PRINTED: 06/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345464	B. WING			C <b>05/11/2017</b>	
	ROVIDER OR SUPPLIER	TER		5	STREET ADDRESS, CITY, STATE, ZIP CODE 118 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139	1 00,	11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 166 SS=B	(j)(2) The resident hamust make prompt ef grievances the reside with this paragraph.  (j)(3) The facility must to file a grievance or resident.  (j)(4) The facility must to ensure the prompt regarding the resident paragraph. Upon requa copy of the grievance policy mustipostings in prominent facility of the right to f (meaning spoken) or grievances anonymous of the grievance officican be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the coindependent entities to be filed, that is, the pequality Improvement Agency and State Looprogram or protection.	s the right to and the facility forts by the facility to resolve ent may have, in accordance to make information on how complaint available to the stablish a grievance policy resolution of all grievances ts' rights contained in this uest, the provider must give be policy to the resident. The trinclude:  Individually or through the locations throughout the file grievances orally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone of expected time frame for the grievance; the right contact information of with whom grievances may tertinent State agency, Organization, State Survey ing-Term Care Ombudsman and advocacy system;	F	166			6/2/17
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/30/2017

**Electronically Signed** 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPLI	
		345464	B. WING		05/1	1/2017
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 166	by the facility; maintal information associate example, the identity grievances submitted written grievance decoordinating with staff necessary in light of staff in the staff in the steps taken to invisually and the date the written grievance with Staff in the steps taken to invisually and the date the written by the facility and the date the written by the facil	any necessary investigations ining the confidentiality of all ad with grievances, for of the resident for those I anonymously, issuing sisions to the resident; and the and federal agencies as specific allegations; using immediate action to tial violations of any resident ad violation is being  483.12(c)(1), immediately violations involving neglect, ries of unknown source, from of resident property, by revices on behalf of the nistrator of the provider; and law;  written grievance decisions grievance was received, a of the resident's grievance, a ment findings or conclusions at's concerns(s), a statement evance was confirmed or not citive action taken or to be a result of the grievance, en decision was issued;	F 16	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	COMPLETED	
		345464	B. WING		C <b>05/11/2017</b>
	ROVIDER OR SUPPLIER  VE HEALTH CARE CE	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139		03/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 166	confirms a violation rights within its area (vii) Maintaining evicesult of all grievand 3 years from the issidecision. This REQUIREMEN by: Based on record refacility failed to investigation and provide in writing a investigation and provide in writing	al law enforcement agency for any of these residents' a of responsibility; and dence demonstrating the test for a period of no less than uance of the grievance.  IT is not met as evidenced eview and staff interviews, the stigate grievances for 1 of 3 Resident #2) and failed to summary of the grievance ovide in writing the results of the for 3 of 3 sampled residents estidents #2, #3 and #6).  Ed:  admitted to the facility on #2 was admitted with  ances revealed Resident #2's RP) filed a teleport through the social are Report through the social are Report description tent #2's dressing was very wet	F 10	,	tten /12/17 rector onitor igation
	concern was that the not receive lunch ye not receive dinner la responsible parties concerns included the dietary Mar	ed to be dry. The second e resident reported that he did esterday or today and also did est night. The form listed the for investigating these he Director of Nursing (DON) hager (DM). This form was a hat a copy was maintained. ttached.		3) On 05/11/2017, the Executive Dir was re-educated by the Regional Di of Clinical Services on the grievance process and the responsibility of the Grievance Officer to ensure a comp thorough investigation has been completed and a written copy of res provided to the concerned party. Of 05/12/2017, the Executive Director re-educated the Interdisciplinary Tea	rector e e e e e e e e e e e e e e e e e e e

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		345464	B. WING _				C / <b>11/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADD	DRESS, CITY, STATE, ZIP CODE	1 00.	
				518 OLD US	HIGHWAY 221		
OAK GRO	VE HEALTH CARE CE	NTER		RUTHERFO	ORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 166	that per interview th delayed as the nurs leave in order to cha understanding. This dated 04/11/17.  There was no evide dietary concerns.  Interview with the D revealed she had no investigate relating to meals.  Interview with the D revealed that the so concern was no long that once she return the nursing issues, it supposed to then painvestigation. She caddition, the DON sonursing issue with the aware the RP shoul investigation and fin Interview with the Ad 1:10 PM that he was to be provided in wrinvestigated.  2. Resident #6 was 08/24/13 with diagnodementia, hemipleg Review of the facility Resident #6 filed a general series.	of the investigation revealed be dressing change was as was waiting for visitors to large it and the RP voiced is was signed by the DON ance of any investigation of the large it and the RP voiced is was signed by the DON ance of any investigation of the large it and the RP voiced any grievance to so Resident #2's missed and large it and worker who took this ger employed. DON stated and the grievance relating to the social worker was lass it to the DM for her lid not do so per the DON. In tated she reviewed the large it in the RP verbally but was not do have gotten a copy of the dings.  Idministrator on 05/11/17 at a sunaware the findings were liting after a grievance was ladmitted to the facility on loses of non-Alzheimer's it and muscle weakness.  If grievances revealed grievance on 02/07/17	F	Admission Medical Busines Clinical Director Supply follow-hired II hire.  4) The and en resolute The Exportion Officer IDT me compliants and entresolute The Exportion of Indiang The remonitor Assurate Command/or Performe evaluate The Indiang Indi	sults of quality improvement oring to be reported to the Qua- ance Performance Improvement ittee monthly by the Administration DCS. The Quality Assurance mance Improvement Committe te the effectiveness of the	or, of t ral lewly l upon nonitor party. rance luring written uality les to very of y at a onths, ial ality ent rator e ee will	
