STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 166 SS=B	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		6/2/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/30/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 166	Continued From page 1	F 166		

conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to investigate grievances for 1 of 3 sampled residents (Resident #2) and failed to provide in writing a summary of the grievance investigation and provide in writing the results of the investigations the for 3 of 3 sampled residents with grievances (Residents #2, #3 and #6). The findings included: 1. Resident #2 was admitted to the facility on 04/08/17. Resident #2 was admitted with pressure ulcers. Review of the grievances revealed Resident #2's responsible party (RP) filed a complaint/Grievance Report through the social worker on 04/10/17. The concern description included that Resident #2's dressing was very wet when it was supposed to be dry. The second concern was that the resident reported that he did not receive lunch yesterday or today and also did not receive dinner last night. The form listed the responsible parties for investigating these concerns included the Director of Nursing (DON) and the Dietary Manager (DM). This form was a two part form so that a copy was maintained. The copy was still attached.	F 166	F166 SS=B Grievances 1) Resident #3 no longer resides in the facility. Resident #6 was given a written response of grievance resolution 05/12/17 by Executive Director for resolution effective 02/08/17. Resident #2 is deceased. 2) On 05/16/2017, the Executive Director completed a quality improvement monitor of grievances received from 3/14/17-5/14/17 to ensure an investigation of the grievance is completed, and a written copy of the investigation and resolution has been provided to the concerned party. 3) On 05/11/2017, the Executive Director was re-educated by the Regional Director of Clinical Services on the grievance process and the responsibility of the Grievance Officer to ensure a complete thorough investigation has been completed and a written copy of resolution provided to the concerned party. On 05/12/2017, the Executive Director re-educated the Interdisciplinary Team	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 166	Continued From page 3 Under the findings of the investigation revealed that per interview the dressing change was delayed as the nurse was waiting for visitors to leave in order to change it and the RP voiced understanding. This was signed by the DON dated 04/11/17. There was no evidence of any investigation of the dietary concerns. Interview with the DM on 05/10/17 at 4:04 PM revealed she had not received any grievance to investigate relating to Resident #2's missed meals. Interview with the DON on 05/11/17 at 10:07 AM revealed that the social worker who took this concern was no longer employed. DON stated that once she returned the grievance relating to the nursing issues, the social worker was supposed to then pass it to the DM for her investigation. She did not do so per the DON. In addition, the DON stated she reviewed the nursing issue with the RP verbally but was not aware the RP should have gotten a copy of the investigation and findings. Interview with the Administrator on 05/11/17 at 1:10 PM that he was unaware the findings were to be provided in writing after a grievance was investigated. 2. Resident #6 was admitted to the facility on 08/24/13 with diagnoses of non-Alzheimer's dementia, hemiplegia and muscle weakness. Review of the facility grievances revealed Resident #6 filed a grievance on 02/07/17 regarding a Nurse Aide (NA) who answered her call light and didn't believe her when the resident	F 166	(IDT), including the Maintenance Director, Admissions Director and Coordinator, Medical Records, Social Services, Business Officer Manager, Director of Clinical Services, Minimum Data Set Director, Dietary Manager and Central Supply on timely investigation and follow-up on assigned grievances. Newly hired IDT members will be educated upon hire. 4) The Grievance Officer to track, monitor and ensure investigation and written resolution delivery to the concerned party. The Executive Director and/or Grievance Officer to discuss grievances daily during IDT meeting Monday-Friday for compliance with investigations and written resolution to concerned party. The Executive Director to conduct quality improvement monitoring of grievances to ensure investigation and timely delivery of written resolution to concerned party at a frequency of weekly for three (3) months, then monthly ongoing until substantial compliance is met. Frequency of monitoring to be modified based on findings. The results of quality improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or DCS. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 166	Continued From page 4 told her she was wet. The grievance stated Resident #6 was told by the NA that she wasn't wet and she had just changed her and pulled the cover back up over her. The findings of the investigation on the facility report revealed the NA went into Resident #6's room, checked the resident for incontinence and found the resident was dry and attempted to explain that to the resident. The plan to resolve the grievance was for the NAs to take another NA or staff member into Resident #6's room when providing care. The complainants remarks were, "ok then." The results communicated section on the facility form revealed the results were verbally communicated without a written copy of the grievance investigation given to the resident. An interview conducted on 05/11/17 at 10:07 AM with the Director of Nursing (DON) revealed she investigated Resident #6's grievance and reviewed the investigation and results with Resident #6 but was not aware she should have received a written copy of the investigation and findings. An interview conducted on 05/11/17 at 1:10 PM with the Administrator revealed he was unaware the findings of grievance investigations were to be provided in writing after the investigation was completed. 3. Resident #3 was readmitted to the facility on 01/10/17. Review of a grievance dated 03/13/17 filed by a staff member revealed Resident #3's family	F 166	necessary, to maintain substantial compliance and ensure investigation and timely delivery of written resolution of grievances to concerned party. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director (quarterly at a minimum) and at least three other members to include but not limited to one direct care giver.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 166	Continued From page 5	F 166		

member had requested for Resident #3's clinical information to be faxed to another facility. The staff member called Resident #3's family member to see if they had concerns about Resident #3. The family member stated that they were upset because a nurse asked if they just wanted comfort medication when Resident #3 was sent out to the hospital in January. The family member stated they felt like some staff were tired of taking care of Resident #3.

Under Action Taken on the grievance form, the information read: the staff member asked the family member if they would like to speak with the Director of Nursing (DON) and offered Resident #3 a private room. The family member stated they would speak with another family member and get back with her. The form also noted that both the Nurse Practitioner and Unit Manager spoke with Resident #3's family member on the day in January about her decline and the decision to keep Resident #3 comfortable or to transfer her to the Emergency Department (ED). Resident #3 was transferred to the ED.

Under Status on the grievance form, the information read: Resident #3 was moved to a private room and the Resident's family member did not want to speak with the DON. The form was signed by the DON and dated 03/14/17.

Interview with the DON on 05/10/17 at 1:45 PM revealed she investigated Resident #3's family's concern but the family member refused to speak with her therefore she could not explain the investigation to the family member nor did she provide the family member with a written copy of the investigation and the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 166	Continued From page 6 Interview with the Administrator on 05/11/17 at 1:10 PM revealed he was unaware that a written copy of the grievance investigation and findings were to be provided to the complainant.	F 166		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 279		6/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 279	Continued From page 7 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan for pressure ulcers for 1 of 4 residents sampled for pressure ulcers (Resident #4). The findings included: Resident #4 was admitted to the facility from the hospital on 04/05/17. Her diagnoses included sepsis secondary to a urinary tract infection, debility, and neuropathy.	F 279	F279 SS=D Develop Comprehensive Care Plans 1) On 05/10/17, the minimum data set (MDS) nurse updated Resident #4 comprehensive care plan to reflect the residents healed pressure sore and current skin concerns and preventative treatment. Resident #4 was discharged home on 5/29/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 279	Continued From page 8 Review of the hospital records dated 04/05/17 and sent to the facility upon discharge revealed under the skin notation that she had a stage 2 pressure ulcer which was present on admission. This was included in the list of discharge diagnoses. The accompanying FL 2 (a form which determines need for skilled nursing care placement) dated 04/05/17 included under the skin section that she had a sacral "stage 2" (pressure ulcer) and discolored legs. Review of the Admission Data Collection form, dated 04/05/17 at 1:05 PM by Nurse #1, included a skin section with a body form which indicated a skin issue on Resident #4's sacrum. This area was hand noted to be a stage 2 (pressure ulcer). The narrative written on this form by Nurse #1 included a statement that a skin assessment was done and there was a "stage 2 ulcer noted to sacrum (symbol for with) cream on it. Unit Manager aware." Review of the admission orders dated 04/05/17 received upon admission by the Unit Manager did not include any treatment orders