

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/20  
FORM APPROVE  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/13/2012
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NAME OF PROVIDER OR SUPPLIER  OAK GROVE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 518 OLD US HWY 221 RUTHERFORDTON, NC 28139
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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to care plan a shoulder harness as a restraint and revise with current interventions for one (1) of two (2) sampled residents observed with positioning devices. (Resident #34).  The findings are:  Resident #34 was admitted with diagnoses including abnormal posture, lack of coordination, dementia, anxiety and Alzheimer's disease.  The most recent quarterly Minimum Data Set (MDS) dated 04/25/12 indicated impairment in short and long term memory and severe	F 280	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>B. Welch</i>	TITLE Exec. Dir.	(X6) DATE 8/6/12
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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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F 280	<p>Continued From page 1</p> <p>impairment in cognition for daily decision making. The MDS also indicated Resident #34 required extensive assistance by staff for personal hygiene and activities of daily living (ADL's). A review of section P of the MDS titled "restraints" indicated "restraints in chair/out of bed: other" was used "daily."</p> <p>A review of a Care Area Trigger (CAT) worksheet dated 11/02/11 indicated a problem area for physical restraints due to confusion, need for assistance with mobility and problems with balance. A review of a CAT worksheet dated 11/2/11 also indicated a problem area for falls. A note documented on the worksheet further indicated Resident #34 had been free from falls since May 2011; had no safety awareness; was dependent on staff for all ADL's, mobility and transfers; and had positioning devices in wheelchair to attempt to prevent falls. There was no documentation regarding care plan considerations or reasons a care plan would or would not be developed.</p> <p>A review of care plans dated 12/14/10 indicated there was no care plan with a problem statement for physical restraints but there was a care plan with a problem statement for falls which indicated Resident #34 was at risk for falls due to a lack of safety awareness related to an expected decline due to advancing dementia and had a positioning harness as a protective device. The goals indicated Resident #34 will sustain no injury related to positioning harness use during next quarter from 05/08/12 through 08/08/12. The approaches on the care plan last updated on 03/15/12 indicated in part to monitor for changes in condition that may warrant increased supervision/assistance and notify the physician; reclined wheelchair with positioning harness in place; anti-tippers to front and back of wheelchair; do not leave resident unattended</p>	F 280	<ol style="list-style-type: none"> <li>1. Resident #34's plan of care was updated to include the shoulder harness restraint and revised to include the current interventions.</li> <li>2. Facility Director of Clinical Services (DCS)/Nurse Manager reviewed all current residents for restraints and any restraints that were identified were care planned to include current interventions. Facility DCS/Unit Manager re-educated all current nursing staff on the facility's Restraint Policy and Procedure to include care planning of the current interventions</li> <li>3. DCS/Nurse Manager will conduct Quality Improvement (QI) monitoring of restraints to ensure that a care plan is in place which includes current interventions. The DCS/Nurse Manager will complete Quality Improvement (QI) monitoring 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months using a sample size of 5.</li> <li>4. DCS/Nurse Manager will report results of QI monitoring to the Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.</li> </ol>	8/10/12



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F 280	<p>Continued From page 2</p> <p>without safety device; it is best to leave resident in high traffic areas when up in wheelchair; monitor for skin breakdown related to use of device; bed alarm while in bed daily.</p> <p>A review of a physician order dated 06/21/12 indicated an order clarification: Shoulder harness for positioning while up in wheelchair. Monitor every two (2) hours and release as needed for toileting, positioning, exercise.</p> <p>During an observation on 07/12/12 at 8:58 AM Resident #34 was sitting in a high back wheelchair with shoulder harness straps attached on the top right (R) and left (L) sides of the of the back of the wheelchair. The harness straps were looped around each shoulder and fastened with Velcro. Resident #34 pushed herself forward against the harness straps with jerking movements of her arms and upper body, turned herself from side to side and arched her back upwards against the harness straps.</p> <p>During an observation on 07/12 /12 at 11:27 AM Resident #34 was sitting in a high back wheelchair in her room with her eyes closed. Both harness straps were fastened with Velcro around each shoulder and she had periodic twitching and jerking movements of her arms, legs and upper body.</p> <p>During an observation on 07/12/12 at 4:20 PM Nursing Assistant (NA) #1 and NA #2 transferred Resident #34 with a lift from her bed to the high back wheelchair and fastened the shoulder harness straps around each shoulder with Velcro.</p> <p>During an interview on 07/12/12 4:34 PM with NA #1 she stated sometimes Resident #34 leaned to the side of her wheelchair and the harness was in place to keep her from sliding out of her chair. She stated Resident #34 did not try to pull on the</p>	F 280		