	regarding a Nurse A	grievance on 02/07/17 ide (NA) who answered her		monito	te the effectiveness of the ring/observation tools for makes to the corrective action, if	king	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION		ATE SURVEY DMPLETED	
		345464	B. WING			C 0 <b>5/11/2017</b>	
	ROVIDER OR SUPPLIER	ITER	STREET ADDRESS, CITY, STATE, ZIP CODE 518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139		,	, 3320	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 166	Continued From pag	e 4	F 166	6			
	Resident #6 was told wet and she had just cover back up over h.  The findings of the in report revealed the N room, checked the refound the resident was explain that to the rette grievance was fo or staff member into	The grievance stated by the NA that she wasn't changed her and pulled the ner.  Investigation on the facility NA went into Resident #6's esident for incontinence and as dry and attempted to sident. The plan to resolve or the NAs to take another NA Resident #6's room when complainants remarks were,		necessary, to maintain substant compliance and ensure investig timely delivery of written resolut grievances to concerned party. Quality Assurance Improvement Committee members consist of limited to, the Administrator, Dic Clinical Services, Medical Direct (quarterly at a minimum) and a three other members to include limited to one direct care giver.	gation and tion of The nt f, but not rector of ctor t least e but not		
	form revealed the rescommunicated witho grievance investigation.  An interview conduct with the Director of Norwestigated Resident reviewed the investigation.	ut a written copy of the on given to the resident.  ted on 05/11/17 at 10:07 AM Jursing (DON) revealed she					
	with the Administrato the findings of grieva be provided in writing completed.	ted on 05/11/17 at 1:10 PM or revealed he was unaware ince investigations were to g after the investigation was					
	01/10/17.  Review of a grievance	ce dated 03/13/17 filed by a ed Resident #3's family					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345464	B. WING		05/11/2017		
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CO 518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139	•		
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F 166	information to be faxe staff member called in to see if they had con The family member is because a nurse ask comfort medication wout to the hospital in stated they felt like so care of Resident #3.  Under Action Taken of information read: the family member if they Director of Nursing (I #3 a private room. The they would speak with and get back with help both the Nurse Practic spoke with Resident and yin January about to keep Resident #3 was transferred to Under Status on the information read: Reprivate room and the did not want to speak was signed by the Dorevealed she investig concern but the famil with her therefore she investigation to the family with the properties of th	ed for Resident #3's clinical ed to another facility. The Resident #3's family member acerns about Resident #3. Itated that they were upset ed if they just wanted when Resident #3 was sent January. The family member ome staff were tired of taking on the grievance form, the staff member asked the would like to speak with the DON) and offered Resident another family member or. The form also noted that itioner and Unit Manager #3's family member on the her decline and the decision comfortable or to transfer and Department (ED). Resident to the ED.  Grievance form, the sident #3 was moved to a Resident's family member with the DON. The form DN and dated 03/14/17.  DN on 05/10/17 at 1:45 PM stated Resident #3's family's y member refused to speak er could not explain the amily member nor did she ember with a written copy of	F 1	66			

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	ROVIDER OR SUPPLIER  VE HEALTH CARE CEN	TER	STREET ADDRESS, CITY, STATE, ZIP CODE 518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139		03/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE COMPLETION
F 166	1:10 PM revealed he	e 6 ministrator on 05/11/17 at was unaware that a written e investigation and findings	F 10	66	
F 279 SS=D	were to be provided	to the complainant. 1) DEVELOP	F 2'	79	6/2/17
	assessments comple months in the resider results of the assess	ust maintain all resident eted within the previous 15 nt's active record and use the ments to develop, review ent's comprehensive care			
	483.21 (b) Comprehensive 0	Care Plans			
	comprehensive persite each resident, consist set forth at §483.10(dincludes measurable to meet a resident's and psychosocial near the second s	develop and implement a con-centered care plan for stent with the resident rights c)(2) and §483.10(c)(3), that objectives and timeframes medical, nursing, and mental eds that are identified in the ssment. The comprehensive ribe the following -			
	or maintain the resident physical, mental, and	are to be furnished to attain ent's highest practicable by psychosocial well-being as 24, §483.25 or §483.40; and			
	under §483.24, §483 provided due to the r	would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse			

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	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139	1 00/11/2017	
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F 279	rehabilitative service provide as a result of recommendations. I findings of the PASA rationale in the residential in the resid	services or specialized es the nursing facility will of PASARR f a facility disagrees with the ARR, it must indicate its lent's medical record.  ith the resident and the ative (s)- coals for admission and  reference and potential for cilities must document t's desire to return to the essed and any referrals to es and/or other appropriate cose.  in the comprehensive care, in accordance with the thin paragraph (c) of this lent is not met as evidenced view and staff interview, the elop a care plan for pressure dents sampled for pressure de.	F 2	F279 SS=D Develop Comprehensive Car 1) On 05/10/17, the minimum dat (MDS) nurse updated Resident # comprehensive care plan to reflect residents healed pressure sore	a set 4 ct the and	
	hospital on 04/05/17	mitted to the facility from the '. Her diagnoses included a urinary tract infection, athy.		current skin concerns and preven treatment. Resident #4 was disch home on 5/29/17.		

