed by the Director of Nursing, the Assistant Director of Nursing and/or a Nurse Manager after every new admission for 12 weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 5 medications stored in her room. Nurse #2 was observed removing the bottle of bismuth, antacid chewable, and the unopened box of [topical treatment for the mouth and gums] from the bedside table. The Nurse stated she was unaware the Resident had those medications at bedside and did not see them in the room when she administered Resident #59's morning medications. The Director of Nursing (DON) was interviewed on 5/1/25 at 4:37 PM. She stated that Resident #59 would often order items that included medications to be delivered to her at the facility. The DON said Resident #59 would not let the facility search her items or her room for any medications she may have ordered. Additionally, the DON stated Resident #59 needed to have a self-administration of medication assessment completed by a nurse and needed a physician's order for her to self-administer medication. The DON said medications should not be stored in the resident's room and needed to be stored on the nurse's medication cart.	F 554	4. On 5/2/25, an ADHOC Quality Assurance Performance Improvement Committee meeting was held and the Executive Director presented the proposed plan of correction for this deficient practice. The Director of Nursing will present the results of the quality monitoring to the Quality Assurance Performance Improvement Committee monthly for 3 months. 5. Compliance date: 6/11/25	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		6/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label and store personal items in 2 of 6 shared bathrooms (room #403 and room #402) and maintain packaged terminal air conditioners (PTACs) in good repair in 6 of 15 resident rooms (room #402, room #404, room #405, room #406, room #408, and room #409). These failures occurred on 1 of 4 halls (400 hall) reviewed for home-like environment.	F 584	1. The broken air conditioner slats in the following rooms: 402, 404,405, 406, 408 and 409, were corrected by 6/10/25. Unlabeled personal items were removed and discarded from the bathroom between rooms 402 and 403 on 5/2/25. 2. All resident room air conditioner units were inspected on 5/2/25 by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7 Findings included: 1. (a). An observation of the shared bathroom of room #403 on 04/27/25 at 10:52 AM revealed a plastic basket containing an unlabeled toothbrush sitting on the side of the sink. Additional observations of the shared bathroom of room #403 on 04/28/25 at 3:20 PM, on 04/29/25 at 11:05 AM, on 04/30/24 at 2:14 PM, and on 05/01/25 at 11:24 AM revealed a plastic basket containing an unlabeled toothbrush sitting on the side of the sink. (b). An observation of the shared bathroom of room #402 on 04/27/25 at 2:56 PM revealed an unlabeled and uncovered bedpan placed between a towel rack and the wall and an unlabeled closed denture cup sitting on a rail behind the toilet. Additional observations of the shared bathroom of room #402 on 04/30/25 at 3:27 PM and 05/01/25 at 11:20 AM revealed an unlabeled and uncovered bedpan placed between a towel rack and the wall and an unlabeled closed denture cup sitting on a rail behind the toilet. An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed all resident care items in shared bathrooms should be labeled and covered appropriately by nursing staff. She stated ensuring personal items were labeled and covered should be monitored as nursing staff came and went from shared bathrooms. 2. (a). An observation of the PTAC unit in room #402 on 04/27/25 at 10:26 AM revealed multiple broken slats to the top of the unit.	F 584	Maintenance Director to identify other air conditioning units that may need to be addressed by 6/10/25. Resident rooms were inspected for unlabeled personal items on 5/2/25 by the Assistant Director of Nursing. Any unlabeled personal items were discarded on 5/2/25 by the Assistant Director of Nursing. 3. The Executive Director provided education to the Maintenance Director and the Assistant Maintenance Director on 5/2/25 regarding the inspection of air conditioning units to ensure front slats are in place. The Director of Nursing, the Assistant Director of Nursing and/or a nurse manager provided education to the nursing staff(licenses nurses and certified nurses aides) between 5/21/25 and 5/28/25 regarding the importance of labeling Resident personal items and ensuring items are stored in bags in the resident rooms and not in the bathroom. The nursing staff who were unavailable during the education period will have the same education prior to their next shift. This facility does not utilize agency staff. The education packet for Maintenance and Nursing will be placed into the staff in-service education book and will be included in new hire orientation. The air conditioning unit corrective action will be monitored by the Executive Director weekly for 12 weeks. Personal item labeling and storage will be monitored by Nursing Leadership 5 times a week for 4 weeks then weekly for 12 weeks. The monitors will be presented to the Quality Assurance Committee each month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 Additional observations of the PTAC unit in room #402 on 04/28/25 at 8:53 AM and 05/01/25 at 11:21 AM revealed multiple broken slats to the top of the unit. (b). An observation of the PTAC unit in room #404 on 04/27/25 at 10:43 AM revealed multiple broken slats to the top of the unit and the control cover of the unit was hanging off the front. Additional observations of the PTAC unit in room #404 on 04/28/25 at 9:06 AM, on 04/30/25 at 2:17 PM, and 05/01/25 at 11:04 AM revealed multiple broken slats to the top of the unit and the control cover of the unit was hanging off the front. (c). An observation of the PTAC unit in room #405 on 04/27/25 at 11:02 AM revealed multiple broken slats to the top and front of the unit. Additional observations of the PTAC unit in room #405 on 04/30/25 at 3:20 PM and 05/01/25 at 11:20 AM revealed multiple broken slats to the top and front of the unit. (d). An observation of the PTAC unit in room #406 on 04/27/25 at 11:05 AM revealed multiple broken slats to the top of the unit. Additional observations of the PTAC unit in room #406 on 04/28/25 at 9:06 AM, 04/20/25 at 2:18 PM, and 05/01/25 at 11:05 AM revealed multiple broken slats to the top of the unit. (e). An observation of the PTAC unit in room #408 on 04/27/25 at 11:19 AM revealed multiple broken slats to the top of the unit.	F 584	4. The Executive Director presented the proposed corrective action plan to the Quality Assurance Performance Improvement Committee on 5/2/25. The Executive Director will present the results of the air conditioning units and the Director of Nursing or Assistant Director of Nursing will present the results of the personal item monitoring to the Quality Assurance Committee will review the monitoring plan monthly for 3 months and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Compliance Date: 6/13/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9 (f). An observation of the PTAC unit in room #409 on 04/27/25 at 11:20 AM revealed multiple broken slats to the top of the unit. Additional observations of the PTAC unit in room #409 on 04/28/25 at 9:07 AM and on 05/01/25 at 11:18 AM revealed multiple broken slats to the top of the unit. An interview with the Maintenance Director on 05/01/25 at 2:35 PM revealed she had been in her position approximately 2 months and was trying to order 2 PTAC units a month but had not gotten around to replacing the PTAC units on 400 hall. She stated she expected the PTAC units to be in good repair. An interview with the Administrator on 05/01/25 at 5:39 PM revealed she was not aware of any concerns with the slats on the PTAC units. She stated management should have noticed the slats during their daily room rounds and notified her so she could see if replacement parts could be ordered or if the entire units would need to be replaced. The Administrator stated she expected the PTAC units to be in good repair.	F 584		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced	F 602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 10	F 602	Past noncompliance: no plan of correction required.	

by:
Based on record review and interviews with the Law Enforcement Detective and staff, the facility failed to protect the residents' rights to be free from misappropriation of controlled medication for 4 of 4 residents reviewed for misappropriation of resident property (Residents #173, #174, #175, and #176).

The findings included:

The facility's Abuse, Neglect, Exploitation and Misappropriation policy, last revised on 11/16/22, revealed in part the facility would ensure all residents were free from misappropriation of property.

a. Resident #173 was admitted to the facility on 11/22/23 with diagnoses that included bipolar disorder and anxiety disorder.

The physician's order dated 01/16/25 revealed Resident #173 had an order to receive one tablet of clonazepam 0.5 milligrams (mg) by mouth every morning (6:00 AM) and at bedtime (9:00 PM) for anxiety/panic attacks.

The pharmacy proof of delivery shipment summary sheet revealed 60 tablets of clonazepam 0.5 mg were shipped on 02/18/25 for Resident #173 and was received by the facility on 02/19/25 at 3:13 AM.

The February 2025 Medication Administration Record (MAR) revealed starting on 02/19/25 Resident #173 received a total of 5 tablets of clonazepam 0.5 mg. The clonazepam was documented as administered per physician order on 02/19/25 at 6:00 AM and 9:00 PM, 2/20/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 11	F 602		

6:00 AM and 9:00 PM, and 02/21/25 at 6:00 AM. No further doses were documented as administered for the remainder of the month and there should have been 55 tablets left remaining.

The shift change controlled substance inventory count sheet revealed the former Director of Nursing (DON) initialed that she removed one card of clonazepam 0.5 mg tablets for Resident #173 from the medication cart on 02/21/25 and noted the medication was being returned to the pharmacy.

The initial allegation report dated 03/01/25 revealed the facility became aware of an incident on 02/28/25 at 7:54 PM when the Administrator was notified by Medication Aide (MA) #3 that Resident #173's clonazepam (medication used to treat panic disorders and seizures) and declining count sheets were missing, and Law Enforcement was notified.

A telephone attempt on 05/01/25 at 2:43 PM for interview with MA #3 was unsuccessful.

The investigative report dated 03/08/25 revealed the facility completed a review of pharmacy and facility documentation which revealed on 02/21/25 the former DON removed Resident #173's clonazepam from the medication cart and noted on the controlled substance shift change report that the medications were sent back to the pharmacy and the declining count sheet could not be located. The pharmacy sent 60 tablets of clonazepam on 02/18/25 and review of Resident #173's medication administration record (MAR) revealed 55 of the 60 tablets were unaccounted for. It was noted that Resident #173 did not suffer any harm or mental anguish, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 12	F 602		

medication was replaced at the facility's expense. The former DON's last day worked was on 02/25/25 and she did not return back to the facility after that date.

Resident #173 passed away at the facility on 04/01/25.

b. Resident #174 was admitted to the facility on 01/07/25 with diagnoses that included chronic pain.

The physician's order dated 01/30/25 revealed Resident #174 had an order to receive one tablet of oxycodone 5 mg by mouth every 6 hours as needed for pain.

The pharmacy proof of delivery shipment summary sheet revealed 30 tablets of oxycodone 5 mg were shipped on 01/30/25 for Resident #174 and was received by the facility on 01/31/25 at 2:08 AM.

The January 2025 MAR for Resident #174 revealed he received a total of 2 tablets of oxycodone 5 mg. The oxycodone was documented as administered per physician order on 01/31/25 at 3:47 PM and 10:09 PM. After the last dose was administered on 01/31/25, there should have been 28 tablets remaining.

The February 2025 MAR for Resident #174 revealed he received a total of 5 tablets of oxycodone 5 mg. The oxycodone was documented as administered per physician order on 02/01/25 at 9:14 PM, 02/02/25 at 11:00 AM, 02/03/25 at 9:46 PM, 02/06/25 at 2:35 PM, and 02/07/25 at 9:56 AM. After the last dose was administered on 02/07/25, there should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 13	F 602		

been 23 tablets of Oxycodone left remaining.

Resident #17 discharged to the hospital on 02/08/25 and had not returned to the facility at the time of this investigation.

The shift change controlled substance inventory count sheet revealed the former DON initialed that she removed one card of oxycodone 5 mg tablets for Resident #174 from the medication cart on 02/21/25.

The initial allegation report dated 03/04/25 revealed the facility became aware on 03/04/25 at 4:40 PM during a narcotic audit that 20 tablets of Resident #174's oxycodone (opioid pain medication) was unaccounted for, and Law Enforcement was notified.

The investigative report dated 03/08/25 revealed during a narcotic audit, it was discovered that the former DON removed Resident #174's oxycodone from the medication cart and the medication was missing along with the declining count sheet.

c. Resident #175 was admitted to the facility on 01/07/25 with diagnoses that included chronic pain.

The physician's order dated 02/10/25 revealed Resident #175 had an order to receive one tablet of oxycodone 5 mg by mouth every 6 hours as needed for pain.

The pharmacy proof of delivery shipment summary sheet revealed 28 tablets of oxycodone 5 mg were shipped on 02/10/25 for Resident #175 and was received by the facility on 02/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 14	F 602		

at 6:15 PM.

The February 2025 MAR for Resident #175 revealed she received at total of 10 tablets of oxycodone 5 mg. The oxycodone was documented as administered per physician order on 02/10/25 at 10:12 PM, 02/11/25 at 10:38 AM, 02/12/25 at 9:22 AM and 3:35 PM, 02/13/25 at 9:40 AM, 02/14/25 at 8:47 AM, 02/15/25 at 2:54 PM and 10:20 PM, and 02/16/25 at 10:04 AM and 10:16 PM. After the last dose was administered on 02/16/25, there should have been 18 tablets remaining.

The shift change controlled substance inventory count sheet revealed the former DON initialed that she removed one card of oxycodone 5 mg tablets for Resident #175 on 02/21/25 and noted the medication was being returned to the pharmacy.

