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 _____	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE HEALTH CARE CENTER	518 OLD US HWY 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 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to stop administration of medication after the medication was discontinued for one (1) of eight (8) residents reviewed for unnecessary medications. (Resident #3) The findings are: Resident #3 was readmitted 4/4/11 with diagnoses including Alzheimer's disease. The most recent Minimum Data Set (MDS) dated 2/23/11 revealed memory problems and severely impaired decision-making skills. The MDS also revealed dependence on staff for Activities of Daily Living. A 5/10/11 review of the pre-printed May 2011 Physician's Orders revealed an order for "Aspirin 81 mg [milligrams] tablet one tablet by mouth daily" along with several other medication orders with a handwritten "dc'd" (discontinued) written next to each order. A comparative review of the physician's orders to the May 2011 Medication Administration Record (MAR) revealed handwritten "dc'd" notation next to the same medication orders, including the Aspirin order. Review of the MAR revealed the discontinued medications were also highlighted with the exception of Aspirin order. Further review of the MAR revealed the Aspirin order was initialed as	F 281	(F 281) A. ASA administration was stopped for Resident #3 on 5/12/11. The resident's physician was notified of the error. B. All residents have the potential to be affected and therefore a chart audit has been completed on all residents to ensure no other errors had been made. No other errors were found C. Systemic changes put in place: institution of a second month end changeover check for all Physician Order sheets, MARs and TAR's . In addition to the system check currently in place, the night shift nurses on the last day of the month will check the current month's MAR and compare to the new month's MAR for any further issues not caught by the first review. In addition, all licensed nurses will be inserviced regarding order transcription and month end verification. Monitoring will be to monitor all readmit orders in daily clinical meeting as it occurs and to monitor new MARS (5) at the beginning of the new month to assure accuracy. By DON or designee D. Results of the Quality Improvement review will be reported to the QI/RM committee monthly x 12 months to identify trends and need for further education and/or monitoring.	6/9/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Traci V. Cotton — TITLE: Administrator — (X6) DATE: 6/2/2011

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

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F 281	Continued From page 1 administered by nursing staff from 5/1/11 through and including 5/10/11. Review of the April 2011 MAR following the 4/4/11 readmission revealed Aspirin was not ordered for the resident. Review of the 4/2/11 FL-2 form in the medical record revealed Aspirin was not among the medications listed for the resident. During an interview on 5/10/11 at 2:45 p.m., Licensed Nurse (LN) #1 stated she reviewed the medications and wrote "d/c'd" on the May 2011 Physician's Orders for Resident #3. The nurse reported the order sheet was a triplicate form and included the May 2001 MAR. LN #1 stated they used the orders on the FL-2 when the resident was readmitted and confirmed Aspirin 81mg daily was not listed on the form. The nurse said she highlighted the discontinued orders on the MAR "but I just missed the Aspirin." An interview was conducted with LN #2 on 5/10/11 at 2:55 p.m. The nurse said she overlooked the "d/c'd" notation next to the Aspirin order and stated the order on the MAR should have been highlighted. During an interview on 5/12/11 at 3:05 p.m., the Director of Nursing stated she expected the nurses to accurately transcribe orders when they reviewed the MARs.	F 281		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide complete incontinence care (Residents #5 and #8) and removal of female facial hair (Residents #11 and #12) for four(4) of twelve (12) residents reviewed for assistance with Activities of Daily Living. The findings are: 1. Review of the Procedure section of the facility's "Perineal Care" policy, dated 8/04 and revised 6/08, revealed the following for providing female incontinent care: "9. Separate the labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum. Avoid the area around the anus. 10. Use a clean wash cloth/wipe and rinse thoroughly from front to back. Some perineal washes/wipes do not require a rinse. 11. Pat the area dry with a bath towel. 12. Apply ordered creams or ointments. Remove gloves, wash hands, and apply clean gloves if original gloves were heavily soiled." Resident #3 was readmitted 4/4/11 with diagnoses including Alzheimer's disease. The most recent Minimum Data Set (MDS) dated 2/23/11 revealed memory problems, severely impaired decision-making skills, and occasional incontinence. The MDS also revealed dependence on staff assistance for Activities of Daily Living including toileting.	F 312	F 312 A. Resident numbers 11 and 12 had facial hair removed. B. All female residents have the potential to be affected by the deficient practice and therefore were observed for the presence of facial hair: none were found. C. All C.N.A 's have been re-educated on the need to provide grooming to female residents for the presence of facial hair. Systemic change put in place is : the assignment of a nursing assistant to check all female residents weekly to ensure their C.N.A. has not left unwanted facial hair on a resident. Monitoring observe 3 residents /week x4 weeks, then 4 residents/month by ADON or designee D. Results of the Quality Improvement review will be reported to the QI/RM committee monthly x 12 months to identify trends and need for further education and/or monitoring.	6/9/11