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		345464	B. WING			C 05/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.0.0.		STREET ADDRESS, CITY, STATE, ZIP COD		15/11/2017	
TVAIVIL OF T	TO VIDER OR OUT LIER				_		
OAK GRO	VE HEALTH CARE CEN	TER		518 OLD US HIGHWAY 221			
				RUTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 279	F 279 Continued From page 8  Review of the hospital records dated 04/05/17 and sent to the facility upon discharge revealed		F 2	2) On 05/12/2017, the Director Services completed a quality improvement monitor of reside			
	under the skin notation	on that she had a stage 2		admitted 4/12/17-5/12/17 and	all current		
	-	was present on admission.		facility residents to ensure the			
	This was included in the	the list of discharge ompanying FL 2 (a form		comprehensive care plan acc reflects the residents curren			
		ed for skilled nursing care		condition, to include residents			
		05/17 included under the		with pressure ulcers and/or fa			
	'	had a sacral "stage 2"		acquired pressure ulcers. No			
	(pressure ulcer) and o			discrepancies were identified.			
	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).			3) On 5/11/17, the Director of Services re-educated licensed the policies and procedures o pressure ulcers, measuring an obtaining and transcribing phy treatment orders, tracking and	d nurses on f assessing nd staging, ysicians□		
		on this form by Nurse #1 that a skin assessment was		residents □ care plan (interim			
		a "stage 2 ulcer noted to		comprehensive) upon admiss			
		rith) cream on it. Unit		and with changes to skin cond	-		
	Manager aware."	,		hired licensed nurses will be e			
		ion orders dated 04/05/17			to appear		
		sion by the Unit Manager did nent orders for the pressure		The admitting licensed nurse and document residents skii			
	ulcer.	nent orders for the pressure		upon admission/readmission			
	dioci.			Admission Data Collection too			
	Review of the initial d	ietary assessment dated		ensure physicians orders ar			
		"stage 2" (pressure ulcer) on		and accurately transcribed on			
		mmendations to add Prostat		treatment administration reco			
	(protein supplement)			pressure ulcer/non-pressure u	• •		
	(p. otom cappiomont)			and interim plan of care is upo			
	Review of the History	and Physical completed by		accordingly. Assessment and			
		6/17 revealed the only		documentation of identified pr			
		s under the area of the		ulcers to include measuremen			
		at her skin was warm and		description and staging (stagi	•		
		nal and she had a double		registered nurse) upon admis	• .		
		ly Inserted Central Catheter)		new identification and weekly			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345464	B. WING			C <b>5/11/2017</b>	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	<del>-1</del>	STREET ADDRESS, CITY, STATE, ZIP COD		5/11/2017	
				518 OLD US HIGHWAY 221			
OAK GRO	VE HEALTH CARE CEN	ΓER		RUTHERFORDTON, NC 28139			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 279	Continued From page	9	F 27	79			
F 279	PICC line in place to redness or edema. To sacral pressure ulcer the past medical history the pa	ther right upper arm without there was nothing about the mentioned including under ory section.  um Data Set (MDS) dated dent #4 with intact cognition, asistance with bed mobility, to being frequently and always incontinent of ambulatory. She was coded tressure ulcer, which was the each accordary to potential and a current "Stage 2" as acrum. The CAA stated continued with daily checks distering post incontinence assure ulcer care was given. The CAA stated a care plan amprove current status of the each developing a pressure.	F 27	The wound nurse/registered in designee to track progress of ulcers weekly and with report by reassessing, measuring, s documenting on the weekly p record and corresponding wo wound nurse/ MDS nurse will comprehensive plan of care is implemented and updated time changes to accurately reflect skin concerns and treatment DCS to review skin concerns morning clinical meeting and risk meetings for compliance.  4) Director of Clinical Service complete quality improvement of residents skin care plan accuracy at a frequency of or weekly for three (3) months a monthly for five (5) residents ongoing until substantial commet. Frequency of monitoring modified based on findings.  The results of quality improvement of the results of quality improvement of the reported to the Assurance Performance Improvement Committee monthly by the Adand/or DCS. The Quality Assurance Improvement Committee the effectiveness of monitoring/observation tools changes to the corrective actinecessary, to maintain substacompliance and ensure accurate.	is pressure led changes led changes led gressure ulcer led changes led gressure ulcer led changes led gressure ulcer led gressure ulcer led gressure the led ensure the led gressure ulcer led gressure the led gressure ulcer led gressure the led gressure ulcer l		
				plan development for residen pressure ulcers. The Quality Improvement Committee mer	ts with Assurance		

C <b>05/11/2017</b>
05/11/2017
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LD BE COMPLETION PRIATE DATE
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6/2/17
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	13/11/2017	
				518 OLD US HIGHWAY 221			
OAK GRO	VE HEALTH CARE CEN	ΓER		RUTHERFORDTON, NC 28139			
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F 281	Continued From page	e 11	F 28	31			
F 201	Incision, Wound Dres (1) piece Mesalt rope, covered Hydrofiber, Silver Imp (1) sheet Aquacel-Ag Aquacel-Ag sheet and Review of the admiss transcribed by Nurse medications as stated no transcribed treatm the order form. The packnowledging the or 04/10/17.  The Admission Data 04/08/17 identified Repictures with a stage 5 cm on right lower a cm x 7 in front abdomem on right buttocks at the piece of the piece	sing: Foam, Other: removed , repacked with (1) piece with 4x4 border foam. oregnated, Other: removed , replaced with (1) d interdry cloth."  ion physician orders #3 on 04/08/17 included the d on the FL 2. There were ent orders of any kind on ohysician signed this form ders were in effect on  Collection tool dated esident #2 via hand written 3 area 2 centimeters (cm) x odomen, a stage 3 area 3 ien, a stage 2 area 4 cm x 6 and an open area on the	F 28	Services completed a quality improvement monitor of resid admitted 4/12/17-5/12/17 and facility residents to ensure tree orders have been accurately onto the TAR for administratic and/or treat pressure sores. In follow up was indicated.  3) On 5/11/17, the Director of Services re-educated licensed the policies and procedures of pressure ulcers, measuring an obtaining and transcribing phystreatment orders, tracking and residents care plan (interim comprehensive) upon admiss and with changes to skin conchired licensed nurses will be expon hire.  The admitting licensed nurse	all current atment transcribed on to prevent lo additional  Clinical d nurses on f assessing nd staging, ysicians d updating and/or ion, weekly dition. Newly educated		