Resident #175 discharged to the hospital on 02/26/25 and had not returned to the facility at the time of this investigation.

The initial allegation report dated 03/04/25 revealed the facility became aware on 03/04/25 at 4:40 PM during a narcotic audit that 18 pills of Resident #175's oxycodone was unaccounted for and Law Enforcement was notified.

The investigative report dated 03/08/25 revealed during a narcotic audit, it was discovered that on 02/21/25 the former DON removed Resident #175's oxycodone from the medication cart and the medication was missing along with the declining count sheet.

d. Resident #176 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 15	F 602		

01/13/25 with diagnoses that included fracture of the lower end of the left radius (one of the two long bones in the forearm located on the thumb side).

The physician's order dated 01/13/25 revealed Resident #176 had an order to receive one tablet of oxycodone 5 mg by mouth every 6 hours as needed for pain.

The physician's order dated 01/15/25 revealed Resident #176 had an order to receive one tablet of oxycodone-acetaminophen 5-325 mg by mouth every 6 hours as needed for pain for one day and to discontinue when the oxycodone 5 mg arrived.

The pharmacy proof of delivery shipment summary sheets for Resident #176 revealed the following:
- 30 tablets of oxycodone 5 mg were shipped on 01/14/25 and was received by the facility on 01/15/25 at 3:57 AM.
- 30 tablets of oxycodone 5 mg were shipped on 01/24/25 and was received by the facility on 01/25/25 at 3:08 AM.
- 30 tablets of oxycodone 5 mg were shipped on 02/04/25 and was received by the facility on 02/04/25 at 6:11 PM.
- 30 tablets of oxycodone 5 mg were shipped on 02/14/25 and was received by the facility on 02/15/25 at 2:34 AM.

The January 2025 MAR for Resident #176 revealed she received one tablet of oxycodone-acetaminophen 5-325 mg on 01/15/15 at 1:24 PM.

The January 2025 MAR for Resident #176 further revealed she received a total of 48 tablets of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 16	F 602		

oxycodone 5 mg. The oxycodone was documented as administered per physician order on:
-01/13/25 at 4:00 PM
-01/14/25 at 12:16 AM
-01/15/25 at 2:36 AM and 9:54 PM
-01/16/25 at 5:31 AM, 11:55 AM and 5:57 PM
-01/17/25 at 12:21 AM, 10:28 AM and 5:52 PM
-01/18/25 at 12:33 AM, 6:34 AM, 1:04 PM, and 9:35 PM
-01/19/25 at 5:42 AM and 10:07 PM
-01/20/25 at 9:09 AM, 4:57 PM and 11:44 PM
-01/21/25 at 5:48 AM, 12:56 PM and 7:12 PM
-01/22/25 at 2:45 AM, 9:09 AM and 3:30 PM
-01/23/25 at 2:05 AM, 9:00 AM, 3:23 PM, and 11:58 PM
-01/24/25 at 11:11 AM and 5:26 PM
-01/25/25 at 8:13 PM
-01/26/25 at 7:02 PM
-01/27/25 at 2:35 AM, 10:15 AM and 5:12 PM
-01/28/25 at 5:10 AM, 12:39 PM and 7:19 PM
-01/29/25 at 6:21 AM and 4:54 PM
-01/30/25 at 12:16 AM, 6:20 AM, 1:34 PM, and 8:27 PM
-01/31/25 at 3:03 AM, 9:57 AM and 7:06 PM.

The February 2025 MAR for Resident #176 revealed she received a total of 51 tablets of oxycodone 5 mg. The oxycodone was documented as administered per physician order on:
-02/01/25 at 4:06 AM, 10:27 AM, 5:12 PM, and 11:45 PM
-02/02/25 at 5:47 AM, 1:10 PM and 8:26 PM
-02/03/25 at 6:00 AM, 12:56 PM and 7:37 PM
-02/04/25 at 5:01 AM and 11:01 AM
-02/05/25 at 9:11 AM, 3:28 PM and 9:30 PM
-02/06/25 at 5:41 AM, 12:50 PM and 8:49 PM
-02/07/25 at 5:56 AM, 12:55 PM and 7:50 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 17	F 602		

-02/08/25 at 4:28 AM, 10:59 AM, 5:38 PM, and 11:47 PM
-02/09/25 at 12:28 PM and 8:15 PM
-02/10/25 at 5:02 AM, 11:16 AM, 5:35 PM, and 11:45 PM
-02/11/25 at 6:45 PM
-02/12/25 at 1:20 AM, 11:45 AM and 5:58 PM
-02/13/25 at 5:02 AM and 8:51 PM
-02/14/25 at 4:27 AM, 11:19 AM and 6:35 PM
-02/15/25 at 2:51 AM and 8:53 PM
-02/16/25 at 5:59 AM and 7:13 PM
-02/17/25 at 9:43 AM and 5:49 PM
-02/18/25 at 6:49 AM, 1:08 PM and 8:23 PM
-02/19/25 at 4:06 AM and 10:24 AM.

Resident #176 discharged home on 02/19/25.

The shift change controlled substance inventory count sheet was signed by MA #2 on 02/21/25 indicating one card of oxycodone 5 mg tablets for Resident #176 was removed from the medication cart. There was no other signature verifying the narcotics were removed.

Included in the facility's investigation documentation was a typed statement dated 03/01/25 written by the current DON that revealed in part, on 02/21/25 MA #2 and the former DON were observed at the 400 Hall medication cart. The former DON was observed removing several narcotic cards and declining count sheets from the medication cart and then walked back up the hallway away from the medication cart with the narcotics and count sheets in hand.

The initial allegation report dated 03/04/25 revealed the facility became aware on 03/04/25 at 4:40 PM that 18 pills of Resident #176's oxycodone was unaccounted for and Law

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 18	F 602		

Enforcement was notified.

The investigative report dated 03/08/25 revealed during a narcotic audit, it was determined that between 01/14/25 to 02/14/25 the pharmacy sent 120 tablets of oxycodone for Resident #176 of which she received 100 doses. There were 20 tablets of oxycodone unaccounted for and the medication was missing along with the declining count sheet.

During phone interviews on 04/29/25 at 12:36 PM and 04/30/25 at 4:42 PM, the former DON stated her last day working at the facility was on 02/25/25 and she left without notice because she no longer felt safe working at the facility. The former DON could not recall the date but stated an Officer came to speak with her to get a statement and hinted that she was being accused of narcotic diversion, but he did not go into the specifics of what she was being accused of. She stated she never and would never take any medication from a facility or resident. The former DON stated during her employment at the facility, narcotic medication that needed to be returned to the pharmacy was kept locked in the medication cart. She explained that was not a process she was comfortable with and felt that the narcotic medication should be locked up in the DON's office until the pharmacy picked them up. She could not recall the exact date but stated it was a day or two before the last day she worked (02/25/25) when the Assistant Director of Nursing at the time, who was now the facility's current DON, asked if she would "clear the carts", which she explained meant removing narcotic medication that needed to be returned to the pharmacy, and help her finish up the pharmacy returns. The former DON stated she removed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 19	F 602		

some narcotic medication with the associated declining count sheets from the 300 Hall medication cart, but she did not recall the name of the resident the medication belonged to or the name of the medication she removed. She scanned the cards to create a pharmacy return, faxed the log to the pharmacy and placed the narcotic medication into a sealed bag for the pharmacy to pick up. She then handed the bagged medication to Nurse #6 to place back on the medication cart until the pharmacy picked it up. The former DON stated she felt that someone was forging her initials on the narcotic count sheets and just before she left, she had voiced her concerns to the Administrator and ADON that she felt there was some drug diversion going on and there needed to be an audit, but they did not seem to take her concerns seriously. The former DON stated she felt this entire accusation was retaliatory on the facility's part because she quit without notice. She restated she never took any narcotic medication and someone at the facility forged her initials.

During a phone interview on 05/01/25 at 9:25 AM, Nurse #6 revealed she no longer worked at the facility. Nurse #6 could not recall the date but stated the former DON had given her some medications that were sealed in a bag for the pharmacy to pick up and she placed the bag in the 100 Hall medication cart because pharmacy usually didn't pick up medications at night which was when she worked.

During a phone interview on 04/29/25 at 4:11 PM, the Law Enforcement Detective stated he and the Drug Enforcement Administration (DEA) Officer spoke with the former DON together and she denied taking any medications from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 20	F 602		

The Law Enforcement Officer stated when he reviewed the facility's records, the documentation was not as clean cut as he would have liked. He explained there were gaps from the date the former DON initialed the sheets as having removed the medications and when the medications were noticed missing which meant others had access to the medications during the time frame. The Law Enforcement Detective stated he was closing his investigation, and no charges were filed as he could not determine what actually happened to the medications but felt there was definitely a breakdown in the facility's process that allowed the diversion to occur.

A joint interview was conducted with the current DON, Administrator and Regional Vice President of Operations on 04/30/25 at 1:26 PM. The Administrator stated on 02/28/25, MA #3 came to let her know that she (MA #3) had tried to get Resident #173's clonazepam refilled but the pharmacy stated it was too soon to refill the medication. The Administrator stated she immediately reviewed the pharmacy sheets for deliveries and then she along with the current DON started looking everywhere to see if Resident #173's clonazepam had been placed in another location by mistake which included checking all medication carts, offices, filing cabinets, desk, and the non-narcotic pharmacy return box. She stated when Resident #173's clonazepam couldn't be located, she called the Regional Vice President of Operations to inform him of the situation, and he instructed them to start an investigation and conduct a narcotic audit going back 30 days. She stated the Pharmacy Account Manager came to the facility to help with the investigation and completed a reconciliation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 21	F 602		

of all resident narcotic medications. The Administrator stated during the narcotic audit they discovered that there were a total of 11 narcotic cards with the declining count sheets that had been removed from the medication carts and 4 of the 11 narcotic cards could not be accounted for, there were no narcotic card, declining count sheets or record of return to the pharmacy. She stated there was one common denominator, the former DON had signed off as having removed all 11 narcotic cards/sheets from the medication carts and they were all removed on the same day. She explained she started comparing the narcotic sheets they were able to locate that the former DON had signed as removing the medication from the medication cart with the pharmacy delivery sheets and report of pharmacy returns. Through that process, she was able to determine what medications were unaccounted for and verify there was no pharmacy order for the unaccounted medications to be returned. She then compared the unaccounted medications with the pharmacy delivery sheets and confirmed there was no order from the pharmacy for a return. She stated they determined the medications that were unaccounted for belonged to Resident #173, #174, #175 and #176. She explained Resident #173 was the only resident still at the facility when the incident occurred and her clonazepam was replaced at the facility's expense. Resident #174 and Resident #175 both had discharged to the hospital and Resident #176 had discharged home. The Administrator stated when the current DON talked to Resident #176, she confirmed no medication was provided to her upon her discharge, but she did get a prescription to have filled. The Administrator stated they could not prove that the former DON took the medications, but it was the only thing they could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 22	F 602		

determine likely happened based on their investigation and the former DON was not returning their calls. The Administrator stated the last day the former DON actually worked at the facility was on 02/25/25 and then she sent a text message on 02/28/25 to the current DON (who was the ADON at the time) stating that she was quitting. She stated the Law Enforcement Detective and DEA Officer came to the facility, talked to each of them individually and then came back to the facility to talk to them again after speaking with the former DON. She stated the Law Enforcement Detective and DEA Officer stated that the former DON denied taking the medications and was basically putting the blame for the missing medications on the current DON.

The interview continued with the current DON, Administrator and Regional Vice President of Operations all stating the former DON never voiced any concerns of diversion to them and as the DON of record at the time, she could have initiated an investigation if she did have concerns but didn't. They all explained the process at the time was for the DON to pull narcotic medications from the medication cart, scan the bar code to initiate a return to the pharmacy, seal the medication in a bag with the bag number for the return, place the bag on the locked medication cart until pharmacy arrived to pick it up and when pharmacy arrived to pick up the medication, they provided a receipt of return. The Administrator and Regional Vice President of Operations both stated they realized the protocol was not being consistently followed and a corrective action plan was discussed at QAPI and implemented.

The facility provided the following corrective action plan with a completion date of 03/06/25:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 23	F 602		

How will corrective action be accomplished for those residents found to have been affected by the deficient practice?

On Friday, February 28, 2025, the Executive Director was notified by a Medication Aide that Resident #173 Clonazepam 0.5mg tablets and declining count sheet was missing. The current Director of Nursing phoned the pharmacy. The pharmacy checked on the missing Clonazepam 0.5 mg tablets and explained to the DON that the Clonazepam was never returned to the pharmacy. The pharmacy replaced the Clonazepam 0.5 mg rapid tablets on the same day as phoned and the charge for those was billed to the facility. A search of the facility was completed by the Executive Director and the Director of Nursing. This included all offices to included desks, filing cabinets, drawers, bookshelves, boxes, shred boxes, removing locks on any locked drawers, filing cabinets, desks, etc. When the search was completed and the missing medication and declining count sheets could not be located, the Regional Vice President of Operations, the Regional Clinical Director of Nursing were notified via telephone conference. It was decided that an audit needed to be started and that an ADHOC QAPI needed to be held to discuss and formulate an action plan.