for the pressure ulcer. Review of the initial dietary assessment dated 04/05/17 identified a "stage 2" (pressure ulcer) on her sacrum with recommendations to add Prostat (protein supplement) for wound healing. Review of the History and Physical completed by the physician on 04/06/17 revealed the only mention of skin issues under the area of the physical exam was that her skin was warm and moist, color was normal and she had a double lumen (Percutaneously Inserted Central Catheter)	F 279	2) On 05/12/2017, the Director of Clinical Services completed a quality improvement monitor of residents admitted 4/12/17-5/12/17 and all current facility residents to ensure their comprehensive care plan accurately reflects the residents current skin condition, to include residents admitted with pressure ulcers and/or facility acquired pressure ulcers. No additional discrepancies were identified. 3) On 5/11/17, the Director of Clinical Services re-educated licensed nurses on the policies and procedures of assessing pressure ulcers, measuring and staging, obtaining and transcribing physicians treatment orders, tracking and updating residents care plan (interim and/or comprehensive) upon admission, weekly and with changes to skin condition. Newly hired licensed nurses will be educated upon hire. The admitting licensed nurse to assess and document residents skin condition upon admission/readmission on the Admission Data Collection tool and ensure physicians orders are obtained and accurately transcribed onto the treatment administration record (TAR), pressure ulcer/non-pressure ulcer record and interim plan of care is updated accordingly. Assessment and documentation of identified pressure ulcers to include measurement, description and staging (staging by registered nurse) upon admission and/or new identification and weekly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 279	Continued From page 9 PICC line in place to her right upper arm without redness or edema. There was nothing about the sacral pressure ulcer mentioned including under the past medical history section. The admission Minimum Data Set (MDS) dated 04/12/17 coded Resident #4 with intact cognition, requiring extensive assistance with bed mobility, transfers and toileting, being frequently incontinent of bladder and always incontinent of bowel, and being nonambulatory. She was coded as having a stage 2 pressure ulcer, which was present on admission. Review of the Care Area Assessment (CAA) or pressure ulcers dated 04/17/17 stated that pressure ulcers triggered secondary to potential for pressure ulcers and a current "Stage 2" (pressure ulcer) to the sacrum. The CAA stated weekly skin checks continued with daily checks by aides when administering post incontinence care as needed. Pressure ulcer care was given daily and as needed. The CAA stated a care plan would be initiated to improve current status of Stage 2 pressure ulcer to sacral area. No care plan related to pressure ulcers was found. During an interview conducted on 05/11/17 at 10:27 AM , the MDS nurse who completed the CAA stated she missed developing a pressure ulcer care plan for Resident #4.	F 279	The wound nurse/registered nurse designee to track progress of pressure ulcers weekly and with reported changes by reassessing, measuring, staging and documenting on the weekly pressure ulcer record and corresponding wound. The wound nurse/ MDS nurse will ensure the comprehensive plan of care is implemented and updated timely with changes to accurately reflect residents skin concerns and treatment plan. The DCS to review skin concerns during morning clinical meeting and weekly skin risk meetings for compliance. 4) Director of Clinical Services to complete quality improvement monitoring of residents skin care plan to ensure accuracy at a frequency of one (1) time weekly for three (3) months and then monthly for five (5) residents, and then ongoing until substantial compliance is met. Frequency of monitoring to be modified based on findings. The results of quality improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or DCS. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if necessary, to maintain substantial compliance and ensure accurate care plan development for residents with pressure ulcers. The Quality Assurance Improvement Committee members	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 279	Continued From page 10	F 279	consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director (quarterly at a minimum) and at least three other members to include but not limited to one direct care giver. AOC date: 6/2/17	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transcribe physician orders for wound care for 1 of 4 residents sampled with wounds upon admission (Resident #2). The findings included: Resident #2 was admitted to the facility from the hospital on 04/08/17. His diagnoses included a scrotal wound, and lymphedema. Review of the FL 2 (a form that screened the level of care needed) included physician orders. This form included medications. Under additional information was information that a dressing was changed to the right scrotal incision wound. The information stated "rt (right) scrotal wound>>Wound Dressing Activity: Changed	F 281	F281 SS=B Services provided meet professional standards 1) On 05/10/17, the Wound Physician made a facility visit to reassess Resident #4 skin condition and provide orders to minimize risk of pressure sores. On 5/10/17, the licensed nurse reassessed Resident #4 skin condition, implemented a non-pressure ulcer record to track progress and accurately transcribed new treatment orders onto the treatment administration record (TAR) per physician orders. Resident #4 was discharged home on 5/29/17. 