	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			and document residents ski upon admission/readmission Admission Data Collection to ensure physicians orders are and accurately transcribed on treatment administration recopressure ulcer/non-pressure ulcer/non-pressure and interim plan of care is upon accordingly. Assessment and documentation of identified prulcers to include measuremer description and staging (staging registered nurse) upon admis new identification and weekly The wound nurse/registered resignee to track progress of ulcers weekly and with reporter	n condition on the ol and e obtained ito the rd (TAR), ulcer record dated ressure int, ing by sion and/or thereafter. hurse pressure		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	
		345464	B. WING			05/	11/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OAK GRO	VE HEALTH CARE CENT	TER		5′	18 OLD US HIGHWAY 221		
OAK OKO	VE HEALIN OAKE OLK	ILK		R	UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	dressings with aquace Systems" the physicial treated for infection in chronic scrotal and in Under "Physical Exaringuinal wound, mace skin folds, chronic skit the skin. Under Planthe skin with "He will wound care of his low scrotal wounds."  Review of the Treatm following wound care during his stay in the 04/10/17:  1. Scrotum wound - copack with alginate silv foam dressing. There this was to be completed from the complete form of times this was to be done during 7p-7a.  The only nursing note treatment was dated of dressing changed to scrotum. Silver alginal	as treated with routine el. Under the Review of an noted he was recently a scrotal wound, he has guinal (groin) wound. m" the physician noted a left eration of wound beneath an changes with thickening of a the physician addressed continue w/ (with) routine wer abdominal, injuinal and  ent Record revealed the provided to Resident #2 facility on 04/09/17 and  leanse with normal saline wer, cover with 4x4 border e was no number of times eted other than during the  ands - cleanse with normal silver in fold. There was no was to be completed other	F	281	by reassessing, measuring, staging and documenting on the weekly pressure usercord 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 the (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 Administrate and/or DCS. The Quality Assurance Performance Improvement Committee 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 transcription of treatment ord	Icer  ine  ine  ine  ine  ine  ine  ine  i	
	Review of the Minimu stated he was indepe	nm Data Set, dated 04/11/17 Indent for daily decision Ensive to total assistance			TAR for administration to prevent and/o heal pressure sores. The Quality Assurance Improvement Committee members consist of, but not limited to,	or	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	1 ,	ATE SURVEY OMPLETED
		345464	B. WING _			C <b>05/11/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	l	<u> </u>	STREET ADDRESS, CITY, STATI	•	00/11/2017
OAK ODG	WE HEALTH CARE O	ENTER		518 OLD US HIGHWAY 221		
OAK GRO	OVE HEALTH CARE C	ENIER		RUTHERFORDTON, NC 2	8139	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page	age 13	F 2	281		
F 281	with most activities stage 2 pressure a all present on adm Review of telephon no telephone orde  An interview with Nesident #2's adm via phone on 05/05 stated that when s verified the hospita physician upon ad the orders, a secon orders for accuracy Interview with the 8:39 AM revealed orders from the hothe facility physicias sheet and medicat administration recorders were no wou would be notified a Manager went throwerified there were A phone interview Nurse #4 who rech for Resident #2 co was conducted. N	s of daily living skills, had 1 and 2 stage 3 pressure ulcers ission.  The orders revealed there were are for treatment for any wound.  The worders was conducted ission orders was conducted ission orders was conducted in a conducte	F2	Administrator, Director Services, Medical Dirminimum) and at least members to include to direct care giver.  AOC Date: 6/2/17	rector (quarterly at a st three other	
	wounds.  Nurse #3 was inter 05/11/17 at 9:27 A verified the wound should have transo	rviewed a second time on  M. Nurse #3 stated she orders with the physician and cribed them to the order form. It put them on the treatment				

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345464	B. WING		C 05/11/2017
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139	1 03/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
	the admission, and be change, Nurse #4 co.  The Director of Nursi 05/11/17 at 9:44 AM abdominal and butto She did not observe expected that nurses orders for each wour the order sheet. She Manager was resport ensure orders for neron the order sheet.  On 05/11/17 at 9:54 during interview that wounds on Monday and she should have on the Weekly Wount was present at this ir lack of physician ord should have been ide Monday.  483.25(b)(1) TREAT PREVENT/HEAL PRE	d. She stated she started recause he arrived at shift ampleted the admission.  Ing stated during interview on that she observed the cks wound and stage them. The scrotum area. She should obtain physician and and write those orders on a further stated that the Unit asible for rechecking to any admissions were in place.  AM, the Unit Manager stated she saw Resident #2's refer admission (04/10/17) transcribed the observation of Worksheet. The DON interview and stated that the ers for Resident 2's wounds rentified and clarified on the semant of a resident, the	F 28		6/2/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345464	B. WING		C <b>05/11/2017</b>
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139	1 00/11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 314	Continued From pag	e 15	F 31	4	