On 2/28/25, the Executive Director and the Director of Nursing conducted a Root Cause Analysis regarding the missing controlled medication for Resident #173. It was determined through the root cause analysis, the system for removing narcotics from the medication cart was not always followed with 2 signatures. It was also identified that shift change controlled substance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 24	F 602		

inventory count sheet was not thorough for accurately tracing of narcotics removed from the cart. Through the review of the Shift Change Controlled Substance Count Sheets, it was identified that the previous Director of Nursing had signed the narcotics off of the cart on 2/21/25. The pharmacy return record of controlled substances was reviewed for the date that the narcotics were signed as removed from the medication cart, lock box and the missing narcotics did not appear on the pharmacy return record of controlled substances. The Medical Director, The Regional Vice President of Operations, and the Regional Director of Clinical Services was made aware of this root cause analysis.

On 2/28/25, an ADHOC QAPI was held with the following quality assurance performance improvement team members: Executive Director, Director of Nursing, Business Office Manager, Social Worker, Medical Records, Maintenance Director, Rehab Manager, Housekeeping Supervisor, and the Medical Director attended by phone. The proposed plan of correction was reviewed, discussed, and agreed upon regarding the corrections needed to attain and sustain compliance.

On 3/1/2025, local law enforcement, the regulatory agency and the Board of Nursing were notified of the missing narcotics. The Board of Nursing was notified of the former Director of Nursing potential involvement in regard to the missing narcotics.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 25	F 602		

The Executive Director and the Director of Nursing completed a quality review of prescribed controlled medications that were received from or returned to the pharmacy over the prior 30 days. This review was conducted from 2/28/25 through 3/4/25 to identify other residents having the potential to be affected by the same deficient practice. Included in the 30-day review were the following:

Shift Change Controlled Substance Count Sheets- which indicates how many narcotic cards/containers are active on the cart and also reveals when controlled substances are added and or removed from the cart.
-Pharmacy Delivery Sheets
-Destruction History
-Current Residents with an order for controlled substances
-Discharge Residents that had an order for controlled substances
-Controlled Substance Declining Count Sheets, Controlled Substances in Medication Carts
-Medication administration records related to controlled substances

At the conclusion of this process on 3/4/25, 3 other residents were affected by this deficient practice. Included here are the results of the audit:

Resident #176 was admitted to the Oaks at Sweeten Creek on 01/13/2025 and discharged home 02/19/2025. Resident #176 had a physician's order for Oxycodone 5mg tablet every 6 hours as needed for pain.

The pharmacy delivery report indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 26	F 602		

following was delivered to the facility: 02/14/2025 Oxycodone 5mg tablet- 30 pills-7 day supply. The last dose being administered on 02/19/2025. The shipment that was received on 02/14/2025 including 30 pills had 18 pills remaining that were unaccounted for, and the declining count sheet was also missing. The DON contacted Resident #176 to ask if she was discharged with the narcotic card of medication. Resident #176 indicated she was not discharged with the medication; but that she received a prescription for the medication.

The previous DON removed the controlled substance and the declining count sheet from the cart on 02/21/2025.

On 03/04/2025, The Executive Director and Pharmacy representative reviewed medications returned to the pharmacy and there was no indication this controlled substance medication was returned, and the declining controlled substance count sheet could not be located.

Resident #174 was admitted to the Oaks at Sweeten Creek in 01/27/2025 and discharged to the hospital on 02/08/2025. On 01/30/2025, Resident #174 received a physician's order for Oxycodone 5mg tablet every 6 hours as needed for pain.

The pharmacy delivery report indicated the following was delivered to the facility: 01/30/2025 Oxycodone 5mg tablet- 30 pills- 7-day supply.

A review of the Medication Administration Record indicated that Resident #174 had 7 pills administered to him during his stay, with the last dose being administered on 02/07/2025. The 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 27	F 602		

remaining pills were unaccounted for. It is noted that the previous DON removed the controlled substances and the declining count sheet from the medication cart on 02/25/2025.

On 03/04/2025, The Executive Director and Pharmacy representative reviewed medications returned to the pharmacy and there was no indication this controlled substance medication was returned to the pharmacy, and the declining controlled substances count sheet could not be located.

Resident #175 was admitted to the Oaks at Sweeten Creek on 02/08/2025 and discharged to the hospital on 02/26/2025. On 02/10/2025, Resident #175 received a physician's order for Oxycodone 5mg tablet every 6 hours as needed for pain.

The pharmacy delivery report indicated the following was delivered to the facility: 02/10/2025 Oxycodone 5mg tablet- 28 pills- 7-day supply.

A review of the Medication Administration Record indicated that Resident #175 received 10 pills with the last dose being administered on 02/16/2025. The controlled substance medication was discontinued on 02/17/2025. There were18 pills remaining that were unaccounted for. It is noted that the previous DON removed the controlled substance from the medication cart on 02/21/2025. On 03/04/2025, The Executive Director and Pharmacy representative reviewed medications returned to the pharmacy and there was no indication this controlled substance medication was returned to the pharmacy, and the declining controlled substances count sheet could not be located.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 28	F 602		

On 3/4/25, the Pharmacy Account Manager came to the facility to assist with the quality review and concurred with the findings.

A licensed nurse completed pain assessments on all current residents on the dates of 3/3/25 through 3/5/25 and there were no residents identified as having pain.

On 3/3/2025, the Social Worker conducted interviews with residents with a BIMS of 8 or greater to determine if any of them were in pain, if they received pain medication when they are experiencing pain, and if they have had any issues with receiving pain medications and there were no issues identified.

On 3/2/2025, the Executive Director reviewed the grievances for the months of January and February for any issues related to the medication without any concerns noted.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?

On 3/1/2025, the VP of Clinical Services educated the Executive Director and Director of Nursing via telephone to ensure narcotic control sheets were being utilized per policy, removing controlled substances from the medication carts that are ZEROs (with no pills remaining), removing controlled substances with pills remaining and utilizing the company's policy regarding the returning/ destruction process.

On 3/1/2025, The Director of Nursing and Executive Director began education for licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 29	F 602		

nurses and medication aides on the policy to ensure proper documentation on controlled substances/ narcotic count sheet and ZERO TOLERANCE- Diversion of Drugs, this education was completed by 3/4/2025 and is included in orientation for newly hired nurses and medication aides.

On 03/04/2025, the Pharmacy Account Manager educated the Executive Director and Director of Nursing on delivery and receipt of controlled substances on 3/4/25. Storage and inventory of medications, controlled substances, and products, returns and disposal of medications and controlled substances, maintenance and the file system of controlled substance declining count sheets, delivery and returns to include 2 nurse or 1 nurse and 1 medication aide verification for receiving controlled substances, how to waste/destroy medications, and the Director of Nursing only is to remove narcotics from medication cart along with 1 nurse or 1 medication aide for verification. Per policy, controlled substances are to be removed by the Director of Nursing, any wasted controlled substance is to be performed by two licensed nurses or a licensed nurse and a medication aide.

On 03/04/2025, the Executive Director and Director of Nursing educated licensed nurses and medication aides on the new Shift Change Controlled Substances Inventory Count Sheet and delivery and receipt of controlled substances, Storage and Inventory of medications, controlled substances, and products, returns and disposal of medications and controlled substances, maintenance and file system of controlled substance declining count sheets, delivery and returns to include 2 nurse or 1 nurse and 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 30	F 602		

medication aide verification for receiving controlled substances, waste/destroy, with the Director of Nursing only to remove narcotics from medication cart with 1 nurse or 1 medication aide for verification. Medication Aides cannot add, remove, destroy/waste of controlled substances without the presence of 1 nurse or the Director of Nursing. Nurses cannot add, remove, destroy/waste of controlled substances without the presence of 1 med aide, another nurse or the Director of Nursing. Newly hired staff will be educated upon hire. The shift change form has been replaced with the Shift Change Controlled Substances Inventory Count Sheet that now includes the following: number of cards, number of count sheets in medication cart, controlled substances added and remove include residents name, medication, strength, number of cards, number of declining count sheets, verified by 2 nurses or 1 nurse and 1 medication aide. Count to be completed with the change of keys from nurse/med aide to nurse/med aide, or when DON is removing controlled substance cards/sheets with doses remaining. It includes the date, time, controlled substance medications at start of the count, declining narcotic count sheets at the start of the count, with 2 signature verification. Also included is the date, time, controlled substance medications at start of the count, declining narcotic count sheets at the start of the count, with 2 signature verification. The directions included on each Shift Change Controlled Substance Inventory Count Sheet are as follows:

-Oncoming Nurse/Med Aide must verify count of all controlled substances anytime the keys are changed. If the keys are changed out several times in one day because working partial shifts, then a new row is to be used stating the date and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 31	F 602		

time the controlled substances are inventory count was completed. Only full legible signatures are to be used, NOT INITIALS.

-Nurse/Med Aide must count the actual total # of Cards/Containers AND actual total # of count sheets for all supplies in the drawer.

-When cards are added, 2 nurses or 1 nurse/1 Med Aide are to add the number of cards/sheets added to include: resident name, drug name, prescription # and number of pills for each card/container & sheet added. A new row is to be used with the date/time these are added.

-When an empty card is removed, it is to be done by the Director of Nursing or the Assistant Director of Nursing. Again this is to include the: resident name, drug name, prescription # and number of pills for each card/container & sheet removed. The top of the card/container is to be stapled to the top of the declining inventory sheet.

-Only the Director of Nursing (DON) can remove a card/container with doses remaining on the card/container. The DON must sign along with 1 Nurse or 1 Med Aide. When the DON and the 1 Nurse or 1 Med Aide sign that the cards are being removed, they are also signing that they agree on the number of pills remaining on the card/container and the countdown sheet. An ADDITIONAL count will be completed with the DON when removing narcotic cards/sheets with doses remaining. The date & time of that count will be completed at the time it is removed.

On 03/4/2025, a new process was reviewed and put into place to ensure that all medications placed in the bag of narcotics to be returned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 32	F 602		

pharmacy are accounted for from the time they are prepared and placed into the bag until the time that the pharmacy driver takes the bag with them. This supports the chain of custody of narcotics prepared for return until they are picked up. Upon removing the narcotics from the medication carts, the DON will then get the Assistant Director of Nursing or the Executive Director to validate that those medications are immediately placed in a return bag and a "Controlled Substance Inventory Form" is completed for return to pharmacy. Then the DON and 1 nurse or 1 med aide will sign a sheet stating that the return sheet and bag of narcotics are provided to the 100 Hall "Return" Narcotics drawer to provide to the pharmacy driver when they pick it up. The pharmacy driver will sign that the narcotics have been placed in their possession on a separate inventory sheet to be retained at the facility in the DON office. Other education included during the in-services, with Licensed Nursing Staff and Medication Aides was education on drug diversion, policy and procedures on complete count of controlled substances/ sheets with documentation, nursing ethics and best practices. The in-services were held in person and all nurses and medication aides currently employed attended the in-services at multiple times during the day and evening on 3/4/2025. All Licensed Nurses and Medication aides are to immediately inform the Director of Nursing and Executive Director of any suspected diversion, missing narcotics, narcotics not received by the pharmacy and any narcotic discrepancy, newly hired staff will be educated upon hire. There is 1 med aide who is on maternity leave, and she will be educated prior to returning to work. All newly hired nurses and medication aides will have the same education

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 33	F 602		

during their orientation. The Director of Nursing and/or the Assistant Director of Nursing will be responsible for keeping track of newly hired nurses and medication aides to ensure the education is received during orientation. The facility does not utilize agency staff.

On 3/4/25, the Pharmacy Account Manager reviewed the process, system, and forms to be used, including the Shift Change Controlled Substances Inventory Count Sheet and the process to ensure narcotic medications are accounted for from the time the narcotics are removed from the carts until they are picked up by the pharmacy driver. The Pharmacy Account Manager approved both new processes.

The department manager staff including: the Receptionist, the Social Worker, the Medical Records Clerk, the Maintenance Director, the Central Supply Clerk, the Rehabilitation Manager, the Dietary Manager, and the Housekeeping Supervisor were in-serviced on drug diversion to validate their understanding and reporting expectations for any suspicious activity and or behavior. Newly hired staff in these positions will be educated upon hire. This education was provided on 03/05/25 by the Executive Director.

How will the facility monitor its corrective actions to ensure the deficient practice will not recur?

The Director of Nursing to complete quality monitoring of the Shift Change Controlled Substances Count on all medication carts weekly for 12 weeks to ensure all narcotic medications are accounted for, that nurses are using proper signatures, and that any cards removed from the cart have the number of remaining narcotics on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 34	F 602		

the sheet when the narcotic is removed to ensure that any discrepancies going forward can be easily tracked.

