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	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Sweeten Creek	3864 Sweeten Creek Road Arden, NC 28704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Potential for minimal harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 39037 Based on record review and staff, Responsible Party (RP), and Medical Director interviews the facility failed to notify the Responsible Party of a new diagnosis of pneumonia for 1 of 1 resident reviewed for notification of change (Resident #1). Findings included: Resident #1 was admitted to the facility 09/27/23 with diagnoses including hypertension (high blood pressure) and non-Alzheimer's dementia. Review of Resident #1's Physician orders revealed an order dated 01/25/24 for a chest x-ray due to cough. Resident #1's chest x-ray result dated 01/28/24 revealed Resident #1 had left lower lobe airspace disease (when air spaces are filled with fluid or pus) which could be related to pneumonia or atelectasis (collapse of an area of the lung). A review of Resident #1's medical record revealed there was no documentation that the Responsible Party (RP) was notified of her diagnosis of pneumonia on 01/28/24. An interview with the Unit Manager on 02/26/24 at 5:46 PM revealed she often worked as a floor nurse, and she cared for Resident #1 on 01/28/24 (she could not recall the exact time she cared for Resident #1). She stated Resident #1's RP called the facility frequently for updates and she probably answered the telephone when Resident #1's RP called to check on her and mentioned the chest x-ray results in conversation. She stated she did not have any memory of calling Resident #1's RP to notify her of the chest x-ray results and confirmed there was no documentation in Resident #1's medical record to reflect her RP had been notified of the chest x-ray results on 01/28/24. A telephone interview with Resident #1's RP on 02/27/24 at 9:10 AM revealed in January 2024 (she was unsure of the specific date) she was notified Resident #1 needed a chest x-ray because she was wheezing. The RP stated she kept calling the facility and was told the chest x-ray results had not returned, and one day when she called to check on the x-ray results, she was notified Resident #1 had been diagnosed with pneumonia. She stated no staff member from the facility called to notify her of Resident #1's chest x-ray results from 01/28/24. (continued on next page)

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

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F 0580 Level of Harm - Potential for minimal harm Residents Affected - Some	A telephone interview with the Director of Nursing (DON) on 02/27/24 at 11:34 AM revealed she worked as a floor nurse when needed and she cared for Resident #1 for a period of time on 01/28/24 (she could not recall the exact times when she cared for Resident #1). She stated she did not notify Resident #1's family that her chest x-ray that resulted 01/28/24 showed pneumonia. The DON stated Resident #1's RP should have been notified by nursing staff that her chest x-ray on 01/28/24 revealed pneumonia and she was not sure why the RP was not notified. A telephone interview with the Medical Director on 02/27/24 at 12:03 PM revealed he expected nursing staff to notify the resident or their RP any time the resident had a test that showed abnormal findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on observations, record reviews and staff interviews, the facility failed to ensure a resident's toenails were trimmed for 1 of 3 sampled residents (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included end-stage renal disease and edema. A physician's order dated 09/27/23 for Resident #1 read, Podiatry as needed. A review of Resident #1's Activities of Daily Living (ADL) care plan, last revised on 12/04/23, addressed an ADL self-care performance deficit related to dementia. Interventions included: requires partial to moderate staff assistance with personal hygiene, staff to check nail length, trim and clean on bath day and as necessary, and report any changes to the nurse. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had severe cognitive impairment. Resident #1 required partial to moderate staff assistance with bathing and personal hygiene and displayed no rejection of care during the MDS assessment period. During an interview on 02/26/24 at 10:54 AM, the Social Worker (SW) revealed Podiatry services typically maintained their own schedule for facility clinics and she received an email letting her know the date of the upcoming clinic and which residents would be seen. The SW stated she added residents to the list when nursing staff informed her a resident needed to be seen; however, no one had mentioned anything to her that Resident #1 needed to be seen by the Podiatrist. During an interview on 02/27/24 at 12:46 AM, Nurse Aide (NA) #1 stated she had provided care to Resident #1 on occasion but she was usually dressed and wearing socks by the time she started her shift. NA #1 stated she did not recall observing Resident #1's toenails but when she did notice a resident with long toenails, she informed the nurse. NA #1 stated she would trim a resident's fingernails but did not trim a resident's toenails especially when the toenails were thick. During an interview on 02/27/24 at 1:24 PM, NA #2 explained she didn't trim resident's toenails and when she noticed a resident's toenails were long, she informed the nurse. NA #2 confirmed she was assigned to provide Resident #1's care on 02/27/24 but did not recall observing her toenails. An interview and observation of Resident #1's toenails was conducted with Nurse #1 on 02/27/24 at 2:10 PM. Nurse #1 stated the NAs had not mentioned anything to her about Resident #1's toenails needing trimmed. Nurse #1 explained typically the NAs would let her know when a resident's toenails were too long and if needed, she would inform the SW for the resident to be placed on the list to be seen by Podiatry. Nurse #1 removed Resident #1's socks off both feet and confirmed the toenails on both of Resident #1's big toes extended approximately 1/2 inch past the tip of the toe. Nurse #1 stated since the toenails on both big toes were thick, they would need to be trimmed by the Podiatrist and she would inform the SW. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 02/27/24 at 2:32 PM, the Director of Nursing (DON) explained a resident was referred to Podiatry for a toenail trim when they were diabetic or had thick toenails. The DON stated NAs should be observing resident's feet when providing daily care, shower or bed bath and reporting to the nurse when the resident's toenails needed trimmed. The DON stated she could understand the NA overlooking Resident #1's toenails at first but for them to have grown out a 1/2 inch past the tip of the toe, she would have expected for the NA to have noticed and informed the nurse, SW or herself so that a podiatry consult could have been made.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37538 Based on record review, observations, and interviews with staff the facility failed to store an unopened insulin pen in the refrigerator until needed for use for 1 of 4 medication carts (200/300 Hall medication cart) and failed to remove medicated mouthwash by the date it was to be discarded from 1 of 1 medication refrigerator reviewed for medication storage. Findings included: 1. Review of manufacturer's package insert recommended to store unused (unopened) insulin aspart in a refrigerator between 36 F to 46 F and in-use (opened) insulin at room temperature for 28 days. An observation of the 200/300 Hall medication cart was conducted with the Unit Manager (UM) on 2/26/24 at 3:54 PM. Stored on the medication cart and available for use was an unopened insulin aspart (fast-acting) pen. There was no date on the insulin pen to indicate when it was placed on the medication cart. During an interview on 2/26/24 at 3:54 PM the UM revealed the insulin aspart pen should be kept in the designated medication refrigerator until needed for use. She stated the nurses were expected to label the pen with the date it was removed from refrigerator or put on medication cart and was discarded after being in use for 28 days. The UM stated her, or the Director of Nursing (DON) completed the audit reviews of the medication carts three times a week that included to ensure insulin pens were dated. She revealed the nurses received the medications delivered from the pharmacy and placed insulin in the refrigerator in the medication room or on the med cart if needed. During an interview on 2/27/24 at 2:59 PM the DON revealed her, and the UM checked the for expired medications and she was unsure why an unopened insulin pen with no date was stored on the med cart. 2. An observation of the refrigerator located in the medication storage room was conducted on 2/26/24 at 4:49 PM with the UM. Two bottles of medicated mouthwash were stored in the refrigerator and available for use. The labels on the back of the medicated mouthwash indicated one of the bottles was to be discarded on 1/1/24 and the other on 1/9/24. During an interview on 2/26/24 at 4:49 PM the UM stated the facility had one medication storage room and either her or the DON check the refrigerator for expired medications. The UM stated the medicated mouthwash should be discarded, and she removed both bottles from the refrigerator and placed them in the return to pharmacy bin. The UM stated she did not see the discard date