	necessary treatment professional standar healing, prevent infe from developing. This REQUIREMEN' by: Based on observation interviews and reside to assess a pressure measure it, obtain progression for 1 of a reviewed for pressure. The findings included Resident #4 was adrhospital on 04/05/17 sepsis secondary to debility, and neuropated Review of the hospit and sent to the facility under the skin notation pressure ulcer which This was included in diagnoses. The accomplication of the Admission dated 04/05/17 at 1:0 a skin section with a skin issue on Reside was hand noted to be	e ulcers (Resident #4).  d:  nitted to the facility from the Her diagnoses included a urinary tract infection, ithy.  al records dated 04/05/17 y upon discharge revealed on that she had a stage 2 was present on admission. the list of discharge ompanying FL 2 (a form ed for skilled nursing care //05/17 included under the had a sacral "stage 2"		F314 Treatment/Services to prevent/heal pressure ulcers SS=D  1) On 5/10/17, the Wound Physician made a facility visit to reassess Resid. #4 skin condition and provide orders to minimize risk of pressure sores. On 5/10/17, the licensed nurse reassesses Resident #4 skin condition, implement a non-pressure ulcer record to track progress and accurately transcribed in treatment orders onto the treatment administration record (TAR) per physician orders. On 05/10/17, the minimum date (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 vidischarged home on 5/29/17.  2) On 05/12/2017, the Director of Clin Services completed a quality improvement monitor of residents admitted 4/12/17-5/12/17 and all current facility residents to ensure residents we pressure sores have a thorough skin assessment to include initial and weel measurements and staging of pressurulcers, accurate transcription and	d ded eed ew cian da e o vas cal ent eith

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345464	B. WING		C <b>05/11/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/11/2011
				518 OLD US HIGHWAY 221	
OAK GRO	VE HEALTH CARE CEN	NTER		RUTHERFORDTON, NC 28139	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFILIENCY)	O BE COMPLETION
F 314	Continued From pag	ge 16	F 314	4	
	done and there was	t that a skin assessment was a "stage 2 ulcer noted to with) cream on it. Unit		administration of treatment orders, updated comprehensive care plan to prevent/treat pressure sores and on weekly tracking of wound progressic additional discrepancies were identification.	going n. No
	received upon admis	sion orders dated 04/05/17 ssion by the Unit Manager did ment orders for the pressure		3) On 5/11/17, the Director of Clinical Services re-educated licensed nurse the policies and procedures of assess pressure ulcers, measuring and stage	es on esing
	04/05/17 identified a	dietary assessment dated  "stage 2" (pressure ulcer) on  ommendations to add Prostat ) for wound healing.		obtaining and transcribing physicians treatment orders, tracking of wound progression and updating residents plan (interim and/or comprehensive) admission, weekly and with changes	s□ □ care upon
	the physician on 04/	y and Physical completed by 06/17 revealed the only es under the area of the		skin condition. Newly hired licensed nurses will be educated upon hire.	
	moist, color was nor lumen (Percutaneou PICC line in place to	hat her skin was warm and mal and she had a double sly Inserted Central Catheter) her right upper arm without There was nothing about the		The admitting licensed nurse to asse and document residents skin cond upon admission/readmission on the Admission Data Collection tool and ensure physicians orders are obtai	ition
		r mentioned including under		and accurately transcribed onto the treatment administration record (TAF pressure ulcer/non-pressure ulcer re	₹),
	coded Resident #4 v extensive assistance and toileting, being the bladder and always being nonambulator	num Data Set dated 04/12/17 with intact cognition, requiring e with bed mobility, transfers frequently incontinent of incontinent of bowel, and y. She was coded as having ulcer, which was present on		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 ar new identification and weekly therea The wound nurse/registered nurse designee to track progress of pressure.	nd/or fter.
	pressure ulcers date pressure ulcers trigg	Area Assessment (CAA) or and 04/17/17 stated that pered secondary to potential and a current "Stage 2"		ulcers weekly and with reported cha by reassessing, measuring, staging documenting on the weekly pressure record and corresponding wound. The	nges and e ulcer

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION (X3) DATE SUR' COMPLETE		
		345464	B. WING			C 5/44/2047
NAME OF P	ROVIDER OR SUPPLIER	0.0.01		STREET ADDRESS, CITY, STATE, ZIP CO	•	5/11/2017
NAME OF T	NOVIDEN ON OUR FEIEN				-DL	
OAK GRO	VE HEALTH CARE CEN	ITER		518 OLD US HIGHWAY 221		
				RUTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	Continued From pag	e 17	F 3	14		
F 314	(pressure ulcer) to the weekly skin checks of by aides when admir care as needed. Predaily and as needed would be initiated to Stage 2 pressure ulcombox.  Review of physician 04/21/17 revealed the ordered to be administed to be	ne sacrum. The CAA stated continued with daily checks nistering post incontinence essure ulcer care was given. The CAA stated a care plan improve current status of cer to sacral area.  to pressure ulcers was  telephone orders dated eat Prostat 30 milliliters was istered every day for 30 days etician's recommendation. ation Administration Record	F3	wound nurse/ MDS nurse with comprehensive plan of care implemented and updated the changes to accurately reflect skin concerns and treatment DCS to review skin concerns morning clinical meeting and risk meetings for compliance.  4) Director of Clinical Service complete quality improveme of residents medical record initial and weekly assessme measurement and staging, a treatment order transcription for administration, updated of (interim and comprehensive weekly tracking of wound proprevent/treat pressure sores frequency of one (1) time were (3) months and then monthly residents, and then ongoing substantial compliance is more of monitoring to be modified findings.  The results of quality improvementioring to be reported to Assurance Performance Impression and the complete to the surface of the complete to the surface performance Impression and the complete to the surface performance Impression and the complete to	is mely with et residents to tresidents to the plan. The solution discovered to the plan. The solution discovered to the plan. The solution discovered to the plan to the the plan	
