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 12/28/2023

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 000	INITIAL COMMENTS A complaint investigation survey was conducted on 12/28/23. Event ID# HH1D11. The following intake was investigated: NC00211251. 5 of the 5 complaint allegations did not result in deficiency.	F 000		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		1/24/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/12/2024

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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§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy,

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resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on

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F 867	Continued From page 3 available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification survey conducted on 6/24/22 and the complaint investigation survey conducted on 5/3/23. This was for a repeat deficiency in the area of infection control that was originally cited on 6/24/22 during the recertification survey, and subsequently recited during the complaint investigation surveys completed on 5/3/23 and 12/28/23. The continued failure of the facility during three 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: F880 - Based on record review, observations and staff interviews, the facility failed to implement their infection control policy when Nurse #1 did not perform hand hygiene after removing soiled dressings with drainage and before donning new gloves to cleanse the wound for 3 of 3 wound care observations on 2 of 2 residents reviewed (Resident #2 and Resident #3). During the recertification and complaint survey on 6/24/22, the facility failed to establish and implement infection control policies and procedures to reduce the risk of growth and spread of Legionella in the building water systems	F 867	The Executive Director held a Quality Assurance Performance Improvement meeting on 1/9/2024 with the Interdisciplinary Team including the Director of Nursing, Unit Manager, Dietary Manager, Housekeeping Supervisor, Minimum Data Set Nurse, Social Services Director, Medical Records Director, and Admissions Director. During this meeting, the Regional Director of Clinical Services along with the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained. Additionally, the Ad Hoc meeting focused on F880 and Infection Control. The discussion included hand hygiene before, during, and after patient care, non-patient care, and before, during, and after wound care/dressing changes. The facility Quality Assurance Performance Improvement Committee reviewed the new plan of correction for maintaining compliance in this area. To prevent the deficient practice from recurring, on 1/2/24 to 1/12/24 the Director of Nursing and/or designee began reeducating facility staff on the facility Infection Control policies and procedures which include, but are not limited to hand hygiene, hand hygiene before, during, and after patient care; hand hygiene after performing non-patient care tasks,	

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which could affect 83 out of 83 residents. In addition, the facility failed to implement infection control policies and procedures when the Staff Development Coordinator failed to perform hand washing after the removal of gloves during wound care for a sampled resident and when Nurse Aide #5 and the Staff Development Coordinator failed to perform hand washing after the removal of gloves following the transfer of a resident observed during a mechanical lift transfer.

During the complaint survey on 5/3/23, the facility failed to implement infection control for hand hygiene when Nurse Aide #1 and Nurse Aide #2 did not remove their gloves and perform hand hygiene after providing incontinence care for a resident observed for incontinence care.

An interview with the Administrator on 12/28/23 at 3:25 PM revealed training on infection control was part of the general orientation for all of their staff and that he expected his staff to do the proper hand hygiene according to their infection control policy. He stated that they had been discussing infection control during their QAA meetings.

F 867

and hand washing during wound care. Staff members reeducated include nursing staff, administrative staff, dietary staff, environmental services staff, and therapy staff. Education was completed on 1/12/2024. Any newly hired staff will be educated during new hire orientation or prior to the start of their first shift. The Director of Nursing and/or Nursing Designee also began conducting hand hygiene assessments with all current staff from 1/2/24 to 1/12/24. Hand hygiene assessments included verbal understanding and discussion of the competency, direct observation, and return demonstration. Any newly hired staff will educated on hand hygiene during new hire orientation or prior to the start of their first shift.

Starting on 1/15/2024 the Director of Nursing and/or nursing designee will conduct random quality observations to ensure proper hand hygiene, including but not limited to hand hygiene before, during, and after patient care; hand hygiene after performing non-patient care tasks, and hand washing during wound care. This observations will be on 5 staff members weekly for 1 month and then 5 staff members monthly for three months thereafter. Completion of these observations will be May, 2024.