The results of the quality monitor of the Shift Change Controlled Substances Count Sheet will be presented by the Director of Nursing to the Quality Assurance Performance Improvement Committee for 3 months. This committee includes the Executive Director, Medical Director, Director of Nursing, the Manager of Social Services, the Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records Clerk, Central Supply Clerk, Admissions Director, Nurse Managers, Dietary Manager, and the Environmental Services Director.

The center Executive Director alleges compliance on 03/06/2025.

The facility's corrective action plan with a correction date of 03/06/25 was validated onsite by observations and interviews.

An observation was conducted during a shift transition for a medication cart between a nurse and MA on 04/30/25. The nurse and MA started with counting the total number of blister cards that contained controlled medication stored in the double-locked compartment in the medication cart and verified the balance on the narcotic count sheet. The nurse and MA then counted each blister card of controlled medication to ensure the quantity listed in the declining narcotic count sheets were consistent with the actual pill count. After all the counts were completed without any discrepancies, they both signed narcotic count sheets and the off-going MA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 35	F 602		

passed the medication cart key to the on-coming nurse.

Observations of medication administration revealed nurses and MAs reviewed the physician orders, the medication label, and MAR prior to administering resident medication. All the medications were administered as ordered without any issues. Controlled medication was retrieved from the double-locked compartment in the medication cart and documented on the declining narcotic count sheet as ordered. Residents with controlled narcotic medications had a declining record that matched the remaining amounts.

Interviews with nurses and MAs on various shifts revealed they had received in-service education related to Misappropriation of Resident's Property and the process for the shift change controlled substance inventory count sheet. Nurses and MAs voiced understanding of the education received and were able to describe the process for the verification of controlled medications on-hand and having two staff sign the controlled substance count sheet, returning discontinued medications to the pharmacy and immediately reporting any discrepancies. Review of monitoring tools revealed all medication carts were audited by the DON weekly beginning 03/05/25 with no concerns identified and results were reported to the QAPI committee for suggestions and/or recommendations.

Interviews with the Administrator and DON revealed the facility conducted mandatory in-service education throughout the day on 03/04/25 to re-educate all the licensed nurses and medication aides regarding the controlled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 36 medication process which included the new shift change controlled substance inventory count sheet. The DON audited all the medication carts to ensure controlled medication counts were conducted appropriately, accounted for and the declining narcotic count sheets were documented properly. Both stated they felt the new process was effective and there had been no similar diversion issues since. The compliance date of 03/06/25 was validated.	F 602		
F 627 SS=D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including	F 627		6/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 627	Continued From page 37	F 627		

Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F)The facility ceases to operate.

§483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i)Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 627	Continued From page 38	F 627		

(ii)The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

§483.15(c)(7) Orientation for transfer or discharge.
A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.

§483.15(e)(1) Permitting residents to return to facility.
A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.
(i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-
(A) Requires the services provided by the facility; and
(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services
(ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 627	Continued From page 39	F 627		

facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

§483.21(c)(1) Discharge Planning Process
The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 627	Continued From page 40	F 627		