	During an interview of at 10:41 AM, she state open place on her best it daily.  An interview with Nu AM revealed that best registered nurse, the	with Resident #4 on 05/09/17 Ited that she had a very small ottom but staff put cream on		Committee monthly by the A and/or DCS. The Quality As Performance Improvement (evaluate the effectiveness or monitoring/observation tools changes to the corrective ac necessary, to maintain substantial compliance and ensure prevention/treatment of press The Quality Assurance Improvements of the committee of the compliance of the compl	Administrator SSUTANCE COMMITTEE WILL If the S for making ction, if stantial SSUTE SOTES.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUC			DATE SURVEY COMPLETED
		345464	B. WING _				C <b>05/11/2017</b>
	ROVIDER OR SUPPLIER	TER		518 OLD US	RESS, CITY, STATE, ZIP CODE HIGHWAY 221 DRDTON, NC 28139	<u> </u>	00/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	was unaware of any further stated then the the area on the week were reviewed every show healing progress worksheets revealed listed on them for me progression of healing Nurse #1 revealed the looking like an openemarked it as a stage.  The Unit Manager was 11:28 AM and revealed completed the initial component was identified as Unit Manager assessing and staging nurse was not a regist could measure the artistated she could not this area or not. She should have been write worksheet for tracking interview on 05/10/17 there would not have cream was the cream #4's sacral pressure unit Manager stated pressure ulcer upon a recall if she knew about the should have been with the sacral pressure ulcer upon a recall if she knew about the should have been with the sacral pressure ulcer upon a recall if she knew about the should have been with the sacral pressure ulcer upon a recall if she knew about the sacral pressure ulcer upon a recall if she knew about the sacral pressure ulcer upon a recall if she knew about the sacral pressure ulcer upon a recall if she knew about the sacral pressure ulcer upon a recall if she knew about the sacral pressure ulcer upon a recall if she knew about the sacral pressure. She stated	essure ulcer. She stated she treatment orders. She e Unit Manager would place ly wound worksheet which Tuesday and measured to ss. Review of these Resident #4 was never asurement, staging or for g. Follow up interview with at she recalled the area d blister and therefore she 2.  As interviewed on 05/10/17 at ed the admitting nurse data collection tool and if ed with a pressure ulcer, was responsible for g the area. The admitting stered nurse, that nurse recall if she was aware of further stated that the area if the non the weekly wound g purposes. Upon follow up at 11:47 AM she stated been an order if barrier in being used on Resident ulcer. At this interview, the she had never observed the admission and could not but it.  And #4 stated she was sure ulcer that started in the staff treated it with cream stated it hurt when she was	F3	Commi limited Clinical (quarte three or limited	ittee members consist of, buto, the Administrator, Director I Services, Medical Director erly at a minimum) and at leasther members to include buto one direct care giver.  Date: 6/2/17	tor of ast	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE COMF	SURVEY PLETED
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	345464	B. WING			05/	11/2017
	TER		51	18 OLD US HIGHWAY 221		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL					(X5) COMPLETION DATE
Continued From page On 05/10/17 at 12:25 Resident #4's sacral a Nurse #1. Nurse #1 p On 05/11/17 at 9:44 A Director of Nursing re the Unit Manager woo admitting nurse was r that the wound would and if necessary call to orders and begin the the facility had no star relation to treatment of 483.75(g)(1)(i)-(iii)(2)(COMMITTEE-MEMBI QUARTERLY/PLANS  (g) Quality assessment (1) A facility must mai and assurance comm minimum of:  (ii) The director of nurse (iii) At least three other	PM, an observations of area was observed with pointed to a healed area.  MM, an interview with the evealed she expected that all look at a wound if the not a registered nurse so be staged and documented the physician for wound tracking system. She stated anding orders to refer to in of open areas.  ii)(ii)(h)(i) QAA ERS/MEET  Int and assurance.  Intain a quality assessment ittee consisting at a sing services;  ter members of the facility's	F	314	CROSS-REFERENCED TO THE APPROPRIA		
individual in a leaders (g)(2) The quality ass committee must: (i) Meet at least quart	chip role; and essurance erly and as needed to					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED FROM PAGE  On 05/10/17 at 12:25 Resident #4's sacral at Nurse #1. Nurse #1 processory of Nursing resident the Unit Manager would admitting nurse was restricted the Wound would and if necessary call the facility had no starrelation to treatment of 483.75(g)(1)(i)-(iii)(2)(COMMITTEE-MEMBI QUARTERLY/PLANS)  (g) Quality assessment (1) A facility must main and assurance communication may be a staff, at least one of wadministrator, owner, individual in a leaders (g)(2) The quality assessment (g)(2) The quality assess	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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	ROVIDER OR SUPPLIER  VE HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  483.75(g)(1)(i)-(iii)(2)(i)(iii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  (g) Quality assessment and assurance.  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(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	A BUILDING  345464  345464  B. WIND  STREET ADDRESS, CITY, STATE, ZIP CODE  918 OLD US INIGHWAY 221  RUTHERFORDTON, N. 28139  SUMMARY STATEMENT OF PERCIENCIES  (EACH DEPROBLEM MUST BE PRECEIBED BY PLL REGULATORY OR LSC DENTIFYING INFORMATION)  COntinued From page 19  Continued From page 19  Con 105/10/17 at 12:25 PM, an observations of Resident #4's sacral area was observed with Nurse #1 pointed to a healed area.  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WING  STREET ADDRESS. CITY. STATE. 2IP CODE  SCALE ADDRESS. CITY. STATE. 2IP CODE  SC

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION		X3) DATE : COMPL	
	345464	B. WING _				05/	)  1/2017
	ΓER		518	OLD US HIGHWAY 221		03/	11/2017
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION S	HOULD BE	Ē	(X5) COMPLETION DATE