2) On 05/12/2017, the Director of Clinical	6/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 281	Continued From page 11 Incision, Wound Dressing: Foam, Other: removed (1) piece Mesalt rope, repacked with (1) piece Mesalt rope, covered with 4x4 border foam. Hydrofiber, Silver Impregnated, Other: removed (1) sheet Aquacel-Ag, replaced with (1) Aquacel-Ag sheet and interdry cloth." Review of the admission physician orders transcribed by Nurse #3 on 04/08/17 included the medications as stated on the FL 2. There were no transcribed treatment orders of any kind on the order form. The physician signed this form acknowledging the orders were in effect on 04/10/17. The Admission Data Collection tool dated 04/08/17 identified Resident #2 via hand written pictures with a stage 3 area 2 centimeters (cm) x 5 cm on right lower abdomen, a stage 3 area 3 cm x 7 in front abdomen, a stage 2 area 4 cm x 6 cm on right buttocks and an open area on the right area of his scrotum. There was no staging or description of these areas. Under current treatment was checked: surgical wound care, application of dressing, and application of ointments/medications. The narrative on this form written 04/08/17 at 6:00 PM stated that he arrived with a diagnoses of a scrotal wound, a skin assessment and medication administration record was verified and completed and faxed to the pharmacy. Review of the history and physical written by the physician on 04/10/17 revealed his history of his present illness included he had a chronic sacral wound at home and developed redness at the wound site. He underwent debridement of necrotic tissue and was debrided to about 3 cm deep, 3 cm wide and 2 cm long. Mesalt dressing	F 281	Services completed a quality improvement monitor of residents admitted 4/12/17-5/12/17 and all current facility residents to ensure treatment orders have been accurately transcribed onto the TAR for administration to prevent and/or treat pressure sores. No additional follow up was indicated. 3) On 5/11/17, the Director of Clinical Services re-educated licensed nurses on the policies and procedures of assessing pressure ulcers, measuring and staging, obtaining and transcribing physicians□ treatment orders, tracking and updating residents□ care plan (interim and/or comprehensive) upon admission, weekly and with changes to skin condition. Newly hired licensed nurses will be educated upon hire. The admitting licensed nurse to assess and document residents□ skin condition upon admission/readmission on the Admission Data Collection tool and ensure physicians□ orders are obtained and accurately transcribed onto the treatment administration record (TAR), pressure ulcer/non-pressure ulcer record and interim plan of care is updated accordingly. Assessment and documentation of identified pressure ulcers to include measurement, description and staging (staging by registered nurse) upon admission and/or new identification and weekly thereafter. The wound nurse/registered nurse designee to track progress of pressure ulcers weekly and with reported changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 281	Continued From page 12 was placed and he was treated with routine dressings with aquacel. Under the Review of Systems" the physician noted he was recently treated for infection in scrotal wound, he has chronic scrotal and inguinal (groin) wound. Under "Physical Exam" the physician noted a left inguinal wound, maceration of wound beneath skin folds, chronic skin changes with thickening of the skin. Under Plan the physician addressed the skin with "He will continue w/ (with) routine wound care of his lower abdominal, injuinal and scrotal wounds." Review of the Treatment Record revealed the following wound care provided to Resident #2 during his stay in the facility on 04/09/17 and 04/10/17: 1. Scrotum wound - cleanse with normal saline pack with alginate silver, cover with 4x4 border foam dressing. There was no number of times this was to be completed other than during the hour 7a-7p. 2. Abdomen fold wounds - cleanse with normal saline, place alginate silver in fold. There was no number of times this was to be completed other than during the hour 7a-7p. 3. Apply barrier cream to coccyx every shift. This was to be done during the hours of 7a-7p and 7p-7a. The only nursing note that described the areas or treatment was dated 04/09/17 at 7a-7p stating dressing changed to surgical site on right side of scrotum. Silver alginate rope placed in abdominal folds, and covered with pillow cases to decrease drainage. Review of the Minimum Data Set, dated 04/11/17 stated he was independent for daily decision making, required extensive to total assistance	F 281	by reassessing, measuring, staging and documenting on the weekly pressure ulcer record and corresponding wound. The wound nurse/ MDS nurse will ensure the comprehensive plan of care is implemented and updated timely with changes to accurately reflect residents skin concerns and treatment plan. The DCS to review skin concerns during morning clinical meeting and weekly skin risk meetings for compliance. 