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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345477 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>05/01/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Oaks at Sweeten Creek |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3864 Sweeten Creek Road<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39037</p> <p>Based on observations and staff interviews, the facility failed to label and store personal items in 2 of 6 shared bathrooms (room [ROOM NUMBER] and room [ROOM NUMBER]) and maintain packaged terminal air conditioners (PTACs) in good repair in 6 of 15 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]). These failures occurred on 1 of 4 halls (400 hall) reviewed for home-like environment.</p> <p>Findings included:</p> <p>1. (a). An observation of the shared bathroom of room [ROOM NUMBER] on 04/27/25 at 10:52 AM revealed a plastic basket containing an unlabeled toothbrush sitting on the side of the sink.</p> <p>Additional observations of the shared bathroom of room [ROOM NUMBER] 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.</p> <p>(b). An observation of the shared bathroom of room [ROOM NUMBER] 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.</p> <p>Additional observations of the shared bathroom of room [ROOM NUMBER] 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.</p> <p>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.</p> <p>2. (a). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 10:26 AM revealed multiple broken slats to the top of the unit.</p> <p>Additional observations of the PTAC unit in room [ROOM NUMBER] 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.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>                                   | <p>(b). An observation of the PTAC unit in room [ROOM NUMBER] 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.</p> <p>Additional observations of the PTAC unit in room [ROOM NUMBER] 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.</p> <p>(c). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 11:02 AM revealed multiple broken slats to the top and front of the unit.</p> <p>Additional observations of the PTAC unit in room [ROOM NUMBER] 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.</p> <p>(d). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 11:05 AM revealed multiple broken slats to the top of the unit.</p> <p>Additional observations of the PTAC unit in room [ROOM NUMBER] 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.</p> <p>(e). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 11:19 AM revealed multiple broken slats to the top of the unit.</p> <p>(f). An observation of the PTAC unit in room [ROOM NUMBER] on 04/27/25 at 11:20 AM revealed multiple broken slats to the top of the unit.</p> <p>Additional observations of the PTAC unit in room [ROOM NUMBER] 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.</p> <p>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.</p> <p>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.</p> |   |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37014</p> <p>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).</p> <p>The findings included:</p> <p>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.</p> <p>a. Resident #173 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder and anxiety disorder.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>A telephone attempt on 05/01/25 at 2:43 PM for interview with MA #3 was unsuccessful.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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 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.</p> <p>Resident #173 passed away at the facility on 04/01/25.</p> <p>b. Resident #174 was admitted to the facility on [DATE] with diagnoses that included chronic pain.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 been 23 tablets of Oxycodone left remaining.</p> <p>Resident #17 discharged to the hospital on 02/08/25 and had not returned to the facility at the time of this investigation.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>c. Resident #175 was admitted to the facility on [DATE] with diagnoses that included chronic pain.</p> <p>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.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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 at 6:15 PM.</p> <p>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.</p> <p>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.</p> <p>Resident #175 discharged to the hospital on 02/26/25 and had not returned to the facility at the time of this investigation.</p> <p>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.</p> <p>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.</p> <p>d. Resident #176 was admitted to the facility on [DATE] 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).</p> <p>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.</p> <p>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.</p> <p>The pharmacy proof of delivery shipment summary sheets for Resident #176 revealed the following:</p> <ul style="list-style-type: none"> <li>- 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.</li> <li>- 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.</li> <li>- 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.</li> <li>- 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.