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F 280	<p>Continued From page 3</p> <p>harness straps but sometimes she held out her hands as if she wanted to touch you and she wiggled and squirmed when she was in her wheelchair and in bed. NA #1 further stated they put the harness on when she was in the wheelchair and took it off the resident when she was in bed but that was all they did with it.</p> <p>During an interview on 07/12/12 at 4:47 PM Licensed Nurse (LN) #1 stated Resident #34 had a history of falls and they had tried various devices to prevent her from falling out of her wheelchair. She explained the shoulder harness had worked for her and kept her sitting upright in her wheelchair. She further explained Resident #34 could not release the Velcro harness straps by herself but sometimes she touched them with her hands. She explained the harness was taken off when Resident #34 was in bed.</p> <p>During an interview on 07/13/12 at 8:09 AM the MDS Coordinator verified she completed the quarterly MDS dated 04/25/12 and coded the shoulder harness as a restraint. She stated it was her routine to observe residents and obtain information from staff and from the medical record.</p> <p>During an interview on 07/13/12 at 10:02 AM the Program Manager of Rehabilitation explained Resident #34 had contracture's without the harness because she pulled her legs up to her chest. She stated the harness actually helped her sit upright and it prevented her from falling out of her chair. She explained they tried various interventions in the past but the devices did not prevent her from falling out of her chair. She further explained therapy obtained the harness for Resident #34 from requests from former Director of Nurses. She stated we've never been asked to contribute to the resident's care plan. She stated when she saw a problem or a need</p>	F 280			

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F 280	Continued From page 4 for a resident she went to nursing staff and talked to them and they discussed resident's needs in the morning meetings with managers and administration.  During an interview on 07/13/12 at 7:38 AM the Nurse Manager stated the shoulder harness for Resident #34 was not a restraint but was a safety device to keep her from falling forward and out of her wheelchair. She further stated she was not sure why the physician's order clarification was written for the harness but the information to monitor the harness every two (2) hours and release as needed for toileting, positioning, exercise had not been added to the care plan with other interventions to prevent the resident from falling but it should have been added.  During an interview on 07/13/12 at 9:37 AM the Director of Nurses (DON) stated the facility used the document titled "Decision Tree - Physical Restraints" to determine the shoulder harness on Resident #34's wheelchair was an enabler and was not a restraint. She further stated it was her expectation for care plans to reflect the care needs of the resident.	F 280	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to use clean pre-moistened wipes during incontinence care for one (1) of two (2) sampled residents observed	F 312	



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F 312	<p>Continued From page 5 during incontinence care. (Resident #34)</p> <p>The findings are:</p> <p>Resident #34 was admitted with diagnoses including abnormal posture, lack of coordination, dementia, anxiety and Alzheimer's disease.</p> <p>The most recent quarterly Minimum Data Set (MDS) dated 04/25/12 indicated impairment in short and long term memory and severe impairment in cognition for daily decision making. The MDS also indicated Resident #34 required extensive assistance by staff for personal hygiene and activities of daily living (ADL's) and was always incontinent of bladder and bowel.</p> <p>During an observation of incontinence care on 07/12/12 at 4:20 PM Nursing Assistant (NA) #1 and NA #2 entered Resident #34's room to get her out of bed into her wheelchair. NA #1 checked Resident #34's brief and stated "she's wet." NA #1 removed Resident #34's brief that was saturated with urine and took two (2) pre-moistened wipes out of a container on Resident #34's bed. NA#1 placed both wipes together in her hand and wiped front to back in Resident #34's perineum four (4) times without turning or changing the cloths. NA#2 then assisted NA #1 to turn Resident #34 on her right (R) side and with the same wipes wiped the residents buttocks four (4) times from front to back without turning or changing the cloths. She placed the wipes inside the resident's wet brief lying on the resident's bed covers and placed a clean brief on Resident #34.</p> <p>During an interview on 07/12/12 at 4:39 AM with NA #1 she stated they were supposed to use multiple wipes for incontinence care. NA #1 verified she used the same wipes to clean</p>	F 312	<ol style="list-style-type: none"> <li>1. Resident #34 suffered no harm.</li> <li>2. Facility DCS/Nurse Manager reviewed all current residents to ensure that dependent residents requiring staff assistance with incontinence care suffered no harm as related to the incontinence care provided. Any identified residents were referred to the physician for evaluation and treatment. Facility DCS/Nurse Manager has re-educated all current nursing staff on the facility's Incontinent Resident Care Policy and Procedure to include a return demonstration.</li> <li>3. Facility DCS/Nurse Manager will conduct QI monitoring of incontinence care for dependent residents requiring staff assistance to ensure proper technique per the facility's Incontinent Resident Care Policy and Procedure. The Facility DCS/Nurse Manager will complete QI monitoring 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months to include a sample size of 5. The sample size will include 2 nursing staff members on 1<sup>st</sup> shift, 2 nursing staff members on 2<sup>nd</sup> shift, and 1 nursing staff member on 3<sup>rd</sup> shift.</li> <li>4. Facility DCS/Nurse Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.</li> </ol>	8/10/12