label located on the back of the bottles of mouthwash, and she just checked the front label for the expiration date. The UM revealed she was not aware medicated mouthwash had a time limit to be discarded after it was delivered by the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 2/27/24 at 2:59 PM with the DON revealed her and the UM checked the refrigerator in the medication storage room for expired meds. She stated she must have checked the expiration date on the front label of the bottles and did not see the discard date located on the back. The DON revealed she was not aware medicated mouthwash had a time limit to be discarded after it was delivered by the pharmacy. She stated going forward she would know to check medicated mouthwash for a discard date. During an interview on 2/27/24 at 4:49 PM the Administrator stated the monitoring tools did not meet the standards for medication storage if deficiency was found and he was not sure what the breakdown in the process was.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37538 Based on record review, observations, and staff interviews the facility failed to: 1) maintain a clean and sanitary kitchen; 2) failed to remove gloves and perform hand hygiene after handling dirty dishes; 3) failed to date opened food items stored in the walk-in refrigerator ready for use; 4) failed to discard thickened juice by the date it could no longer be used; and 5) failed to seal and date an open bag of cereal for 1 of 1 kitchen. These practices had the potential to affect ninety-one (91) residents who resided in the facility. Findings included: The initial walk-through observation of the kitchen was conducted on 2/26/24 from 9:05 AM through 10:06 AM with the Dietary Manager (DM). The observations revealed the following: 1 a. During an observation on 2/26/24 at 9:14 AM a metal table with sliding cabinet doors used to store hot and cold beverage serving containers appeared dirty. The tracks on the metal table used to open and shut the cabinet doors had a thick buildup of black colored debris all along the tracks and the inside of the cabinets had crumb-like and paper debris throughout the cabinet shelves. b. During an observation on 2/26/24 at 9:14 AM a heavy-duty can opener attached to a metal table had a buildup of thick black colored debris on the sharp end used to puncture metal cans of food. c. During an observation on 2/26/24 at 9:28 AM the wall directly above the dishwasher sink where dirty dishes were rinsed had a large black colored stain. d. During an observation on 2/26/24 at 9:46 AM the floor in the walk-in refrigerator and freezer cooler appeared dirty. There was a thick black colored build-up of debris at the threshold of the door between the refrigerator and freezer. There was an empty plastic container and other crumb-like debris on the floor in the freezer underneath the shelving where food was stored. e. During an observation on 2/26/24 at 10:06 AM the dry storage room along the lower portion of wall behind the shelving where food was stored appeared dirty in multiple areas. There were stains that appeared as a liquid substance was spilled on the wall and left to dry. The areas of floor along the wall molding underneath the shelving where food was stored had a thick black colored buildup of debris in multiple areas. An interview with the DM conducted on 2/26/24 at 10:06 AM revealed Dietary Staff were responsible for cleaning kitchen equipment and the Cooks were responsible for the daily sweeping and mopping the floors and he was responsible for checking the cleanliness of the kitchen. The DM revealed he was newly hired and since he took over the kitchen on 2/21/24 he was still getting familiar with things. He revealed since he started several dietary staff did not show up for work and if he did not find someone to cover their shift it was his responsibility and he had worked extended hours on multiple occasions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2) During an observation of the dishwasher in use on 2/26/24 at 9:28 AM Dietary Aide (DA) #1 was washing and rinsing off dirty dishes that she loaded onto racks and sent through the dishwasher. DA #1 was wearing gloves while she washed and rinsed three racks of dirty dishes. After the dishware completed the wash and rinse cycles DA #1 moved from dirty side to the clean side and began to unload the clean dishes. DA #1 did not wash her hands after handling dirty dishes and wore the same gloves she used to wash and rinse dirty dishware to unload the clean dishes. An interview was conducted on 2/26/24 at 9:36 AM with DA #1. DA #1 stated typically she would remove her gloves and wash her hands after handling dirty dishes. DA #1 stated hand hygiene was done to prevent cross contamination from dirty dishes to clean. During an interview on 2/26/24 at 2:34 PM the Regional Dietary Manager stated when washing dishes dietary staff were supposed to remove their gloves and wash their hands before going to the clean side of the dishwasher and receive training about cross contamination. 