person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 627	Continued From page 41 (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and resident, Family Member and staff interviews, the facility failed to have a discharge planning process in place that included documentation of referrals submitted to other skilled nursing facilities (SNF) and documenting the responses to the referrals submitted for a resident who wished to discharge to another SNF closer to family for 1 of 1 sampled resident (Resident #41). Findings included:	F 627	1. The Social Worker spoke with resident #41 on 4/28/25 regarding her wishes for a transfer to a facility closer to her mom. The discharge care plan was reviewed and revised by the interdisciplinary team on 5/27/25 to reflect resident #41 more accurately related to preference for discharge. 2. The last 30 days of discharges along with all current residents, were reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 627	Continued From page 42 Resident #41 was admitted to the facility on 06/07/23 with diagnoses that included quadriplegia (form of paralysis that affects all four limbs and torso, pressure ulcer of the sacral region, osteomyelitis (bone infection), bipolar disorder, and anxiety disorder. Resident #41's comprehensive care plans included a discharge care plan, initiated on 06/13/23 and last revised on 02/02/24, that revealed Resident #41 wished to return to a facility closer to her family and would remain at the current facility for long-term care until a transfer could be made. Review of the Social Services progress notes for Resident #41 for January 2024 to April 2025 revealed the following: - An entry dated 06/14/24 written by the former SW revealed a referral was emailed to a SNF located close to Resident #41's Family Member at the Family Member's request. There was no entry after 06/14/24 noting the SNF's response to the referral sent on 06/14/24. Other than the referral submitted to a SNF on 06/14/24, there were no further entries indicating additional referrals were made to other SNF closer to Resident #41's Family Member during the period January 2024 to April 2025. The admission Minimum Data Set (MDS) assessment dated 01/19/25 revealed Resident #41 had intact cognition and there was no active discharge plan in place. During a phone interview on 04/28/25 at 1:19 PM,	F 627	by the Executive Director and/or Social Worker on 5/14/25 to determine if the same deficient practice with discharges occurred with no further issues identified. 3. The Executive Director provided education to the Social Services Director on stressing the importance of sufficient documentation for referrals to other facilities as well as documentation on follow up for the referrals made for transfer. This education also included the need to review discharge plans with each OBRA assessment and to confer with the resident and/or their responsible party to ensure the care plan is current according to their wishes. The education packet will be included in new hire orientation for Social Services. The Executive Director developed a tracker for the Social Worker to use that includes the following: Current residents who have expressed that they would like to discharge, location of where they want to be discharged to(home vs assisted living or skilled nursing facility), a list of where they would like any referrals to go, proof of e-faxed referral, 2 follow ups with the referral location within 10 days, then provide resident and/or responsible party of the outcome of the referral. The referral documentation corrective action will be monitored by the Executive Director weekly for 12 weeks. The monitors will be presented to the Quality Assurance Committee each month. 4. The Executive Director presented the monitoring plan to the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 627	Continued From page 43 Resident #41's Family Member expressed she wanted Resident #41 to move to a SNF closer to her so that she could be more involved in her care. The Family Member revealed she had asked the SW multiple times to send referrals to a SNF near where she lived but when she (Family Member) called the SNF, they had not received any referrals from the SW. The Family Member stated when she tried to call the SW to follow-up on the referrals, the SW didn't call her back. During an interview on 04/28/25 at 3:04 PM, Resident #41 expressed she wanted to transfer to a SNF closer to her home but only if it was an hour or less from her Family Member, otherwise she would just stay at this facility. The former SW was unable to be interviewed during this investigation. During an interview on 04/28/25 at 3:42 PM, the SW revealed she had only been back at the facility since January 2025. The SW stated she had sent several referrals to SNF closer to Resident #41's Family Member but she would have to look through her files to see where and when the referrals were sent. The SW stated she did not follow-up with the SNF after she sent the referral. She explained if the SNF was willing to accept Resident #41, they would contact her but so far she had not received any responses. She stated the Administrator recently printed off a list of SNF close to Resident #41's Family Member and they were currently working on sending additional referrals. During a follow-up interview on 04/30/25 at 12:15 PM, the SW stated she faxed referrals to SNF located close to Resident #41's Family Member	F 627	Performance Improvement Committee on 5/2/25. The Quality Assurance Committee will review the monitoring plan monthly for 3 months and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5.Compliance Date: 6/13/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 627	Continued From page 44 on 02/07/25, 02/25/25, 03/03/25, 03/24/25, 04/01/25, and 04/11/25. The SW explained she did not write down the names or contact information of the SNF she faxed the referrals to, only the city where the SNF was located. During an interview on 05/01/25 at 3:02 PM, the Administrator revealed she recently printed off a list of SNF and highlighted each one within a 50 mile radius of Resident #41's Family Member for referrals to be sent. She stated that she knew the SW had previously sent referrals to SNF for Resident #41 but she was not sure if it was feasible for the SW to follow-up on each referral as the other SNF didn't always respond if they were not wanting to make a bed offer. The Administrator stated there should be documentation in the resident's medical record noting where and when referrals were sent when requested by the resident or Responsible Party.	F 627		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 641		6/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 45 §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the area of active diagnosis for 2 of 23 residents reviewed for MDS accuracy (Resident #16 and Resident #19). Findings included: 1. Resident #16 was admitted to the facility 03/28/25 with a diagnosis including depression. Resident #16's admission Minimum Data Set (MDS) assessment dated 04/04/25 indicated she had a diagnosis of post-traumatic stress disorder (PTSD). Review of a Psychiatry evaluation note for Resident #16 dated 04/04/25 read in part as, "She did not [have] a history of PTSD." In an interview with the MDS Coordinator on 05/01/25 at 11:57 AM she confirmed she completed Resident #16's admission MDS dated 04/04/25. She stated the MDS should not have	F 641	1. Resident #19s, Minimum Data Set (MDS) was corrected by the RN MDS Coordinator by removing the diagnosis of Schizophrenia from the incorrectly coded annual assessment was modified by the MDS RN with an attestation date of 5-2-25. Resident 16s admission assessment was modified to remove the diagnosis of PTSD by the RN MDS Coordinator with an attestation date of 5-2-25. 2. A quality review was completed on the current residents most recent MDS in the areas psychiatric diagnosis to validate the most recent MDS assessment has been coded to accurately and was completed by the MDS Coordinator on 5/25/25. Any assessments identified with coding errors during the quality will be corrected and transmitted by 5/28/25. 3. The Executive Director educated the RN MDS Coordinator on the importance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 46 been coded to reflect Resident #16 had a diagnosis of PTSD and this was a coding error. An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed she expected MDS assessments to be coded accurately. An interview with the Administrator on 05/01/25 at 5:39 PM revealed she expected MDS assessments to be coded correctly. 2. Resident #19 was admitted on 4/15/24 and re-admitted on 12/31/24. Resident #19's diagnoses included paranoid schizophrenia that was present on admission (4/15/24). Resident #19 was care planned for receiving antipsychotic therapy (haloperidol) for diagnosis of paranoid schizophrenia dated 10/28/24. Resident #19's annual Minimum Data Set (MDS) assessment dated 1/9/25 included an active diagnosis of schizophrenia. A review of Resident #19's physician orders revealed an order for haloperidol 0.5 milligrams 2 times daily for diagnosis of paranoid schizophrenia dated 3/14/25. Resident #19's quarterly Minimal Data Set (MDS) assessment dated 4/7/25 did not include an active diagnoses of schizophrenia. On 5/01/25 at 11:57 AM the MDS Nurse stated Resident #19 was readmitted to the facility on 12/31/24 with a diagnosis of paranoid schizophrenia. The MDS Nurse stated she was directed to not code a diagnosis of schizophrenia on the MDS by direction of the facilities corporate	F 641	to monitor for coding errors as well as to accurately coding Minimum Data Sets as related to psychiatric diagnosis on 5/25/25. This same education will be provided to any newly hired MDS Coordinators during their orientation period by the Executive Director or the Assistant Director of Nursing. The Executive Director will conduct Quality reviews of 3 residents MDS assessments in the areas psychiatric diagnosis to ensure the MDSs are coded accurately weekly for 12 weeks. 4. An ADHOC Quality Assurance Performance Improvement Committee will be held on 5/2 2025 to formulate and approve a plan of correction for the deficient practice. The Executive Director will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement Committee (QAPI) monthly for 3 months. Compliance Date: 6/11/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 47 office after Resident #19's annual MDS assessment had been completed and submitted. She stated Resident #19 did not have enough supporting documentation available when admitted to the facility and the MDS assessment dated 1/9/25 should not have included the diagnosis of schizophrenia and that was a coding error. The Administrator was interviewed on 5/01/25 at 5:24 PM and stated MDS assessments should be coded accurately.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F 655		6/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 48 care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a baseline care plan that addressed the resident's immediate needs within 48 hours of admission for 4 of 13 sampled residents (Residents #73, #16, #72, and #323). The findings included: 1. Resident #73 was admitted to the facility on 04/25/25 with diagnoses that included diabetes, chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and chronic obstructive pulmonary disease (difficulty breathing). The nursing admission data collection assessment initiated on 04/28/25 and completed on 04/29/25 revealed Resident #73 received	F 655	1. Residents #72 was discharged on 3/3/2025. Resident #323 discharged on 8/2/2024. Resident #16s colostomy care is included in her comprehensive care plan. #73s Baseline care plan was reviewed with her and signed on 4/28/2025. 2. An audit was conducted by the Director of Nursing on 5/15/25, all residents admitted within the last 90 days to determine if their baseline care plans were thoroughly completed, reviewed and a copy provided to the resident/family within 48 hours of admission with no other discrepancies noted. 3. On 5/7/25, the Executive Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 49 insulin injections, antidepressant and diuretic medications. Review of Resident 73's electronic medical record on 04/29/25 revealed no evidence a baseline care plan that addressed her immediate needs was initiated or completed within 48 hours of her admission to the facility on 04/25/25. During an interview on 04/30/25 at 9:13 AM, the Director of Nursing (DON) explained when residents admitted after-hours (after normal business hours) or over the weekend, nursing staff called her and she assisted them with entering physician orders and starting a baseline care plan for the resident. The DON could not explain why a baseline care plan was not initiated for Resident #73 and stated either she or the nurse should have completed a baseline care plan within 48-hours of Resident #73's admission to the facility on 04/25/25. During an interview on 05/01/25 at 5:37 PM, the Administrator stated baseline care plans should be completed within 48 hours of a resident's admission. She stated the baseline care plan should contain pertinent information that addressed a resident's immediate care needs for staff until the comprehensive care plans were developed. 2. Resident #72 was admitted to the facility on 02/28/25 with a diagnosis including muscle weakness. Resident #72 discharged home on 03/03/25. Review of Resident #72's medical record revealed there was no baseline care plan included in the medical record.	F 655	educated the Director ofNursing, the Assistant Director of Nursing and the Registered Nurse Unit Manager related to the Federal Regulations, F-655, Baseline Care Plans. This education will be provided to any newly hired nurse managers during their orientation process. Between the dates of 5/21/25 and 5/28/25, the Director of Nursing, the Assistant Director of Nursing and/or the Registered Nurse Unit Manager educated licensed nurses related to the Federal Regulations, F-655, Baseline Care Plans that includes time frames for presentation to the residents and/or responsible parties and the need to be thorough to ensure the provision of care. Licensed nursing staff who were unavailable during the education period will have the education prior to their next shift. This facility does not utilize agency staff. This education will be provided to any newly hired nurses during their orientation process by the Director of Nursing, the Assistant Director of Nursing and/or a Nurse Manager. A quality monitor was implemented on 5/28/25 to ensure that all newly admitted residents have their baseline care plan formulated, is thorough for the provision of care, meeting the guidelines of F-655 and will be presented to the resident and/or family within 48 hours. This monitor will be completed by the Director of Nursing, the Assistant Director of Nursing and/or a Nurse Manager after every new admission for 12 weeks. 4. The Executive Director presented the monitoring plan to the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 50 An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed the interdisciplinary team initiated the baseline care plan upon admission and it was sent to the MDS Coordinator to assist with developing the comprehensive care plan. She stated once the comprehensive care plan was initiated, the baseline care plan was sent to medical records to be scanned into the electronic medical record. The DON confirmed Resident #72 should have had a baseline care plan and it was overlooked. An interview with the Administrator on 05/01/25 at 5:39 PM revealed she was unaware a baseline care plan was not completed for Resident #72. The Administrator stated she expected all residents to have a baseline care plan completed within 48 hours of the resident's admission. 3. Resident #16 was admitted to the facility 03/28/25 with a diagnosis including colostomy status (having a colostomy in place). Review of Resident #16's baseline care plan dated 03/28/25 did not reflect she had a colostomy (a surgically created opening that connects one end of the large intestine to the abdomen). Review of the admission Minimum Data Set (MDS) assessment dated 04/04/25 revealed Resident #16 had a colostomy. An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed the interdisciplinary team initiated the baseline care plan upon admission and it was sent to the MDS Coordinator to assist with developing the	F 655	Performance Improvement Committee on 5/2/2025. The results of the quality monitoring will be presented to the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee will review the monitoring plan y and make updates and/or recommendations to the plan based upon the results of the quality monitoring. 5. Compliance Date: 6/13/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 51 comprehensive care plan. She stated once the comprehensive care plan was initiated, the baseline care plan was sent to medical records to be scanned into the electronic medical record. The DON stated Resident #16's baseline care plan should have reflected that she had a colostomy, and it was an oversight. An interview with the Administrator on 05/01/25 at 5:39 PM revealed she expected baseline care plans to be accurate. 4. Resident #323 was admitted to the facility on 7/23/24 with diagnoses that included lack of coordination and dementia. Review of Resident #323's medical record revealed there was no baseline care plan completed within 48 hours of Resident #323's admission. An interview with the Director of Nursing (DON) on 5/01/25 at 5:15 PM revealed that she had medical records look for Resident #323's baseline care plan. She stated that a baseline care plan could not be found. She stated that the interdisciplinary team (IDT) was responsible for completing the baseline care plan. An interview with the Administrator on 5/01/25 at 5:44 PM revealed that her expectation was that a baseline care plan be completed within 48 hours of a resident's admission to provide comprehensive care.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		6/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 52 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to perform activities of daily living (ADL) care for a resident (Resident #30). This was for 1 of 11 residents reviewed for (ADL) care. Findings included: Resident #30 was admitted on 4/23/24 with diagnoses that included Parkinson's disease. A review of Resident #30's care plan dated 5/2/24 found he had a care plan for activities of daily living (ADL) self-care performance deficit related to generalized muscle weakness and impaired mobility. Interventions included improved level of function in ADL performance through next review date, clean, check nail length and trim on bath days. An additional intervention included revealed Resident #30 required set-up or clean-up assistance with personal hygiene. A review of Resident #30's quarterly Minimum Data Set (MDS) assessmnet dated 1/28/25 coded him as cognitively intact. Resident #30 had impairment to both sides for upper and lower extremities, needed maximum assistance with bathing, and set-up or clean-up assistance with personal care. A review of the facility's shower schedule found Resident #30's assigned bath days were Tuesday and Friday.	F 677	1. Resident #30 was not shaved because the assigned Cerrtified Nurses Aide (CNA) #2 felt tremulous and did not want to put the resident at risk for injury. CNA #2 stated that she asked another CNA to shave Resident $30 but could not remember who it was and she did not follow up to ensure that the care was provided. Resident #30 was shaved on 5/5/25. 2. CNA #2 was educated on the importance of following through when letting a resident know she will get additional help from another staff member or if she is uncomfortable with an ADL task, she needs to consult the Director of Nursing (DON) or the Assistant Director of Nursing (ADON). CNA #2 was educated on the importance of providing all ADL care & to seek further training from the Director of Nursing or Assistant Director of Nursing if there is an ADL she is uncomfortable with. All residents in the facility were visually observed to identify other residents who may need shaving. The residents who were identified as needing to be shaved were offered shaving care on 5/21/25 by assigned nursing staff members. 3. On 5/21/25 through 5/28/25, education was provided to the Licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 53 On 4/27/25 at 1:17 PM Resident #30 was observed in his room lying on his bed with approximately ½ inch long whiskers and beard hair on his face. The resident stated he preferred to have his face shaved and that he had not had a bath in a week. A review of Resident #30's Nurse Aide (NA) task summary for showers and bathing from 4/1/25 through 4/30/25 found no record of showers or bathing completed for Resident #30. A review of Resident #30's shower sheet records for April 2025 found a shower sheet dated 4/22/25 and 4/29/25 completed for the resident. The 4/29/25 shower sheet was signed completed by NA #2. An in-room observation and interview with Resident #30 on 4/29/25 at 1:35 PM found the resident's beard and whisker hair to remain unchanged. Resident #30 stated he had received a bed bath on 4/29/25 and he had requested the bed bath over a shower. Resident #30 said he asked NA #2 to shave him, and NA #2 had said she would not shave him because she was too nervous. The resident said NA #2 did not come back to tell him who would shave him or when he would be shaved. Resident #30 stated he was not able to shave himself and that he thought he had only been shaved one time in April. NA #2 was interviewed on 4/30/25 at 1:29 PM. She stated she provided the bed bath to the resident Resident #30 on 4/29/25. NA #2 said Resident #30 declined a shower and asked for a bed bath. She said Resident #30 had asked her to shave his face during the bed bath and she told the resident she did not feel comfortable	F 677	Nurses, by the Director of Nursing, or the Assistant Director of Nursing regarding the importance of monitoring for shaving and supervising the Certified Nurses Aides to ensure completion of shaving during grooming care. The licensed nurses were also educated to personally speak to any resident who initially refuses shaving from the Certified Nurses Aides, to identify why they may have refused shaving and to try to remove any barrier. If the resident continues to refuse to be shaved, the nurse will need to document that shaving was refused. Any Licensed Nurse who were unavailable during the education period will have the education prior to their next shift. This facility does not use agency staff. Newly hired nurses will be provided the same education during the orientation process. On 5/21/25 through 5/28/25, education was provided to the Certified Nurses Aides the Director of Nursing, or the Assistant Director of Nursing, on the importance of encouraging and providing ADL care to include bathing/showering,grooming (to include shaving) to assigned residents each shift worked. The education also included to inform the nurse of any refusals and ask the nurse to approach the resident in effort to get the resident to accept the ADL care as listed above. Any Certified Nurses Aides who were unavailable during the education period will have the education prior to their next shift. This facility does not use agency staff. Newly hired Certified Nurses Aides will be provided the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 54 shaving him because of her arm tremors. NA #2 said she told Resident #30 someone else would come back and shave him. The NA stated she was not able to recall who she asked to shave the resident after completing the bed bath on 4/29/25. NA #2 said she does forget to fill out the shower sheets for residents after completing a shower or bath, but she had always given her assigned residents a shower or bath when scheduled. A follow-up interview with NA #2 was conducted on 4/30/25 at 2:41 PM. NA #2 stated she was unaware if Resident #30 was able to shave himself with a razor. She added that the resident would probably be able to use an electric razor to shave himself. NA #2 said shaving a resident was completed when providing a bath or shower for a resident that liked to be shaved. The Director of Nursing (DON) was interviewed 5/1/25 at 4:37 PM. The DON stated shower sheets were supposed to be completed by NAs after every shower or bath. The DON stated if Resident #30 had requested to be shaved then he should have been shaved by NA#2 or the NA who agreed to shave Resident #30.	F 677	same education during the orientation process. A quality monitor was implemented put in place related to shaving. This monitor will be completed 3 times a week for 4 weeks, then 2 times a week for 8 weeks by the Executive Director, the Director of Nursing, the Assistant Director of Nursing, or a Nurse Manager. 4. An ADHOC Quality Assurance Performance Improvement Committee was held on 5/2 2025 to formulate and approve a plan of correction for the deficient practice. The results of the quality monitoring of shaving will be report by the Director of Nursing to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. 5. Compliance Date:6/11/25	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		6/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to post cautionary and safety signs that indicated the use of oxygen and ensure the physician order included the oxygen flow rate (amount of oxygen administered in liters per minute) and delivery method (nasal cannula) for 1 of 1 resident reviewed for respiratory care (Resident #73). Findings included: Resident #73 was admitted to the facility on 04/25/25 with diagnoses that included chronic respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and chronic obstructive pulmonary disease (difficulty breathing). A physician's order dated 04/25/25 for Resident #73 read, respiratory: oxygen-continuous. The physician order did not indicate the oxygen flow rate to be administered or directions or how the oxygen was to be delivered, such as nasal cannula. The Brief Interview for Mental Status (BIMS) assessment (tool used to gauge an individual's cognition) dated 04/25/25 revealed Resident #73 had intact cognition. During an observation and interview on 04/27/25 at 12:22 PM, Resident #73 was lying in bed receiving supplemental oxygen via nasal cannula with the flow rate on the oxygen concentrator set at 3 liters per minute (LPM). Resident #73 stated she used supplemental oxygen to help with her breathing but was not sure how many LPM she	F 695	1. The oxygen order was corrected for Resident # 73 on 5/2/2025 and correct signage placed on the door on 5/1/2025. 2. An audit was conducted on 5/5/2025 by the Director of Nursing to ensure that all oxygen orders in place were complete to include the number of liters per minute and that the Oxygen signage was in place. 3. The Director of Nursing and/or the Assistant Director of Nursing provided education from 5/21/25 through 5/28/25, to all licensed nurses on entering the correct liters per minute order entry for oxygen orders as well as placing signage on the resident room doors. Any Licensed Nurses who were unavailable during the education period will have the education prior to their next shift. This facility does not use agency staff. The education packet will be placed into the licensed nurse in-service education book for new hires and will be included in new hire orientation for licensed nurses. The oxygen order and signage corrective action will be monitored by Nursing Leadership 2 times a week for 12 weeks. 4. The Director of Nursing presented the monitoring plan to the Quality Assurance Performance Improvement Committee on 5/2/2025. The Director of Nursing will present the results of the quality monitors to the Performance Improvement Committee monthly for 3 months. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 56 was supposed to receive. There was no cautionary signage posted on the door, doorframe or in Resident #73's room to indicate oxygen was in use. During subsequent observations conducted on 04/28/25 at 8:00 AM, 04/29/25 at 4:50 PM and 04/30/25 at 8:31 AM, Resident #73 was lying in bed receiving supplemental oxygen via nasal cannula with the oxygen concentrator set at 3 LPM. There was no cautionary signage posted on the door, doorframe or in Resident #73's room to indicate oxygen was in use. During an interview on 04/30/25 at 9:13 AM and follow-up interview on 04/30/25 at 12:31 PM, the Director of Nursing (DON) confirmed there was no cautionary signage placed on the door, doorframe or in Resident #73's room to indicate oxygen was in use and explained there should have been as that was the facility's process. The DON stated the placement of the signage was likely overlooked because Resident #73 admitted to the facility after-hours (after normal business hours). The DON was unaware Resident #73's oxygen order did not indicate the oxygen flow rate and explained it was an oversight that she did not include the LPM when she entered Resident #73's oxygen order in her electronic medical record. During an interview on 05/01/25 at 5:37 PM, the Administrator stated physician orders for oxygen use should include the amount of oxygen to be administered and cautionary signage should be posted on the doors of residents' rooms who were receiving supplemental oxygen.	F 695	Quality Assurance Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Compliance Date:6/11/25	