</li> </ul> <p>(continued on next page)</p> |   |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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.</p> <p>The January 2025 MAR for Resident #176 further revealed she received a total of 48 tablets of oxycodone 5 mg. The oxycodone was documented as administered per physician order on:</p> <ul style="list-style-type: none"> <li>-01/13/25 at 4:00 PM</li> <li>-01/14/25 at 12:16 AM</li> <li>-01/15/25 at 2:36 AM and 9:54 PM</li> <li>-01/16/25 at 5:31 AM, 11:55 AM and 5:57 PM</li> <li>-01/17/25 at 12:21 AM, 10:28 AM and 5:52 PM</li> <li>-01/18/25 at 12:33 AM, 6:34 AM, 1:04 PM, and 9:35 PM</li> <li>-01/19/25 at 5:42 AM and 10:07 PM</li> <li>-01/20/25 at 9:09 AM, 4:57 PM and 11:44 PM</li> <li>-01/21/25 at 5:48 AM, 12:56 PM and 7:12 PM</li> <li>-01/22/25 at 2:45 AM, 9:09 AM and 3:30 PM</li> <li>-01/23/25 at 2:05 AM, 9:00 AM, 3:23 PM, and 11:58 PM</li> <li>-01/24/25 at 11:11 AM and 5:26 PM</li> <li>-01/25/25 at 8:13 PM</li> <li>-01/26/25 at 7:02 PM</li> <li>-01/27/25 at 2:35 AM, 10:15 AM and 5:12 PM</li> <li>-01/28/25 at 5:10 AM, 12:39 PM and 7:19 PM</li> <li>-01/29/25 at 6:21 AM and 4:54 PM</li> <li>-01/30/25 at 12:16 AM, 6:20 AM, 1:34 PM, and 8:27 PM</li> <li>-01/31/25 at 3:03 AM, 9:57 AM and 7:06 PM.</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>-02/01/25 at 4:06 AM, 10:27 AM, 5:12 PM, and 11:45 PM</li> </ul> <p>(continued on next page)</p> |   |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>-02/02/25 at 5:47 AM, 1:10 PM and 8:26 PM</p> <p>-02/03/25 at 6:00 AM, 12:56 PM and 7:37 PM</p> <p>-02/04/25 at 5:01 AM and 11:01 AM</p> <p>-02/05/25 at 9:11 AM, 3:28 PM and 9:30 PM</p> <p>-02/06/25 at 5:41 AM, 12:50 PM and 8:49 PM</p> <p>-02/07/25 at 5:56 AM, 12:55 PM and 7:50 PM</p> <p>-02/08/25 at 4:28 AM, 10:59 AM, 5:38 PM, and 11:47 PM</p> <p>-02/09/25 at 12:28 PM and 8:15 PM</p> <p>-02/10/25 at 5:02 AM, 11:16 AM, 5:35 PM, and 11:45 PM</p> <p>-02/11/25 at 6:45 PM</p> <p>-02/12/25 at 1:20 AM, 11:45 AM and 5:58 PM</p> <p>-02/13/25 at 5:02 AM and 8:51 PM</p> <p>-02/14/25 at 4:27 AM, 11:19 AM and 6:35 PM</p> <p>-02/15/25 at 2:51 AM and 8:53 PM</p> <p>-02/16/25 at 5:59 AM and 7:13 PM</p> <p>-02/17/25 at 9:43 AM and 5:49 PM</p> <p>-02/18/25 at 6:49 AM, 1:08 PM and 8:23 PM</p> <p>-02/19/25 at 4:06 AM and 10:24 AM.</p> <p>Resident #176 discharged home on 02/19/25.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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 Enforcement was notified.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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. 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.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>A joint interview was conducted with the current DON, Administrator and Regional [NAME] 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 [NAME] 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 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 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.</p> <p>The interview continued with the current DON, Administrator and Regional [NAME] 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 [NAME] 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.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>The facility provided the following corrective action plan with a completion date of 03/06/25:</p> <p>How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>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 [NAME] 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.</p> <p>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 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 [NAME] President of Operations, and the Regional Director of Clinical Services was made aware of this root cause analysis.</p> <p>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.</p> <p>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.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>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:</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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.</p> <ul style="list-style-type: none"> <li>-Pharmacy Delivery Sheets</li> <li>-Destruction History</li> <li>-Current Residents with an order for controlled substances</li> <li>-Discharge Residents that had an order for controlled substances</li> <li>-Controlled Substance Declining Count Sheets, Controlled Substances in Medication Carts</li> <li>-Medication administration records related to controlled substances</li> </ul> <p>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:</p> <p>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.</p> <p>The pharmacy delivery report indicated the 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.</p> <p>The previous DON removed the controlled substance and the declining count sheet from the cart on 02/21/2025.</p> <p>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.</p> <p>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.</p> <p>The pharmacy delivery report indicated the following was delivered to the facility: 01/30/2025 Oxycodone 5mg tablet- 30 pills- 7-day supply.</p> <p>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 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.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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.</p> <p>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.