identifying issues with assessment and assumecessary; and  (ii) Develop and impleaction to correct identify action to correct identify. (h) Disclosure of informs Secretary may not recreted as the community of such communities with a section.  (i) Sanctions. Good factor communities with a section.  (i) Sanctions. Good factor communities will not be sanctions.  This REQUIREMENT by:  Based on record revitable failed to dinterventions and procompliance for 1 deficience failed to dinterventions and procompliance for 1 deficience for 1 deficiency with the complaint are peated deficiency with provided that meet proposed that meet proposed failure to transcribe to failure to transcribe to failure to transcribe to failure to the facility's effective Quality Assumers.	ement appropriate plans of cified quality deficiencies; emation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this entered as a basis for the is not met as evidenced ew and staff interviews, the sament and Assurance evelop and implement cedures to maintain ciency cited during the of 12/15/16 and cited again survey of 05/11/17. The vas in the area of services of deficiency involved the eatment orders at the time peated deficiency during for record show an isolated in ability to implement an irance Program.	F		made a facility visit to reassess #4 skin condition and provide o minimize risk of pressure sores 5/10/17, the licensed nurse rea Resident #4 skin condition, imp a non-pressure ulcer record to progress and accurately transcitreatment orders onto the treatment orders onto the treatmed ministration record (TAR) per orders. Resident #4 was dischard on 5/29/17.  2) On 05/12/2017, the Director	Residen riders to . On ssessed elemented rack ribed nevent r physicial riged hor	d v an me	
This tag is crossed re	ferred to:			Services completed a quality improvement monitor of resider	nts		
	SUMMARY ST. (EACH DEFICIENCY REGULATORY OR I.  Continued From page identifying issues with assessment and assunecessary; and  (ii) Develop and imple action to correct identifying issues with assessment and assunecessary; and  (ii) Develop and imple action to correct identify action to correct identify is section.  (i) Sanctions. Good facommittee with its section.  (i) Sanctions. Good facommittee to identify deficiencies will not be sanctions.  This REQUIREMENT by:  Based on record revifacility's Quality Asset Committee failed to dinterventions and procompliance for 1 deficience for 1 deficience for 1 deficience for 1 deficiency with a complaint strepeated deficiency with provided that meet proposed that meet proposed failure to transcribe troof admission. This retwo federal surveys of pattern of the facility's effective Quality Assume The findings included.	TORRECTION  345464  ROVIDER OR SUPPLIER  VE HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	ROVIDER OR SUPPLIER  VE HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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:	A BUILDING  345464  B. WING  STE STE STE STE STE STE STE STE STE ST	A BUILDING  345464  ROVIDER OR SUPPLIER  VE HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH OFFICIENCY MUST BE PRECEDED BY PULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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The findings included:  2) On 05/12/2017, the Director Services completed a quality	TOURIDER OR SUPPLIER  VE HEALTH CARE CENTER  SUMMARY STATEMENT OF DEPICIENCIES  SUMMARY STATEMENT OF DEPICIENCIES  REQUIATORY OR LSC IDENTIFYING INPORMATION)  Continued From page 20  Continued From page 20  (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;  (in) 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 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 aliele to develop and implement interventions and procedures to maintain compliance for 1 deficiency of 15/11/17. The repeated deficiency was in the area of services provided that meet professional standards of quality. The current deficiency will not be a read of services provided that meet professional standards of quality. The current deficiency during two federals surveys of 102/11/17. The repeated deficiency was in the area of services provided that meet professional standards of quality. The current deficiency during two federals surveys of record show an isolated pattern of the facility's inability to implement an effective Quality Assurance Program.  The findings included:  2 D D FROMDERS RLANG FORDROM (EACH ORDROM) (EACH O	A BUILDING  345464  345666  3456666666668  34546666666669  346466666666969  3464666666666969  346466666666969  346466666666969  34646666666969  346466666666969  346466666666969  346466666666969  346466666666969  346466666666969  346466666666969  346466666666969  34646666666696969669696

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NAME OF PROVIDER OR SUPPLIER  OAK GROVE HEALTH CARE CENTER    SUMMARY STATEMENT OF DEFICIENCIES   SIGN US HIGHWAY 221 RUTHERFORDTON, NC 28139		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  OAK GROVE HEALTH CARE CENTER    CAN   ID   SUMMARY STATEMENT OF DEFICIENCIES   RUTHERFORDTON, NC 28139			0.45404					
Sta OLD US HIGHWAY 21   PALTY   CAPE CENTER   SUMMANY STATEMENT OF DEFICIENCIES   PRETEX   FACIOR SECTION SECURATION SHOULD BE   CAPE CICIENCY MUST BE PRECEDED BY FILL   REGULATORY OR LSC IDENTIFYING INFORMATION.   PRETEX TAG   PREFIX TAG    F 520   Continued From page 21   F 520   admitted 4/12/17-5/12/17 and all current facility residents to ensure treatment orders have been accurally transcribed onto the TAR for administration to prevent and/or treat pressure sores. No additional discrepancies were identified.   Services re-educated licensed nurses on the policies and procedures of assessing pressure ulcers, measuring and staging, obtaining and transcribing physicians: I treatment orders, tracing and updating residents care plan (interim and/or comprehensive) upon admission weekly and with changes to skin condition upon admission orders.   The admitting licensed nurse to assess and document residents is skin condition upon admission/readmission on the Admission Data Collection tool and ensure physicians: I treatment orders, tracing and updating residents is one to the pressure ulcers, measuring and staging, obtaining and transcribing physicians: I treatment orders, tracing and updating residents is one to the pressure ulcers, measuring and staging, obtaining and transcribing physicians: I treatment orders, tracing and updating residents is one to the pressure ulcers, measuring and staging, obtaining and transcribing physicians: I treatment orders, tracing and updating residents is one condition. Newly hired licensed nurses will be educated upon hire.    The admitting licensed nurse to assess and document residents is skin condition upon admission patched in the Admission Data Collection tool and ensure physicians: I treatment administration record (TAR), pressure ulcer/non-pressure ulcer from the pres			345464	B. WING			05/	11/2017