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F 312	Continued From page 6 Resident #34's peri area and buttocks and verified she did not turn the wipes over as she cleaned her. She stated she knew she didn't do the procedure right and she was not sure why she did it the way she did.  During an interview on 07/13/12 at 9:27 AM the Nurse Manager stated the facility had in-service training and a policy for incontinence care. She explained staff should use a separate pre-moistened wipe each time they wipe the resident's skin and the pre-moistened wipes should not be used multiple times.  During an interview on 07/13/12 at 9:37 AM the Director of Nurses (DON) stated it was her expectation during incontinence care for staff to use one pre-moistened wipe for each time they wiped the resident's skin. She further stated it was not acceptable for staff to use wipes multiple times during incontinence care.	F 312		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		



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F 431	Continued From page 7 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, manufacturer package insert and facility policy review the facility failed to provide safe handling and disposal of a Scheduled II controlled substance (Fentanyl Transdermal Patch) for one (1) of three (3) sampled residents observed for medication administration of a controlled substance. (Resident #86).  The findings are:  A policy provided by the facility titled "Controlled Drug Medication Disposal" dated 03/12 revealed controlled substances were to be destroyed and flushed down the toilet.  Review of the Fentanyl Transdermal System (Fentanyl Patch) manufacturer package insert, revised December 2009, revealed the following instructions for disposal:  "Disposing a Fentanyl Transdermal System Fold the used fentanyl transdermal system in half so that the stick sides stick to itself. Flush the	F 431	1. Resident #86 suffered no harm. 2. Facility DCS/Nurse Manager reviewed all current residents to ensure that suffered no harm as related to the handling and disposal of a Schedule II controlled substance. Any identified residents were referred to the physician for evaluation and treatment. Facility DCS/Nurse Manager re-educated all current licensed nursing staff on the facility's Controlled Drug Medication Disposal Policy and Procedure. 3. Facility DCS/Nurse Manager will conduct QI monitoring of the disposal of narcotics to ensure proper technique per the facility's Controlled Drug Medication Disposal Policy and Procedure. Facility DCS/Nurse Manager will complete QI monitoring 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months using a sample size of 5. 4. Facility DCS/Nurse Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.	8/10/12



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F 431	<p>Continued From page 8</p> <p>used fentanyl trasdermal system down the toilet right away."</p> <p>The package insert stated that the patch should be kept in a safe place and included the following warning (printed as is in bold):</p> <p>"A used fentanyl trasdermal system CAN be VERY dangerous for or even lead to death in babies, children, pets, and adults who have not been prescribed fentanyl trasdermal system."</p> <p>During continuous observations of medication administration on 07/12/12 from 09:20 AM to 09:37 AM LN #2 was observed changing and disposing of Resident #86's used Fentanyl Patch. LN #2 exited the resident's room, placed the used patch on top of the medication cart, and proceeded to walk approximately 19 feet down the hall while the Fentanyl Patch remained unattended on the cart in the hall. After approximately one minute LN #2 returned to the cart to prepare additional medication for Resident #86. While preparing the medication LN #2 advised LN #3, who was coming down the hall, that she needed a witness for disposal of the Fentanyl Patch and that Resident #86 needed assistance to the toilet. While LN #3 was assisting the resident to the toilet LN #2 entered the room to administer medication leaving the Fentanyl Patch unattended on top of the medication cart for a second time. LN #2 remained in the room while LN #3 proceeded to the medication cart where she cut the Fentanyl Patch into strips, picked them up with a tissue and disposed of the items in the sharps box.</p> <p>During an interview, 07/12/12 at 09:37 AM, LN #2 and LN #3 confirmed the used Fentanyl Patch was on the medication cart in the hall unattended and out of sight while both nurses were in Resident #86's room. The interview revealed</p>	F 431			