F 700 SS=D	Bedrails	F 700		6/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 57 CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to assess a resident for risk of entrapment prior to installing and/or using bed rails for 1 of 4 sampled residents reviewed for accidents (Resident #18). Findings Included: Resident #18 was admitted to the facility on 07/25/22. Her cumulative diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebrovascular disease	F 700	1. The bed rail assessment for Resident # 18 was completed on 5/22/25 by the Assistant Director of Nursing. 2. All residents with bed rails had side rail assessments completed by 5/27/25 by the Director of Nursing, the Assistant Director of Nursing or by a Nurse Manager. 3. The Director of Nursing and/or the Assistant Director of Nursing or Nurse Manager provided education to the nurses between 5/21/25 and 5/28/25 regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 58 (conditions that affect blood flow to the brain) affecting the left dominant side, left knee contracture and chronic pain. The significant change Minimum Data Set (MDS) assessment dated 03/04/25 revealed Resident #18 had intact cognition. She had impairment on one side of the lower extremity, was dependent on staff for assistance with bed mobility and did not use bed rails during the MDS assessment look-back period. During an observation and interview on 04/27/25 at 11:20 AM, quarter bed rails were observed in the upright position on each side of Resident #18's bed. Resident #18 explained she used the bed rails to reposition herself when lying in bed. Review of Resident #18's electronic medical record on 04/28/25 revealed no evidence Resident #18 was assessed for risk of entrapment prior to installing and/or using bed rails. An additional observation conducted on 04/29/25 at 4:40 PM revealed Resident #18 lying in bed watching TV with quarter bed rails in the upright position on each side of the bed. During an interview on 04/30/25 at 9:13 AM, the Director of Nursing (DON) explained when therapy agreed bed rails would aid a resident with independent bed mobility, an initial bed rail assessment was completed and then bed rails were installed for the resident to use. The DON also stated residents were reassessed quarterly to determine the continued need for bed rail use. The DON stated she did not realize a bed rail assessment needed to be completed for Resident	F 700	the assessment requirement for bed rail use. This education included types of other interventions that could be utilized prior to a bed rail, why the bed rail is being considered, the resident's physical condition, cognition, communication, bed mobility, transfers, and risk factors related to the use of bed rails. Any Licensed Nurses who were unavailable during the education period will have the education prior to their next shift. This facility does not use agency staff.The education packet will be placed into the staff in-service education book and will be included in new hire orientation for nurses. A quality monitoring tool was implemented to ensure the timely assessment for those residents with bed rails. This quality monitoring tool will be completed weekly for 12 weeks. 4. An ADHOC Quality Assurance Performance Improvement Committee Meeting was held on 5/2/25 and the plan of correction was presented to them by the Director of Nursing. The Director of Nursing and/or the Assistant Director of Nursing or Nurse Manager will present the results of the monitoring tool to the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 59 #18 because the use of bed rails were ordered by Hospice. During an interview on 05/01/25 at 8:32 AM, Nurse Aide #1 revealed Resident #18 used the quarter bed rails for independent bed mobility and repositioning. During an interview on 05/01/25 at 5:27 PM, the Administrator stated she would expect bed rail assessments to be completed per the facility policy.	F 700	Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Compliance date: 6/11/25.	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding	F 726		6/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 60 to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a system in place to ensure Nurse Aides (NA) were able to demonstrate the competency and skills necessary for providing care to meet the individual care needs of residents' that included hand hygiene during incontinence care for 3 of 5 employee files reviewed (NA #2, NA #3 and NA #4). On 04/30/25, NA #3 did not remove soiled gloves and perform hand hygiene before applying a clean brief and touching other items in the resident's environment after providing incontinent care to a dependent resident. Findings included: This tag is crossed referenced to: F 880: Based on observations, record review, and staff interviews the facility failed to implement their infection control policies when Nurse Aide (NA) #3 did not don (put on) a gown while providing urinary catheter (a tube that drains urine out of the body) care to Resident #65 who required enhanced barrier precautions (EBP) due to the presence of a urinary catheter and failed to follow their Hand Hygiene policy when NA #3 did not remove soiled gloves and perform hand	F 726	1. After a review of the files of Certified Nurses Aide #2, Certified Nurses Aide #3, and Certified Nurses Aide #4, the facility was unable to provide the required competencies on hand hygiene on 5/1/25. 2. An audit of Certified Nurses Aides files, the facility was unable to locate hand hygiene competencies for any certified nurses aides. The audit was conducted by the Director of Nursing and the Assistant Director of Nursing on 5/6/25. 3. The Director of Nursing and/or the Assistant Director of Nursing provided education to the Nursing staff (Licensed Nurses and Certified Nurses Aides) on 5/21/25 through 5/28/25 to include the required competencies for each discipline. Any Certified Nurses Aides or Licensed Nurseswho were unavailable during the education period will have the education prior to their next shift. This facility does not use agency staff. The competency packet will be placed into the staff in-service education book and will be required during new hire orientation for Licensed Nurses and Certified Nurses	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 61 hygiene before applying a clean brief and touching other items in the resident's environment while providing incontinence care to Resident #65. This deficient practice occurred for 1 of 4 staff members observed for infection control practices (NA #3). a. Review of NA #2's employee file revealed she had been employed at the facility since 12/01/22. The employee file did not contain any evidence that NA #2's skills or competencies were checked upon hire or thereafter. b. Review of NA #3's employee file revealed she had been employed at the facility since 03/17/25. The employee file did not contain any evidence that NA #3's skills or competencies were checked upon hire or thereafter. During an interview on 04/30/25 at 2:49 PM, NA #3 stated she had not received any training from the facility regarding her removing gloves, performing hand hygiene and applying clean gloves after removing stool during incontinent care and before touching other items in the room. c. Review of NA #4's employee file revealed she had been employed at the facility since 08/24/23. The employee file did not contain any evidence that NA #4's skills or competencies were checked upon hire or thereafter.	F 726	Aides. The nursing staff competency corrective action will be monitored by The Director of Nursing, The Assistant Director of Nursing or a Licensed Nurse Manager weekly for 12 weeks. 4. An ADHOC Quality Assurance Performance Improvement Committee Meeting was held on 5/2/25 and the plan of correction was presented to them by the Director of Nursing. The Director of Nursing and/or the Assistant Director of Nursing will present the results of the quality monitoring monthly for 3 months to The Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Compliance Date: 6/11/25	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		6/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 62 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to record opened dates on multi-dose oral inhalers and label and date opened multi-dose bottles of eye drops on 3 of 4 medication carts (400 Hall, 200 Hall, and 300 Hall) reviewed for medication storage. Findings included: 1. An observation was made of the 400 Hall medication cart on 05/01/25 at 2:35 PM in the presence of Medication Aide (MA) #1. The observation revealed the following: (a). An opened and undated 7.5 milliliter (ml) multi-dose bottle of Neomycin and Polymyxin	F 761	1.The unlabeled, undated medications were discarded by the Director of Nursing on 5/2/25. The medications that were removed from the 400 medication cart were as follows: An opened and undated 7.5 milliliter (ml) multi-dose bottle of Neomycin and Polymyxin (antibiotics) eye drops were stored on the medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding on or before the expiration date. An opened and undated multi-dose bottle of Prednisolone Acetate (steroid) 1% eye drops was stored on the medication cart.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 63 (antibiotics) eye drops were stored on the medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding on or before the expiration date. (b). An opened and undated multi-dose bottle of Prednisolone Acetate (steroid) 1% eye drops was stored on the medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding them on or before the expiration date. (c). An opened, undated, and unlabeled 15 ml multi-dose bottle of Polyethylene Glycol 400 4% and Propylene Glycol 0.3% (eye lubricants) was stored on the medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding on or before the expiration date. (d). An opened and undated multi-dose oral inhaler containing Fluticasone Propionate (a steroid) 250 micrograms (mcg) and Salmeterol Xinafoate (medication to keep airways open) 50 mcg was stored on the medication cart. The manufacturer recommended discarding one month after opening the foil pack. (e). An opened, undated, and unlabeled multi-dose oral inhaler containing Fluticasone Propionate 250 mcg and Salmeterol Xinafoate 50 mcg was stored on the medication cart. The medication did not include the name of the resident it had been dispensed for. The manufacturer recommended discarding one month after opening the foil pack. An interview with MA #1 on 05/01/25 at 2:35 PM	F 761	The manufacturer recommended dating the eye drops when they were opened and discarding them on or before the expiration date. An opened, undated, and unlabeled 15 ml multi-dose bottle of Polyethylene Glycol 400 4% and Propylene Glycol 0.3% (eye lubricants) was stored on the medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding on or before the expiration date. An opened and undated multi-dose oral inhaler containing Fluticasone Propionate (a steroid) 250 micrograms (mcg) and Salmeterol Xinafoate (medication to keep airways open) 50 mcg was stored on the medication cart. The manufacturer recommended discarding one month after opening the foil pack. An opened, undated, and unlabeled multi-dose oral inhaler containing Fluticasone Propionate 250 mcg and Salmeterol Xinafoate 50 mcg was stored on the medication cart. The medication did not include the name of the resident it had been dispensed for. The manufacturer recommended discarding one month after opening the foil pack. The medications that were removed from the 200 cart were as follows: An opened and undated multi-dose oral inhaler containing Fluticasone Propionate 100 mcg and Salmeterol 50 mcg was stored on the medication cart. The manufacturer recommended discarding one month after opening the foil pack. The medications that were removed from the 300 cart were as follows: . Two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 64 revealed she was not sure why the eye drops and inhalers did not have an opened date or why the Fluticasone Propionate and Salmeterol Xinafoate inhaler did not have a resident name on it. 2. An observation of the 200 Hall medication cart was conducted in the presence of Nurse #5 on 05/01/25 at 2:56 PM. The observation revealed the following: (a). An opened and undated multi-dose oral inhaler containing Fluticasone Propionate 100 mcg and Salmeterol 50 mcg was stored on the medication cart. The manufacturer recommended discarding one month after opening the foil pack. An interview with Nurse #5 on 05/01/25 at 2:56 PM revealed all multi-dose oral inhalers should be dated when opened and she did not notice the inhaler did not have a date. 3. An observation of the 300 Hall medication cart was conducted in the presence of Medicatio Aide (MA) #2 on 05/01/25 at 3:11 PM. The Assistant Director of Nursing (ADON) was also present for part of the observation. The observation revealed the following: (a). Two opened and undated 2.5 ml bottles of Latanoprost 125 micrograms (mcg) were stored on the medication cart. The manufacturer recommended dating the medication when opening and discarding within 6 weeks after opening. (b). An opened and undated 5 ml bottle of Levobunolol 0.5% drops (drops that lower pressure inside the eye) was stored on the	F 761	opened and undated 2.5 ml bottles of Latanoprost 125 micrograms (mcg) were stored on the medication cart. The manufacturer recommended dating the medication when opening and discarding within 6 weeks after opening. An opened and undated 5 ml bottle of Levobunolol 0.5% drops (drops that lower pressure inside the eye) was stored on the medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding on or before the expiration date. An opened and undated multi-dose oral inhaler containing Umeclidinium 62.5 mcg and Vilanterol 25 mcg (medications used to relax airways) was stored on the medication cart. The manufacturer recommended dating the inhaler when removing from the foil pack and discarding the medication 6 weeks after opening. An opened and undated multi-dose oral inhaler containing Fluticasone Propionate 250 mcg and Salmeterol Xinafoate 50 mcg was stored on the medication cart. The manufacturer recommended discarding one month after opening the foil pack. An opened and undated multi-dose oral inhaler containing Olodaterol (medication used to relax airways) 2.5 mcg was stored on the medication cart. The manufacturer recommended discarding within 3 months of first use. 2. A quality review was completed by the Director of Nursing and/or Assistant Director of Nursing on current prescribed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 65 medication cart. The manufacturer recommended dating the eye drops when they were opened and discarding on or before the expiration date. (c). An opened and undated multi-dose oral inhaler containing Umeclidinium 62.5 mcg and Vilanterol 25 mcg (medications used to relax airways) was stored on the medication cart. The manufacturer recommended dating the inhaler when removing from the foil pack and discarding the medication 6 weeks after opening. (d). An opened and undated multi-dose oral inhaler containing Fluticasone Propionate 250 mcg and Salmeterol Xinafoate 50 mcg was stored on the medication cart. The manufacturer recommended discarding one month after opening the foil pack. (e). An opened and undated multi-dose oral inhaler containing Olodaterol (medication used to relax airways) 2.5 mcg was stored on the medication cart. The manufacturer recommended discarding within 3 months of first use. An interview with MA #2 on 05/01/25 at 3:11 PM revealed all opened medication should have an opened date and he was not sure why the eye drops and inhalers were undated. An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed all opened medications should be labeled with the resident's name and date they were opened by the staff member who opened the medication. The DON stated third shift was responsible for checking medication carts nightly to ensure all medications	F 761	medications to ensure all medications have been dated and labeled upon opening and have not passed the manufactures recommendations storage or expiration on 5/2/25 on all medication carts and in the medication storage room. No other issues were identified. 3. On 5/21/25 through 5/28/25, the Director of Nursing and/or the Assistant Director of Nursing re-educated all licensed nurses and medication aides regarding medication storage to include dating upon opening and returning medications after manufacturers recommended storage time has expired. Any licensed nurses or medication aides who were unavailable during the education period will have the same education prior to their next shift. This facility does not use agency staff. The same education packet will be placed into the licensed nurse and Medication Aide in-service education book for new hires and will be included in new hire orientation for licensed nurses and medication aides to be given by the Director of Nursing or the Assistant Director of Nursing. Starting on 5/30/25 the Director of Nursing, the Assistant Director of Nurses or a Unit Manager will conduct random Quality Reviews of medication carts and medication storage room to ensure current medications are dated, labeled and stored per the manufactures recommendations 2 times a week for 8 weeks then weekly for 4 weeks. 4. An ADHOC Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 66 were labeled and dated and the staff member assigned to the medication cart was also responsible for ensuring medications were labeled and dated. An interview with the Administrator on 05/01/25 at 5:39 PM revealed she expected all medications to be labeled and dated at the time they were opened.	F 761	Performance Improvement Committee Meeting was held on 5/2/25 where the Executive Director introduced the plan of correction. The results of the quality monitoring will be presented to the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Assurance Performance Improvement Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. 5. Compliance Date: 6/13/25	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and	F 803		6/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 67 ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with staff, the facility failed to follow the meal spreadsheet and posted menu when they ran out of a food item while plating meals. This deficient practice impacted 7-9 residents who did not receive regular consistency carrots for their lunch meal. Findings included: The facility's menu spreadsheet for the lunch meal dated 4/29/25 was reviewed. The spreadsheet read Swedish meatballs with gray, buttered noodles, and sliced carrots. On 4/29/25 at 11:40 AM an observation of the lunch meal tray line found the posted lunch meal was Swedish Meatballs with gravy, buttered noodles, and carrots. An observation of the tray line on 4/29/25 at 12:12 PM found the Cook plating the last available serving of regular consistency carrots from the trayline.	F 803	1. The cook was educated by the Food Services Director on 5/2/25 on the need to inform him of any potential shortages of food prior to preparing the meal so it can be discussed, so the residents can be informed in advance. 2. On 5/2/25, the Food Services Director and the District Manager for HealthCare Services Group conducted an audit in which they reviewed the menus for the upcoming week and compared them to the food on hand to ensure that there was enough food for each menu. There were no issues identified. 3. On 5/27/25, the District Manager for HealthCare Services Group provided education to the Dietary Staff on stressing the importance of accurate meal preparation to ensure enough food is prepared to serve all residents adequate portions for each meal. In addition, the Dietary Staff were in serviced on 5/27/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 68 On 4/29/25 at 12:14 PM the Cook stated there were not enough regular consistency carrots to finish serving the 300 hall residents (7-9) for the meal. The Cook said she had used all the carrots available in the kitchen for the meal. She also said the District Dietary Manager was cooking capri vegetables (mixed vegetables) as a substitute for carrots. On 4/29/25 at 12:16 PM the District Dietary Manager was observed cooking the capri vegetables. On 4/29/25 at 12:17 PM the Cook stated she normally needed 6 bags of carrots to prepare a meal for all the residents, and she only had 5 bags to use for the lunch meal. An observation on 4/29/25 at 12:22 PM found the substituted capri vegetable were placed on the tray and the Cook resumed plating the lunch meal with the capri vegetables. On 4/29/25 at 12:35 PM the Cook stated she did not notify the Dietary Manager that she might not have enough carrots for the meal until the lunch meal tray line had started. The Dietary Manager stated on 5/01/25 at 1:43 PM the cook should have notified the Dietary Manager when she was preparing the meal. The Dietary Manager stated the facility would have purchased more carrots from a store to make sure there were enough for the meal. The Administrator was interviewed on 5/01/25 at 5:24 PM. She stated the posted menu should be followed and accurate. The Administrator stated	F 803	regarding the requirement to notify the Residents of a menu item change and to ensure portion sizes were adequate. Any dietary staff members that were unavailable during the education were provided the education prior to their next shift. Agency staff is not utilized by this facility. The education packet will be placed into the staff in-service education book and will be included in new hire orientation for Dietary Staff. The portion control/menu notification corrective action will be monitored by the Food Services Director/Designee five (5) times a week for four (4) weeks then weekly for eight (8) weeks. The monitors will be presented to the Quality Assurance Committee each month. 4.The results of the quality monitoring will be presented to the Quality Assurance Performance Improvement Committee monthly for 3 months by the Food Services Director or the Executive Director. The Quality Assurance Performance Improvement Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 69 the cook should have communicated to the DM there were not enough carrots when she first knew the amount on hand was not going to be enough.	F 803	5. Compliance Date 6/11/25.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove food stored past the use by date from the dry goods storage area. Additionally, the facility failed to clean a circulatory fan cover and prevent water from dripping onto stored food in 1 of 2 kitchen refrigerators (the walk-in refrigerator). This practice had the potential affect food served to residents.	F 812	1. All expired and undated food items were removed and discarded on 5/1/25 by the Food Services Director. There were no Residents affected by the alleged deficient practice. The circulatory fan was cleaned by the Maintenance Director on 4/29/2025. The leaking pipe in the walk-in fridge was assessed by Asheville Refrigeration as condensation and 3 feet of insulation and insulation tape placed by	6/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 70 The findings included: a. On 4/27/25 at 10:20 AM an observation of the dry goods storage area's bread rack with a fill in Dietary Manager (DM #2) from a sister facility found stored bread past the use by date. DM #2 stated the facility's Dietary Manager (DM #1) was not available on 4/27/25, and he was filling in for the day. The bread rack contained 8 loaves of sliced bread with a use by date of 4/25/25 and 3 packages of hamburger buns with a use by date of 4/23/25. The DM #2 stated during the observation the procedure was to remove the bread from the brad rack and place it into the freezer before the use by date. The DM #2 stated the DM #1 was responsible for ensuring the bread was removed before the use by date. b. On 4/27/25 at 10:27 AM an observation of the walk-in refrigerator with the fill in DM #2 found the refrigeration unit leaking water. The water was a steady drip coming from a pipe connected to the back of the refrigeration unit to the wall. The water was dripping onto a lid of a container labeled pickles, and water was observed on the floor of the walk-in refrigerator. The circulatory fan cover was also observed to contain a thick buildup of crumbly black and gray substance on the cover. The DM #2 stated he did not know how long the refrigerator unit had been dripping water and would notify maintenance about the water and the fan cover. The DM #1 was interviewed on 5/1/25 at 1:43 PM. He stated he had not seen the refrigerator unit dripping water before and the circulatory fan cover would be included on a regular cleaning schedule. The DM #1 said the bread was ultimately his responsibility to ensure it was	F 812	a contract worker corrected the issue on 4/30/25 2. The kitchen and nourishment room were inspected on 5/2/25 by the HealthCare Services Group District Manager to ensure food items were labeled with the open date, stored properly and any expired food products were discarded. The walk in refridgerator and the circulatory fan were inspected by the Executive Director on 4/30/24 with no issues noted at that time. 3. The District Manager for Healthcare Services Group provided the kitchen staff with education on 5/27/25 to discuss the importance of correctly labeling opened products, proper storage of food products as well as discarding expired food items. Any staff members who were not available during the education will receive the education prior to their next shift. Newly hired staff will be provided with the learning module during orientation. The plan of correction will be monitored by the Food Services Director five (5) times per week for four (4) weeks and then three (3) times per week for eight (8) weeks. The monitors will be presented to the Quality Assurance Committee each month. The Food Services Director was educated on 4/30/25 by the Executive Director to place an order in the TELS system that goes to the Maintenance Director re: any issues with dietary equipment, such as potentially leaking pipes and/or dirty circulatory fans. Included in the education was to follow up with the Executive Director if no action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 71 frozen by the use by date. The Maintenance Supervisor was interviewed on 5/1/25 at 2:00 PM. She stated a refrigerator repair company was called and came to the facility on 4/28/25 to fix the water leak and she had not been aware of the leaking water prior to 4/28/25. The Maintenance Supervisor stated a pipe was not fully insulated and was causing condensation to drip and was fixed. The Maintenance Supervisor stated the fan cover was not on a routine cleaning schedule, and she would include it. The Administrator was interviewed on 5/1/25 at 5:24 PM. She stated the bread should have been removed or frozen by the use by date and the walk-in refrigerator fan cover should be cleaned routinely. She also stated the water dripping from the refrigeration unit should be repaired to prevent any potential contamination of food.	F 812	takes place within 24 hours. The Maintenance Director and Assistant Maintenance Director were educated on 4/30/25 to respond promptly to any issues in the kitchen as it has the potential to affect all residents in the facility. All were present for this education. This same education will be provided to any newly hired Food Services Director, Maintenance Director or Maintenance Assistant during their orientation period. A monitor will be completed by the Executive Director and/or the Maintenance Director weekly for 12 weeks to ensure there are no leaks or condensation in the walk in cooler or the freezer and that there is no dirt or dust build up on the circulatory fan. 4. The results of the quality monitoring will be presented to the Quality Assurance Performance Improvement Committee monthly for 3 months by the Food Services Director or Executive Director. The Quality Assurance Performance Improvement Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. 5.Compliance Date: 6/11/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		6/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 73 by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain complete and accurate medical records by not documenting when residents admitted to the facility, discharged from the facility or expired at the facility for 3 of 23 sampled residents (Residents #73, #71, and #72). Findings included: 1. The profile page in Resident #73's electronic	F 842	1. Resident #s 71 and 72 no longer reside in the facility. Resident #73s admission assessments were completed on 4/28/25. 2. The Director of Nursing completed an audit on all admissions and discharged patients over the last 60 days to determine other missed opportunities for documentation on 5/11/25. When the audit was conducted, there were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 74	F 842		