4) Director of Clinical Services to complete quality improvement monitoring of residents TAR to ensure accurate transcription of treatment orders at a frequency of one (1) time weekly for three (3) months and then monthly for five (5) residents, and then ongoing until substantial compliance is reached. Frequency of monitoring to be modified based on findings. The results of quality improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or DCS. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if necessary, to maintain substantial compliance and ensure accurate transcription of treatment orders onto the TAR for administration to prevent and/or heal pressure sores. The Quality Assurance Improvement Committee members consist of, but not limited to, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 281	Continued From page 13 with most activities of daily living skills, had 1 stage 2 pressure and 2 stage 3 pressure ulcers all present on admission. Review of telephone orders revealed there were no telephone orders for treatment for any wound. An interview with Nurse #3 who transcribed Resident #2's admission orders was conducted via phone on 05/09/17 at 3:47 PM. Nurse #3 stated that when she did an admission she verified the hospital medications with the physician upon admission. After she transcribes the orders, a second nurse double checks the orders for accuracy. Interview with the Unit Manger on 05/11/17 at 8:39 AM revealed that the medication and wound orders from the hospital were to be verified with the facility physician then transcribed to the order sheet and medication and treatment administration records. She further stated that if there were no wound orders then the physician would be notified and orders obtained. The Unit Manager went through the medical record and verified there were no wound orders documented. A phone interview on 05/11/17 at 9:18 AM with Nurse #4 who rechecked the admission orders for Resident #2 completed originally by Nurse #3 was conducted. Nurse 4 was unable to recall anything about the orders or Resident #2's wounds. Nurse #3 was interviewed a second time on 05/11/17 at 9:27 AM. Nurse #3 stated she verified the wound orders with the physician and should have transcribed them to the order form. She stated she just put them on the treatment	F 281	Administrator, Director of Clinical Services, Medical Director (quarterly at a minimum) and at least three other members to include but not limited to one direct care giver. AOC Date: 6/2/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 281	Continued From page 14 administration record. She stated she started the admission, and because he arrived at shift change, Nurse #4 completed the admission. The Director of Nursing stated during interview on 05/11/17 at 9:44 AM that she observed the abdominal and buttocks wound and stage them. She did not observe the scrotum area. She expected that nurses would obtain physician orders for each wound and write those orders on the order sheet. She further stated that the Unit Manager was responsible for rechecking to ensure orders for new admissions were in place on the order sheet. On 05/11/17 at 9:54 AM, the Unit Manager stated during interview that she saw Resident #2's wounds on Monday after admission (04/10/17) and she should have transcribed the observation on the Weekly Wound Worksheet. The DON was present at this interview and stated that the lack of physician orders for Resident 2's wounds should have been identified and clarified on Monday.	F 281		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 314		6/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 314	Continued From page 15 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and resident interview, the facility failed to assess a pressure ulcer upon admission, measure it, obtain physician orders, and track its progression for 1 of 4 sampled residents reviewed for pressure ulcers (Resident #4). The findings included: Resident #4 was admitted to the facility from the hospital on 04/05/17. Her diagnoses included sepsis secondary to a urinary tract infection, debility, and neuropathy. Review of the hospital records dated 04/05/17 and sent to the facility upon discharge revealed under the skin notation that she had a stage 2 pressure ulcer which was present on admission. This was included in the list of discharge diagnoses. The accompanying FL 2 (a form which determines need for skilled nursing care placement) dated 04/05/17 included under the skin section that she had a sacral "stage 2" (pressure ulcer) and discolored legs. Review of the Admission Data Collection form, dated 04/05/17 at 1:05 PM by Nurse #1, included