CALID   CAL	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RUTHERRORDIO, No. 23413    SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REQUIRED MAN SHOULD BE PRECEDED BY FULL TAG.   PREPIX REGULATORY OR LSC IDENTIFYING INFORMATION)   PREPIX TAG.	OAK GRO	VE HEALTH CARE CEN	TER		5′	18 OLD US HIGHWAY 221		
F 520  Continued From page 21  F 520  Continued From page 21  F 520  F 520  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.  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 condition. Newly hired licensed nurses will be educated upon hire.  The facility transcriptions on new admission orders.  T 620  F 520  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.  Services re-educated licensed nurses on the policies and procedures of assessing pressure ulcers, 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 is skin condition upon admission on the Admission Data Collection tool and ensure physicians: orders are obtained and accurately transcribed onto the treatment administration record (TAR), pressure ulcer/fono-pressure ulcer record and interim plan of care is updated accordingly. Assessment and documentation of identified pressure ulcers to include measurement,	OAK OKO	VE HEALIH OAKE OEK	LIK		R	UTHERFORDTON, NC 28139		
## 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.  ### The admitting licensed nurse to assess and document residents □ stare order to the treatment administration on the Admission Data Collection tool and ensure physicians □ orders are obtained and accurately transcribed onto the treatment administration record (TARK), pressure ulcer/non-pressure ulcer record and interim plan of care is updated accordingly. Assessment and documentation of identified pressure ulcers to include measurement,	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
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	F 520	F281: Based on reco interviews, the facility physician orders for v residents sampled wi (Resident #2).  The facility was origin recertification survey implement physician administration and fa order for laboratory was During an interview of Administrator stated to on the facility's transo and did not check transo	ord review and staff or failed to transcribe evound care for 1 of 4 th wounds upon admission  ally cited during a on 12/15/16 for failure to orders for medication illure to follow a physician's ork.  on 05/11/17 at 1:10 PM, the the facility had concentrated cription from month to month	F	520	admitted 4/12/17-5/12/17 and all currer facility residents to ensure treatment orders have been accurately transcribe onto the TAR for administration to prev and/or treat pressure sores. No additio discrepancies were identified.  3) On 5/11/17, the Director of Clinical Services re-educated licensed nurses of 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, week and with changes to skin condition. Ne 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 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/new identification and weekly thereafted the wound nurse/registered nurse designee to track progress of pressure ulcers weekly and with reported changed by reassessing, measuring, staging and	ed ent nal on ng g, g kly wly on ed or er. es d	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED
		345464	B. WING			C
	ROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, 518 OLD US HIGH RUTHERFORDT		05/11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 520	Continued From page	e 22	F	record and of wound nurse comprehens implemented changes to a skin concern DCS to revie morning clin risk meeting.  On 5/11/17, Clinical Serval Interdiscipling Executive Data Admissions Medical Recomplemented Business Of Clinical Serval Director, Die Supply on Factor, Director, Die Supply on Factor, Director, Die Supply on Factor, Director, Director, Director and Director and and Perform (QAPI) programmented between determined and procedure viewing and plans for are been identified substantial in provide the	corresponding wound. The e/ MDS nurse will ensure the sive plan of care is dependent of and updated timely with accurately reflect residents and treatment plan. The ew skin concerns during nical meeting and weekly skings for compliance.  The Regional Director of vices re-educated the mary Team (IDT), including the pricetor, Maintenance Director and Coordinator, cords, Social Services, fficer Manager, Director of vices, Minimum Data Set etary Manager and Central federal Regulation F520 and QAPI Committee Policy and ongoing Quality Assuration and the Executive Director, Clinical Services, Medical dat least 3 other members at least monthly (Medical east quarterly). The processes are of implementing, and revising ongoing action eas of deficiency that have fied to attain and maintain regulatory compliance and highest level of care to lewly hired IDT employees dupon hire.	citin the ttor,

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345464	B. WING _			05/	11/2017
	ROVIDER OR SUPPLIER	ren.			TREET ADDRESS, CITY, STATE, ZIP CODE 18 OLD US HIGHWAY 221		
OAK GRO	VE HEALTH CARE CENT	IEK		R	UTHERFORDTON, NC 28139		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	23	F	520	4) The Director of Clinical Services to complete quality improvement monitori of residents ☐ TAR to ensure accurate transcription of treatment orders at a frequency of one (1) time weekly for the (3) months and then monthly for five (5 residents, and then ongoing until substantial compliance is met. Frequer 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 Administrate and/or DCS. The Quality Assurance Performance Improvement Committee 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/o heal pressure sores. The Quality Assurance Improvement Committee members consist of, but not limited to, Administrator, Director of Clinical Services, Medical Director (quarterly at minimum) and at least three other members to include but not limited to o direct care giver.  AOC Date: 6/2/17	ree ) ncy  rea  rea  ree  ree  ree  ree  ree  re	