3. During an observation of the walk-in refrigerator on 2/26/24 at 9:46 AM opened food and beverage items did not have visible dates to determine when it was open, or how long it should be served to residents included the following: a. Half a block of Swiss cheese slices opened and wrapped in plastic. b. One-fourth of block of American cheese slices opened and wrapped in plastic. c. One open 8-ounce carton of milk. d. A small bowl of apple sauce wrapped in plastic. e. A thawed 4-ounce chocolate shake supplement. During an interview on 2/26/24 at 9:46 AM the DM stated when food items were open dietary staff were to write the date it was opened and use by date on the item. He revealed it depended on the product how long it could be in use and served to residents. He stated the use by date for cheese was 7 days and supplement shakes were used 14 days after thawed. He was unsure why a small bowl of applesauce and one open 8-ounce carton of milk were in the refrigerator and stated those should have been dated. 4. During an observation of the walk-in refrigerator on 2/26/24 at 9:46 AM an opened 46 fluid ounce container of thickened orange juice was available for use with an open date 2/7/24 but no use by date. During an interview on 2/26/24 at 9:46 AM the DM stated thickened orange juice should be discarded after being in use for 14 days and should have been removed from the refrigerator on 2/21/24. 5. An observation of the dry storage room revealed on 2/26/24 at 10:06 AM a large bag of rice crispy cereal was not sealed and left open to air with no date. During an interview on 2/26/24 at 10:06 AM the DM stated when cereal was opened it was put in plastic container and label with the date it was open and the date it should be use by. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 2/26/24 at 2:34 PM the Regional Dietary Manager observed the areas identified for cleanliness. She stated the stain on the wall by dishwasher was an ongoing issue and maintenance would be informed. She stated dietary staff were expected to clean as needed and the metal storage cabinet tracking should be cleaned once a week to prevent buildup of debris and the can opener daily after each use. She stated the floors should be swept and mopped daily and deep cleaned once a week to prevent debris buildup. She revealed the kitchen cleaning schedule included daily tasks to complete and stated she was going to update the schedule to ensure tasks were specifically assigned to a dietary staff member. During an interview on 2/27/24 at 4:49 PM the Administrator revealed he officially started his position on 2/10/24. He stated after the last survey (01/16/24) there were no citations related to dietary or the kitchen and was not his focus. He stated cleanliness and the other issues discussed should be addressed as part of the daily routine of maintaining the kitchen.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on [DATE]. This was for a repeat deficiency in the area of label/store drugs and biologicals that was originally cited during the recertification survey completed on [DATE] and subsequently recited during the revisit and complaint investigation completed on [DATE]. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F761: Based on record review, observations, and interviews with staff the facility failed to store an unopened insulin pen in the refrigerator until needed for use for 1 of 4 medication carts (,d+[DATE] Hall medication cart) and failed to remove medicated mouthwash by the date it was to be discarded from 1 of 1 medication refrigerator reviewed for medication storage. During the recertification survey of [DATE], the facility failed to secure an opened tube of antifungal cream, label insulin pens stored in the medication cart with the date they were opened and remove expired over-the-counter medications in accordance with the manufacturer's expiration date. During an interview on [DATE] at 4:50 PM, the Administrator explained since starting at the facility on [DATE], his focus had been on the processes put into place to correct the concerns identified from the recertification survey and he wasn't sure where the breakdown occurred regarding the repeat deficiency. The Administrator stated they did not meet their standards as identified previously by QAPI. He stated the QA committee would be reviewing and discussing the repeat concern and his goal going forward was to make sure they had effective processes in place that met regulatory guidance.