a skin section with a body form which indicated a skin issue on Resident #4's sacrum. This area was hand noted to be a stage 2 (pressure ulcer). The narrative written on this form by Nurse #1	F 314	F314 Treatment/Services to prevent/heal pressure ulcers SS=D 1) On 5/10/17, the Wound Physician made a facility visit to reassess Resident #4 skin condition and provide orders to minimize risk of pressure sores. On 5/10/17, the licensed nurse reassessed Resident #4 skin condition, implemented a non-pressure ulcer record to track progress and accurately transcribed new treatment orders onto the treatment administration record (TAR) per physician orders. On 05/10/17, the minimum data set (MDS) nurse updated Resident #4 comprehensive care plan to reflect the residents healed pressure ulcer and current skin concerns and treatment to prevent pressure sores. Resident #4 was discharged home on 5/29/17. 2) On 05/12/2017, the Director of Clinical Services completed a quality improvement monitor of residents admitted 4/12/17-5/12/17 and all current facility residents to ensure residents with pressure sores have a thorough skin assessment to include initial and weekly measurements and staging of pressure ulcers, accurate transcription and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 314	Continued From page 16 included a statement that a skin assessment was done and there was a "stage 2 ulcer noted to sacrum (symbol for with) cream on it. Unit Manager aware." Review of the admission orders dated 04/05/17 received upon admission by the Unit Manager did not include any treatment orders for the pressure ulcer. Review of the initial dietary assessment dated 04/05/17 identified a "stage 2" (pressure ulcer) on her sacrum with recommendations to add Prostat (protein supplement) for wound healing. Review of the History and Physical completed by the physician on 04/06/17 revealed the only mention of skin issues under the area of the physical exam was that her skin was warm and moist, color was normal and she had a double lumen (Percutaneously Inserted Central Catheter) PICC line in place to her right upper arm without redness or edema. There was nothing about the sacral pressure ulcer mentioned including under the past medical history section. The admission Minimum Data Set dated 04/12/17 coded Resident #4 with intact cognition, requiring extensive assistance with bed mobility, transfers and toileting, being frequently incontinent of bladder and always incontinent of bowel, and being nonambulatory. She was coded as having a stage 2 pressure ulcer, which was present on admission. Review of the Care Area Assessment (CAA) or pressure ulcers dated 04/17/17 stated that pressure ulcers triggered secondary to potential for pressure ulcers and a current "Stage 2"	F 314	administration of treatment orders, updated comprehensive care plan to prevent/treat pressure sores and ongoing weekly tracking of wound progression. No additional discrepancies were identified. 3) On 5/11/17, the Director of Clinical Services re-educated licensed nurses on the policies and procedures of assessing pressure ulcers, measuring and staging, obtaining and transcribing physicians□ treatment orders, tracking of wound progression and updating residents□ care plan (interim and/or comprehensive) upon admission, weekly and with changes to skin condition. Newly hired licensed nurses will be educated upon hire. The admitting licensed nurse to assess and document residents□ skin condition upon admission/readmission on the Admission Data Collection tool and ensure physicians□ orders are obtained and accurately transcribed onto the treatment administration record (TAR), pressure ulcer/non-pressure ulcer record and interim plan of care is updated accordingly. Assessment and documentation of identified pressure ulcers to include measurement, description and staging (staging by registered nurse) upon admission and/or new identification and weekly thereafter. The wound nurse/registered nurse designee to track progress of pressure ulcers weekly and with reported changes by reassessing, measuring, staging and documenting on the weekly pressure ulcer record and corresponding wound. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 314	Continued From page 17 (pressure ulcer) to the sacrum. The CAA stated weekly skin checks continued with daily checks by aides when administering post incontinence care as needed. Pressure ulcer care was given daily and as needed. The CAA stated a care plan would be initiated to improve current status of Stage 2 pressure ulcer to sacral area. No care plan related to pressure ulcers was found. Review of physician telephone orders dated 04/21/17 revealed that Prostat 30 milliliters was ordered to be administered every day for 30 days per the registered dietician's recommendation. Review of the Medication Administration Record revealed this was started 04/22/17. Review of the medical record revealed that the only skin evaluations completed for Resident #4 after the initial assessment dated 04/05/17 had two entries. The first was dated 04/15/17 with picture notes but nothing about a sacrum pressure ulcer and the second was