</p> <p>The pharmacy delivery report indicated the following was delivered to the facility: 02/10/2025 Oxycodone 5mg tablet- 28 pills- 7-day supply.</p> <p>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 were 18 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.</p> <p>On 3/4/25, the Pharmacy Account Manager came to the facility to assist with the quality review and concurred with the findings.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur?</p> <p>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.</p> <p>On 3/1/2025, The Director of Nursing and Executive Director began education for licensed 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.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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.</p> <p>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 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:</p> <p>-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 time the controlled substances are inventory count was completed. Only full legible signatures are to be used, NOT INITIALS.</p> <p>-Nurse/Med Aide must count the actual total # of Cards/Containers AND actual total # of count sheets for all supplies in the drawer.</p> <p>-When cards are added, 2 nurses or 1 nurse/1 Med Aide are to [TRUNCATED]</p> |   |  |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45272</p> <p>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.</p> <p>Findings included:</p> <p>Resident #30 was admitted on [DATE] with diagnoses that included Parkinson's disease.</p> <p>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.</p> <p>A review of Resident #30's quarterly Minimum Data Set (MDS) assessment 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.</p> <p>A review of the facility's shower schedule found Resident #30's assigned bath days were Tuesday and Friday.</p> <p>On 4/27/25 at 1:17 PM Resident #30 was observed in his room lying on his bed with approximately 1/2 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>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 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.</p> <p>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.</p> <p>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.</p> |   |  |

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| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>37014</p> <p>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.</p> <p>Findings included:</p> <p>This tag is crossed referenced to:</p> <p>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 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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> |   |  |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37014</p> <p>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).</p> <p>Findings included:</p> <p>1. The profile page in Resident #73's electronic medical record revealed she was admitted to the facility on [DATE].</p> <p>Review of the staff progress notes for Resident #73 revealed no entry on [DATE] regarding her admission to the facility, such as the time of her arrival, condition or care needs.</p> <p>An unsuccessful telephone attempt was made [DATE] at 2:43 PM to interview Nurse #2 who had provided Resident #73's care on [DATE].</p> <p>During an interview on [DATE] 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).</p> <p>2. The profile page in Resident #71's electronic medical record revealed he was admitted to the facility on [DATE].</p> <p>Review of Resident #71's Minimum Data Set (MDS) assessment history revealed a death in the facility tracking record dated [DATE].</p> <p>Review of the staff progress notes for Resident #71 revealed the last documented staff progress note was an entry dated [DATE] at 9:47 AM. There was no entry on [DATE] detailing the events of Resident #71's death.</p> <p>During a phone interview on [DATE] at 12:35 PM, Nurse #1 recalled being notified by staff on [DATE] that Resident #71 had passed which 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.</p> <p>During an interview on [DATE] 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.</p> <p>39037</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>3. The profile page in Resident #72's electronic medical record revealed he was admitted to the facility [DATE].</p> <p>The discharge return not anticipated Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #72 discharged home.</p> <p>Review of staff progress notes for Resident #72 on [DATE] revealed no documentation of his discharge home. Further review of Resident #72's medical record revealed all applicable discharge notices were issued as required.</p> <p>Review of the schedule revealed a medication aide (MA) was assigned to care for Resident #72 on [DATE] and Nurse #3 and Nurse #4 were assigned to oversee the MA.</p> <p>A telephone interview with Nurse #3 revealed she did not specifically remember working on [DATE] 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 [DATE].</p> <p>Nurse #4 was unavailable for interview during the investigation.</p> <p>An interview with the Director of Nursing (DON) on [DATE] 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.</p> <p>A follow-up interview with the DON on [DATE] 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 [DATE].</p> <p>An interview with the Administrator on [DATE] 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.</p> |