medical record revealed she was admitted to the facility on 04/25/25.

Review of the staff progress notes for Resident #73 revealed no entry on 04/25/25 regarding her admission to the facility, such as the time of her arrival, condition or care needs.

An unsuccessful telephone attempt was made 05/01/25 at 2:43 PM to interview Nurse #2 who had provided Resident #73's care on 04/25/25.

During an interview on 04/30/25 at 9:14 AM, the Director of Nursing (DON) stated she would have expected for the nurse to have written a progress note when Resident #73 admitted to the facility that included details such as the time she arrived to the facility and her condition upon arrival. The DON stated it was likely that the nurse just forgot since Resident #73 admitted to the facility after-hours (after normal business hours).

2. The profile page in Resident #71's electronic medical record revealed he was admitted to the facility on 03/11/22.

Review of Resident #71's Minimum Data Set (MDS) assessment history revealed a death in the facility tracking record dated 03/05/25.

Review of the staff progress notes for Resident #71 revealed the last documented staff progress note was an entry dated 03/01/25 at 9:47 AM. There was no entry on 03/05/25 detailing the events of Resident #71's death.

During a phone interview on 05/01/25 at 12:35 PM, Nurse #1 recalled being notified by staff on 03/05/25 that Resident #71 had passed which

numerous descrepancies noted. These descrepancies were not corrected.
3. The Director of Nursing and/or the Assistant Director of Nursing provided education to the Licensed Nurses on 5/21/25 through 5/28/25 to include the review of the federal regulation regarding nursing documentation as related to Admissions/Discharges and will stress the importance that the medical record must contain- Physician's, nurse's, and other licensed professional's progress notes; and laboratory, radiology and other diagnostic services reports. This education also included that the licensed nurse should make observations/assessments of the resident upon admission and discharge, that admission assessments needed to be completed within 24 hours of admission. Upon discharge, observations/assessments need to be done regarding the residents state at the time of discharge (via SBAR/progress note), if the resident understood any discharge instructions if discharging homef and if they understand their medication regimin, if medications or prescriptions were provided at the time of discharge, and notification of the family/responsible party and medical provider if there was a discharge related to a death. Any Licensed Nurses who were unavailable during the education period will have the education prior to their next shift. This facility does not use agency staff. This same education packet will be placed into the staff in-service education book and will be required during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 75	F 842		

she confirmed upon her assessment. Nurse #1 stated she should have written a progress note detailing the events of his death and was not sure why she had not.