dated 04/22/17 which indicated her skin was intact. In addition there were no indications in the nursing notes about the sacral pressure ulcer or on the Treatment record indicating any treatment was being provided beginning the day of admission. During an interview with Resident #4 on 05/09/17 at 10:41 AM, she stated that she had a very small open place on her bottom but staff put cream on it daily. An interview with Nurse #1 on 05/10/17 at 11:13 AM revealed that because she was not a registered nurse, the Unit Manger would have been responsible for assessing and measuring	F 314	wound nurse/ MDS nurse will ensure the comprehensive plan of care is implemented and updated timely with changes to accurately reflect residents skin concerns and treatment plan. The DCS to review skin concerns during morning clinical meeting and weekly skin risk meetings for compliance. 4) Director of Clinical Services to complete quality improvement monitoring of residents medical records to ensure initial and weekly assessment, measurement and staging, accurate treatment order transcription onto the TAR for administration, updated care plan (interim and comprehensive) and ongoing weekly tracking of wound progression to prevent/treat pressure sores at a frequency of one (1) time weekly for three (3) months and then monthly for five (5) residents, and then ongoing until substantial compliance is met. Frequency of monitoring to be modified based on findings. The results of quality improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or DCS. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if necessary, to maintain substantial compliance and ensure prevention/treatment of pressure sores. The Quality Assurance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 314	Continued From page 18 the sacral stage 2 pressure ulcer. She stated she was unaware of any treatment orders. She further stated then the Unit Manager would place the area on the weekly wound worksheet which were reviewed every Tuesday and measured to show healing progress. Review of these worksheets revealed Resident #4 was never listed on them for measurement, staging or for progression of healing. Follow up interview with Nurse #1 revealed that she recalled the area looking like an opened blister and therefore she marked it as a stage 2. The Unit Manager was interviewed on 05/10/17 at 11:28 AM and revealed the admitting nurse completed the initial data collection tool and if someone was identified with a pressure ulcer, she as Unit Manager was responsible for assessing and staging the area. The admitting nurse was not a registered nurse, that nurse could measure the area. The Unit Manager stated she could not recall if she was aware of this area or not. She further stated that the area should have been written on the weekly wound worksheet for tracking purposes. Upon follow up interview on 05/10/17 at 11:47 AM she stated there would not have been an order if barrier cream was the cream being used on Resident #4's sacral pressure ulcer. At this interview, the Unit Manager stated she had never observed the pressure ulcer upon admission and could not recall if she knew about it. Interview with Resident #4 on 05/10/17 at 12:04 PM revealed Resident #4 stated she was admitted with a pressure ulcer that started in the hospital. She stated staff treated it with cream every day. She then stated it hurt when she was first admitted but has no pain now.	F 314	Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director (quarterly at a minimum) and at least three other members to include but not limited to one direct care giver. AOC Date: 6/2/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 314	Continued From page 19 On 05/10/17 at 12:25 PM, an observations of Resident #4's sacral area was observed with Nurse #1. Nurse #1 pointed to a healed area. On 05/11/17 at 9:44 AM, an interview with the Director of Nursing revealed she expected that the Unit Manager would look at a wound if the admitting nurse was not a registered nurse so that the wound would be staged and documented and if necessary call the physician for wound orders and begin the tracking system. She stated the facility had no standing orders to refer to in relation to treatment of open areas.	F 314		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as	F 520		6/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 520	Continued From page 20 identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Assurance Committee failed to develop and implement interventions and procedures to maintain compliance for 1 deficiency cited during the recertification survey of 12/15/16 and cited again during the complaint survey of 05/11/17. The repeated deficiency was in the area of services provided that meet professional standards of quality. The current deficiency involved the failure to transcribe treatment orders at the time of admission. This repeated deficiency during two federal surveys of record show an isolated pattern of the facility's inability to implement an effective Quality Assurance Program. The findings included: This tag is crossed referred to:	F 520	F520 QAA SS= D 1) On 05/10/17, the Wound Physician made a facility visit to reassess Resident #4 skin condition and provide orders to minimize risk of pressure sores. On 5/10/17, the licensed nurse reassessed Resident #4 skin condition, implemented a non-pressure ulcer record to track progress and accurately transcribed new treatment orders onto the treatment administration record (TAR) per physician orders. Resident #4 was discharged home on 5/29/17. 