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F 431	Continued From page 9 controlled substances should not be left unattended at any time. The interview further revealed LN #3 cut and disposed of the Fentanyl Patch in the medication cart sharps box. During a follow-up interview at 09:39 AM LN #2 confirmed the Fentanyl Patch was left unattended and out of her sight earlier when she walked approximately 19 feet down the hall away from the medication cart. LN #2 stated immediate measures should have been taken to properly dispose of the patch when she first left Resident #86's room.  During an interview on 07/13/12 at 2:35 PM the Director of Nursing (DON) stated, used Fentanyl Patches should never be left unattended on the medication cart in the hall. The DON further revealed the patch should have been peeled open, folded so sides closed, and flushed down the toilet.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441			



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(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 441	<p>Continued From page 10</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to dispose of soiled linens in soiled linen barrels after incontinence care for one (1) of two (2) sampled residents. (Resident #40).</p> <p>The findings are:</p> <p>A review of a facility policy "Incontinent Resident Care" with an effective date of March 2012 indicated in part "Do not put linen on the floor."</p> <p>During an observation on 07/12/12 at 4:05 PM Nursing Assistant (NA) #1 provided incontinence care to Resident #40 and put soiled linens with urine and stool in two (2) plastic trash bags. She assisted the resident to her wheelchair and opened the door of the room. She placed both bags of soiled linens with the tops of each plastic bag open on the floor partially in the doorway to the resident's room and partially into the hallway. The soiled linens were visible in the opening of</p>	F 441	<ol style="list-style-type: none"> <li>1. Resident #40 suffered no harm.</li> <li>2. Facility DCS/Nurse Manager reviewed all current residents to ensure that they suffered no harm related to the disposal of soiled linens in soiled linen barrels after incontinence care. Any identified residents were referred to the physician for evaluation and treatment. Facility DCS/Nurse Manager re-educated all current nursing staff on the facility's Handling of Soiled Linens Policy and Procedure.</li> <li>3. Facility DCS/Nurse Manager will conduct QI monitoring of the disposal of soiled linen to ensure proper technique per the facility's Handling of Soiled Linens Policy and Procedure. Facility DCS/Nurse Manager will complete QI monitoring 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1x weekly for 4 weeks, and then 1 x monthly for 9 months using a sample size of 5.</li> <li>4. Facility DCS/Nurse Manager will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision.</li> </ol>	8/10/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 11</p> <p>each bag. NA #1 left the (2) open plastic bags in the floor and walked out of Resident #40's room and pushed a lift down the hallway and into another room. There were 2 visitors walking by the trash bags and there were 2 residents transferring themselves in wheelchairs in the hallway next to the (2) trash bags. NA #1 walked back down the hallway after three (3) minutes to Resident #40's room, picked up each plastic bag, tied the tops of each one and carried them to a soiled linen barrel in the hallway.</p> <p>During an interview on 07/12/12 at 4:39 PM with NA #1 she verified she put plastic bags of soiled linen on the floor to the doorway and hallway of Resident #40's room after she provided incontinence care. She stated she was aware she was not supposed to put bags of linen on the floor and should have taken them immediately to the linen barrels for soiled linens or to the soiled linen room.</p> <p>During an interview on 07/13/12 at 9:27 AM the Nurse Manager stated even when soiled linens were in plastic bags they should not be placed on the floor but should be tied off and taken to the soiled linen barrels or soiled linen room.</p> <p>During an interview on 07/13/12 at 9:37 AM the Director of Nurses (DON) stated it was her expectation staff should put soiled linens in plastic bags, tie them off and take them immediately to a soiled linen barrel or the soiled linen room. She further stated the plastic bags they should not be placed on the floor.</p>	F 441			