During an interview on 04/30/25 at 9:14 AM, the Director of Nursing (DON) stated she would have expected for the nurse to have written a staff progress note when Resident #71 passed away that included details such as how he was found, the time of death and that the funeral home, Responsible Party and provider were all notified.

3. The profile page in Resident #72's electronic medical record revealed he was admitted to the facility 02/28/25.

The discharge return not anticipated Minimum Data Set (MDS) assessment dated 03/03/25 indicated Resident #72 discharged home.

Review of staff progress notes for Resident #72 on 03/03/25 revealed no documentation of his discharge home. Further review of Resident #72's medical record revealed all applicable discharge notices were issued as required.

Review of the schedule revealed a medication aide (MA) was assigned to care for Resident #72 on 03/03/25 and Nurse #3 and Nurse #4 were assigned to oversee the MA.

A telephone interview with Nurse #3 revealed she did not specifically remember working on 03/03/25 but if a MA was assigned to care for a resident and was discharged home, she or another nurse was responsible for writing a discharge note. She was unable to state why there was no discharge note for Resident #72 on

new hire orientation for Licensed Nurses. The nursing staff admission/discharge documentation corrective action will be monitored by Nursing Leadership 2 times weekly for 12 weeks
to include monitoring for completed admission assessments, documentation re: residents condition at the time of discharge, the resident/family understanding of medication administration if discharging home and documentation related to circumstances of death or discharge to the hospital with notification of the resident and/or the responsible party.

4. An ADHOC Quality Assurance Performance Improvement Committee Meeting was held on 5/2/25 and the plan of correction was presented to them by the Director of Nursing. The Director of Nursing and/or the Assistant Director of Nursing will present the results of the quality monitoring monthly to The Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will review the monitoring plan monthly for 3 months and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 76 03/03/25. Nurse #4 was unavailable for interview during the investigation. An interview with the Director of Nursing (DON) on 04/30/25 at 9:17 AM revealed any time a resident was discharged home there should be a nurse's note including what time the resident left, who they left with, any complaints or concerns they may have had, and their condition at the time they left the facility. A follow-up interview with the DON on 05/01/25 at 4:38 PM revealed if a MA was working and a resident discharged home, it was the responsibility of nurse who was overseeing the MA to write a discharge note and she was not sure why there was not a discharge note for Resident #72 on 03/03/25. An interview with the Administrator on 05/01/25 at 5:39 PM revealed she expected a nurse's note to be included in a resident's medical record including their status at discharge.	F 842	5. Compliance Date: 6/17/25	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.	F 851		6/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 77 §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 78 §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit accurate payroll data on the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) related to Registered Nurse (RN) hours and licensed nursing coverage 24-hours per day. This was for 1 of 3 quarters reviewed for sufficient nurse staffing (Quarter 1: October 1-December 31, 2024). Findings included: The PBJ report for the Fiscal Year Quarter 1 2025 (October 1 through December 31, 2024) revealed there were no Registered Nurse (RN) hours for 10/12/24, 10/13/24, 11/17/24, 12/14/24, 12/15/24, and 12/22/24. The PBJ report also noted the facility failed to have licensed nursing coverage 24 hours a day for 10/12/24, 10/13/24, 11/09/24, 11/10/24, 11/17/24, and 12/14/24. The daily staff schedules for 10/12/24, 10/13/24, 12/14/24, 12/15/24, and 12/22/24 revealed there was a RN onsite for at least 8 hours a day. Further review revealed on 11/17/24 there was no RN onsite for at least 8 hours a day. The nursing staff time detail reports for 10/12/24,	F 851	1. After review of the payroll ledgers and schedules, the facility could not provide sufficient data to satisfy that there was a Registered Nurse on duty for 8 hours a day on 10/12/2024, 10/13/2024, 11/17/2024, 12/14/24, 12/15/24, and 12/22/24 nor could the facility provide sufficient data to satisfy that were was a licensed nurse for 24 hours a day on 10/12/24, 10/13/24, 11/09/24, 11/10/24, 11/17/24, and 12/14/24. 2. On 5/11/25, the Executive Director and the Human Resources Director reviewed all of the payroll ledgers and schedules for the last 90 days to ensure that there was an RN on for at least 8 hours per day and a licensed nurse on duty for 24 hours a day and there were no issues noted. 3. The Executive Director provided education to the Director of Nursing, Assistant Director of Nursing, Nurse Managers, Human Resources Coordinator and the Nursing Scheduler on 5/6/25, (all of whom were present) stressing the importance of ensuring a Registered Nurse staff member is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 79 10/13/24, 11/17/24, 12/14/24, 12/15/24, and 12/22/24 revealed there was no RN onsite for at least 8 hours a day. The daily staff schedules revealed there was no licensed nursing coverage at the facility 24 hours a day on 10/12/24 and 10/13/24. Further review revealed there was licensed nursing coverage at the facility 24 hours a day on 11/09/24, 11/10/24, 11/17/24, and 12/14/24. The nursing staff time detail reports revealed there was no licensed nursing coverage at the facility 24 hours a day on 10/12/24, 10/13/24, 11/09/24, 11/10/24, 11/17/24, and 12/14/24. During an interview on 04/28/25 at 10:26 AM, the Regional Vice President of Operations revealed for the dates of 10/12/24, 10/13/24, 11/09/24, 11/10/24, 11/17/24, 12/14/24, 12/15/24, and 12/22/24, the facility did have an RN 8 hours a day and licensed nursing coverage for 24 hours a day. He explained the facility did not use agency staffing and on the above dates, the Administrator at the time, who was an RN, and Director of Nursing both worked shifts as nurses on various days but since they were both salaried they did not clock in or out and their hours would not show on the time detail reports. He stated the corporate office had to manually adjust and input any hours salaried nursing staff worked covering shifts. He explained when nurses from sister facilities worked shifts at this facility, their hours would not show up on the time detail reports because they were only able to clock in and out at their home facility. He stated the corporate office had to manually adjust their hours from the home facility and input the hours at the facility where they had worked. The Regional Vice President of	F 851	scheduled for eight hours a day/seven days a week. In addition, the education included the importance of ensuring that there is a licensed nurse on duty 24 hours a day, 365 days a year. This facility do not use agency staff. The education packet will be placed into the staff in-service education book and will be included in new hire orientation for the Director of Nursing, Assistant Director of Nursing, Nurse Managers, Human Resources Coordinator Nursing Scheduler. The Director of Nursing educated all licensed nurses between 6/6/2025 through 6/10/25 on not leaving the building if they were not relieved by a licensed nurse. The licenses nurses were educated to call the nurse on call or the Director of Nursing (in case of no answer by the nurse on call) so someone could be assigned to relieve them as soon as possible. Any licensed nurses that were unavailable during the education period will be educated prior to their next shift. The facility does not use agency staff. This education packet will be placed into the staff in-service book for all newly hired licensed nurses. The scheduling corrective action will be monitored by Nursing Leadership weekly for 12 weeks. The monitors will be presented to the Quality Assurance Committee each month. 4. An ADHOC Quality Assurance Performance Improvement Committee Meeting was held on 5/2/25 and the plan of correction was presented to them by the Director of Nursing. The Director of Nursing and/or the Assistant Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 80 Operations revealed the corporate office was not always consistent with the process of manually adjusting and inputting nursing staff hours for payroll data to accurately reflect nursing staff coverage on the PBJ reports submitted to CMS which was why no RN coverage and no licensed nursing staff coverage triggered.	F 851	Nursing will present the results of the quality monitoring monthly for 3 months to The Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct caregiver. 5. Compliance Date: 6/13/25	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		6/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 81 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 82 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement their infection control policies when Nurse Aide (NA) #3 did not don (put on) a gown while providing urinary catheter (a tube that drains urine out of the body) care to Resident #65 who required enhanced barrier precautions (EBP) and failed to follow their Hand Hygiene policy when NA #3 did not remove soiled gloves and perform hand hygiene before applying a clean brief and touching other items in the resident's environment while providing incontinence care to Resident #65. This deficient practice occurred for 1 of 4 staff members observed for infection control practices (NA #3). Findings included: Review of the facility's Hand Hygiene policy last revised 02/05/21 read in part as follows: "The CDC [Centers for Disease Control] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel). Hand Hygiene should be performed before initiating a clean procedure, after contact with body fluids or excretions, when hands are moved from a contaminated-body site to a clean body	F 880	1. Certified Nurses Aide #3 was terminated on 5/1/24. 2. An audit of Certified Nurses Aides files, the facility was unable to locate hand hygiene competencies for any certified nurses aides. The audit was conducted by the Director of Nursing and the Assistant Director of Nursing on 5/6/25. 3. The Director of Nursing and/or the Assistant Director of Nursing provided education to the Nursing staff (Licensed Nurses and Certified Nurses Aides) on 5/21/25 through 5/28/25 to include the review of the facilities Enhanced Barrier Policy and will stress the importance of briefly reviewing the signage on the door to refresh their memory of the need for appropriate personal protective equipment (PPE) when coming in close contact with the resident during care. Additionally, the education will include the importance of hand hygiene when moving from a contaminated-body site to a clean body site during patient care and after glove removal. Any Licensed Nurses or Certified Nurses Aides who were unavailable during the education period will have the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 83 site during patient care, and after glove removal." Review of the facility's Enhanced Barrier Precautions (EBP) policy last updated in August 2022 read in part as follows: "EBPs are utilized to prevent the spread of multi-drug-resistant organisms (MDROs). EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include device care or use (urinary catheter and feeding tube)." An observation of Resident #65's door on 04/30/25 at 2:39 PM revealed a sign hanging on the door indicating he was on EBP and a shelf containing gowns and gloves was hanging on the door. A continuous observation of NA #3 on 04/30/25 from 2:40 PM until 2:49 PM revealed she performed hand hygiene with alcohol-based hand rub, entered Resident #65's room, applied gloves, pulled back his bed cover, un-fastened his brief, cleaned his penis and urinary catheter with a resident care wipe, discarded the wipe in a trash bag, assisted Resident #65 onto his right side, removed stool with a resident care wipe, rolled the soiled wipe up into the used brief, rolled a clean brief under Resident #65's right side, assisted Resident #65 onto his back, pulled the brief into place and fastened it, placed a pillow under his head and under his right side, pulled his bed cover into place, picked up the bed control and used it to raise the head of his bed, clipped the bed control to his blanket, picked up the soiled brief, placed it in a trash bag, removed her gloves and placed them in the bag, gathered the	F 880	education prior to their next shift. This facility does not use agency staff.This same education packet will be placed into the staff in-service education book and will be required during new hire orientation for Licensed Nurses and Certified Nurses Aides. The nursing staff enhanced barrier protection corrective action will be monitored by Nursing Leadership 2 times weekly for 12 weeks. 4. An ADHOC Quality Assurance Performance Improvement Committee Meeting was held on 5/2/25 and the plan of correction was presented to them by the Director of Nursing. The Director of Nursing and/or the Assistant Director of Nursing will present the results of the quality monitoring monthly for 3 months to The Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will review the monitoring plan monthly and make updates and/or recommendations to the plan. The Quality Assurance Committee consists of, but is not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Social Services Director Medical Director, Maintenance Director Housekeeping/Laundry Manager, Food Service Director, Minimum Data Set Nurse and one direct Caregiver. 5. Compliance Date: 6/11/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 05/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 84	F 880		

trash bag containing the soiled brief, performed hand hygiene with alcohol-based hand rub, and exited resident #65's room. NA #3 did not don a gown before performing urinary catheter care and did not remove gloves and perform hand hygiene after removing stool and before touching other items and surfaces.

An interview with NA #3 on 04/30/25 at 2:50 PM revealed she was not aware that Resident #65 was on EBP, and use of a gown was required when performing catheter care. She also stated she did not usually change her gloves after during incontinence care unless they were visibly soiled with stool, and she did not see any stool on her gloves when she was performing incontinence care for Resident #65.

An interview with the Assistant Director of Nursing (ADON) on 04/30/25 at 3:03 PM revealed staff should wear a gown when providing urinary catheter care according to EBP guidelines. She stated gloves should be removed and hand hygiene should be performed any time there was contact with stool.

An interview with the Director of Nursing (DON) on 05/01/25 at 4:38 PM revealed she expected staff to wear a gown when providing catheter care and gloves should be removed and hand hygiene should be performed after cleaning stool and before touching other items.

An interview with the Administrator on 05/01/25 at 5:39 PM revealed she expected staff to follow EBP signage and the policy for hand hygiene when providing incontinence care.