2) On 05/12/2017, the Director of Clinical Services completed a quality improvement monitor of residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 520	Continued From page 21 F281: Based on record review and staff interviews, the facility failed to transcribe physician orders for wound care for 1 of 4 residents sampled with wounds upon admission (Resident #2). The facility was originally cited during a recertification survey on 12/15/16 for failure to implement physician orders for medication administration and failure to follow a physician's order for laboratory work. During an interview on 05/11/17 at 1:10 PM, the Administrator stated the facility had concentrated on the facility's transcription from month to month and did not check transcriptions on new admission orders.	F 520	admitted 4/12/17-5/12/17 and all current facility residents to ensure treatment orders have been accurately transcribed onto the TAR for administration to prevent and/or treat pressure sores. No additional discrepancies were identified. 3) On 5/11/17, the Director of Clinical Services re-educated licensed nurses on the policies and procedures of assessing pressure ulcers, measuring and staging, obtaining and transcribing physicians□ treatment orders, tracking and updating residents□ care plan (interim and/or comprehensive) upon admission, weekly and with changes to skin condition. Newly hired licensed nurses will be educated upon hire. The admitting licensed nurse to assess and document residents□ skin condition upon admission/readmission on the Admission Data Collection tool and ensure physicians□ orders are obtained and accurately transcribed onto the treatment administration record (TAR), pressure ulcer/non-pressure ulcer record and interim plan of care is updated accordingly. Assessment and documentation of identified pressure ulcers to include measurement, description and staging (staging by registered nurse) upon admission and/or new identification and weekly thereafter. The wound nurse/registered nurse designee to track progress of pressure ulcers weekly and with reported changes by reassessing, measuring, staging and documenting on the weekly pressure ulcer	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 520	Continued From page 22	F 520	record and corresponding wound. The wound nurse/ MDS nurse will ensure the comprehensive plan of care is implemented and updated timely with changes to accurately reflect residents skin concerns and treatment plan. The DCS to review skin concerns during morning clinical meeting and weekly skin risk meetings for compliance. On 5/11/17, the Regional Director of Clinical Services re-educated the Interdisciplinary Team (IDT), including the Executive Director, Maintenance Director, Admissions Director and Coordinator, Medical Records, Social Services, Business Officer Manager, Director of Clinical Services, Minimum Data Set Director, Dietary Manager and Central Supply on Federal Regulation F520 and Consulates QAPI Committee Policy regarding the expectations regarding maintaining an ongoing Quality Assurance and Performance Improvement (QAPI)program. The QAPI Committee consists of the Executive Director, Director of Clinical Services, Medical Director and at least 3 other members and meets at least monthly (Medical Director at least quarterly). Education also included the processes and procedures of implementing, reviewing and revising ongoing action plans for areas of deficiency that have been identified to attain and maintain substantial regulatory compliance and provide the highest level of care to residents. Newly hired IDT employees will be educated upon hire.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345464	A. BUILDING _____ B. WING _____	C 05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(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 520	Continued From page 23	F 520	4) The Director of Clinical Services to complete quality improvement monitoring of residents TAR to ensure accurate transcription of treatment orders at a frequency of one (1) time weekly for three (3) months and then monthly for five (5) residents, and then ongoing until substantial compliance is met. Frequency of monitoring to be modified based on findings. The results of quality improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or DCS. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action, if necessary, to maintain substantial compliance and ensure accurate transcription of treatment orders onto the TAR for administration to prevent and/or heal pressure sores. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director (quarterly at a minimum) and at least three other members to include but not limited to one direct care giver. AOC Date: 6/2/17	