The QAPI Committee will evaluate the effectiveness of these measures and amend as needed. The Executive Director is responsible for implementing this plan and will report on the results of

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F 867	Continued From page 5	F 867	the quality monitoring (audits/observations) to the Quality Assurance Performance Improvement Committee monthly. The Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for three months to validate the findings. The completion date of this plan of correction is 1/24/2024.	
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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		1/24/24

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F 880	Continued From page 6 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. §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	F 880		

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F 880	Continued From page 7 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to implement their infection control policy when Nurse #1 did not perform hand hygiene after removing a soiled dressings with drainage and before donning new gloves to cleanse the wound for 3 of 3 wound care observations on 2 of 2 residents reviewed (Resident #2 and Resident #3). The findings included: The facility's policy entitled "Hand Hygiene Policies and Procedures" which is part of their Infection Control Policies and Procedures last revised on 2/5/21 indicated that hand hygiene should be performed: * After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin, or wound dressings. * When hands are moved from a contaminated body site to a clean body site during patient care. * After glove removal. a. An observation of wound care by Nurse #1 was made on 12/28/23 at 10:07 AM. Nurse #1 rubbed hand sanitizer to both hands and put on gloves. She removed the old dressing which included a packing on Resident #2's buttock wound. The old dressing including the packing had moderate amount of serosanguinous (contains or relates to both blood and the liquid part of blood) drainage. She rolled the old dressing into a ball and removed her gloves over the old dressing and discarded it into the trash can. Without doing hand hygiene, she reached into her pocket and proceeded to put on a new	F 880	Nurse #1 was educated on 12/28/2023 by the Director of Nursing regarding proper hand hygiene. The wound nurse completed a hand hygiene competency and a clean dressing change competency while being supervised by the Director of Nursing on 12/28/2023. From 1/2/2024 to 1/12/2024 a quality review was completed by the Director of Nursing and/or designee on current staff regarding proper hand hygiene/handwashing. Quality review means testing each individual verbally or by demonstration utilizing the individual competency checklist for hand hygiene. Current staff will be re-educated on hand hygiene starting 1/2/2024 to 1/12/2024 by the Director of Nursing/designee utilizing the handwashing/hygiene policy. Current staff includes all departments including dietary, housekeeping, and therapy. All newly hired staff will receive this education during orientation. Measures facility will take to ensure the problem does not recur: Starting on 1/15/2024, the Director of Nursing and/or designee will conduct random quality reviews/audits to ensure proper hand hygiene is being performed on 5 staff members weekly for 1 month and then 5 staff members monthly for 3 months. The Director of Nursing	

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F 880	Continued From page 8 pair of gloves to both hands. She then cleaned the wound with normal saline-soaked gauze and packed it with a medicated gauze. She covered the wound with a dry dressing. Nurse #1 discarded any unused supplies and washed her hands at the sink. Another observation of wound care was made for Resident #2 on 12/28/23 at 10:26 AM. Nurse #1 put gloves on after washing both hands. She removed the dressing to Resident #2's left hand which had moderate amount of clear drainage. Nurse #1 removed her gloves and without performing hand hygiene, put on a new pair of gloves. She cleaned the skin tear with normal saline-soaked gauze, applied antibiotic ointment and covered it with a dry dressing. She discarded any unused supplies and washed her hands at the sink. b. An observation of wound care was made for Resident #3 on 12/28/23 at 10:44 AM. Nurse #1 applied hand sanitizer to both hands and put on gloves. Nurse #1 removed the old dressing to Resident #3's wound on the left foot which had a large amount of serosanguinous drainage. She wiped the wound with normal saline-soaked gauze and tried to remove some of the debris off the wound bed with her gloved hand. Nurse #1 then removed both gloves and without performing hand hygiene, reached into her pocket and put new gloves on. She wiped the wound with gauze moistened with povidone iodine solution using her right hand and then removed the glove on her right hand. She put on a new glove on the right hand, wrapped Resident #3's left foot with a gauze wrap, taped it and removed both gloves. She applied Resident #3's sock on his left foot, gathered any unused supplies and washed her	F 880	introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 1/9/2024. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee consists of but is not limited to Administrator, Director of Nursing, Unit Manager, Social Services Director, Medical Director, Maintenance Director, Housekeeping Services Director, Dietary Manager, MDS Coordinator, and at least direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The completion date for this plan is 01/24/2024.	

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hands at the sink.

An interview with Nurse #1 on 12/28/23 at 10:57 AM revealed she was supposed to perform hand hygiene before and after each dressing change. Nurse #1 stated she knew that she was also supposed to perform hand hygiene after removing the old dressing and removing her gloves, but she did not do so because she was busy moving and doing the procedure during the dressing changes.

An interview with the Director of Nursing (DON) on 12/28/23 at 3:10 PM revealed she was currently in charge of infection control at the facility, and she shared that Nurse #1 had just started working as the treatment nurse. The DON stated that she was not sure whether Nurse #1 received training specifically regarding hand hygiene during wound care, but she knew that Nurse #1 has had experience as a treatment nurse before. The DON stated Nurse #1 should have done hand hygiene after removing old dressings and dirty gloves and that she would need to do some education.