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F 312	Continued From page 3 On 5/11/11 at 10:43 a.m., Resident #3 was observed receiving incontinence care from two Nursing Assistants (NAs). The resident's groin and labial areas were cleansed and dried by the first NA, and the resident was turned onto her left side. NA #2 washed the resident's buttocks and rectal area, applied barrier cream to the buttocks and rectal area without drying the skin, and assisted redressing the resident. During an interview on 5/11/11 at 10:49 a.m., NA#2 stated she did not always dry the skin when she provided incontinence care and reported she was not taught to do so. An interview with the Assistant Director of Nursing on 5/11/11 at 12:25 p.m. revealed staff were expected to dry the skin after incontinence care. During an interview on 5/11/11 at 12:30 p.m., the Director of Nursing stated she expected staff to follow policy for drying skin when providing incontinence care. 2. Resident #12 was readmitted 10/30/10 with diagnoses including hemiplegia and spinal stenosis. The most recent Minimum Data Set (MDS) dated 3/6/11 revealed severe cognitive impairment. The MDS also revealed dependence on staff assistance for Activities of Daily including personal hygiene. Review of the resident's shower schedule revealed she received showers on Mondays and Thursdays. Continued review of the shower	F 312	F 312 A Both Staff members who provided the incontinent care to Resident's 5 and 8 were immediately reeducated on the procedure of drying the resident following incontinent care. B All residents with incontinence have the potential for be affectedby the deficient practice. All c.n.a. staff reeducated on the procedure drying the resident following incontinent care C Monitoring will be to observe peri Care with 3 residents per week X 4 weeks then 4 residents per month X 11 months by DON or designee D Results of the Quality Improvement review will be Reported to the QI/RM Committee monthly X 12 months To identify trends and need for further education and/or monitoring.	6/9/11

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F 312	Continued From page 4 schedule revealed documentation that the resident last received a shower on 5/9/11 and was scheduled for a shower on 5/12/11. On 5/12/11 at 10:05 a.m., Resident #12 was observed sitting in her wheelchair in the 400 hallway. The resident was appropriately dressed and her hair was neatly combed, but straggly facial hair growth of approximately 1/2 inch in length was observed dotted across her chin area. During an interview on 5/12/11 at 10:25 a.m., Nursing Assistant (NA) #1 said she was Resident #12's NA for the day and revealed the resident had refused a shower earlier but she did plan to reapproach the resident. NA #1 stated she usually worked another hall and did not regularly provide care for Resident #12, but stated shower duties included nail care, cleaning of ears, checking toenails and cleaning between toes, and shaving. On 5/12/11 at 2:00 p.m., observation of the resident's chin revealed the facial hair had not been shaved. A second review of the resident's shower schedule for 5/12/11 revealed documentation of the resident's refusal of a shower. During an interview on 5/12/11 at 2:20 p.m., Licensed Nurse (LN) #3 stated that NA#1 had already left for the day. The nurse also reported shaving was part of the usual daily care and said, "The Nursing Assistants know they they are supposed to do it." 3. Review of the Procedure section of the	F 312		

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F 312	Continued From page 5 facility's "Perineal Care" policy, dated 8/04 and revised 6/08, revealed the following for providing female incontinent care: "9. Separate the labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum. Avoid the area around the anus. 10. Use a clean wash cloth/wipe and rinse thoroughly from front to back. Some perineal washes/wipes do not require a rinse. 11. Pat the area dry with a bath towel." Resident #8 was admitted to the facility on 07/19/07 with diagnoses including Alzheimer's Disease, Parkinson's Disease, and Blindness in left eye. An annual Minimum Data Set dated 02/24/11 indicated the resident had short and long-term memory problems, was totally dependent on staff for personal hygiene, and always incontinent of urine and bowel movements. On 05/11/11 at 1:00 PM Nursing Assistant (NA) #3 was observed providing incontinence care to Resident #8. The resident's brief contained a moderate amount of urine. NA #3 sprayed perineal wash on wet wash cloths and cleaned the perineal area using proper technique then rinsed using a plain wet wash cloth. NA #3 then assisted Resident #8 on her side and cleaned and rinsed the resident's buttocks area in the same manner. A dry brief was then applied. NA #3 was not observed drying the resident's perineal or buttocks area after rinsing with the wet wash cloth. During an interview on 05/11/11 at 1:10 PM NA #3 indicated she had never been instructed to dry	F 312		

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F 312	Continued From page 6 residents' skin after cleaning and rinsing when she provided incontinence care. An interview with the Assistant Director of Nursing on 5/11/11 at 12:25 p.m. revealed staff were expected to dry the skin after incontinence care. During an interview on 5/11/11 at 12:30 p.m., the Director of Nursing stated she expected staff to follow policy for drying skin when providing incontinence care. 4. Resident #11 was admitted to the facility 11/13/2003 with diagnoses including Vascular Dementia, Cerebral Vascular Accident (CVA) and Depression. On the most recent Minimum Data Set (MDS), a quarterly dated 02/28/2011, Resident #11 was assessed as having short and long term memory problems, severely impaired cognitive skills for daily decision making, and as requiring limited physical assistance and with one person support for personal hygiene and bathing. A 12/11/2010 Care Plan addressing Activities of Daily Living (ADLs), revision date undocumented, revealed Resident #11 had ADL deficits related to diagnoses of CVA and Dementia, inability to provide own needs due to cognitive impairment, short and long term memory impairment, and an inability to make decisions. Goals and approaches toward managing Resident #11's ADL deficits included providing and assisting with baths/showers as scheduled, encouraging resident to help with personal hygiene care as feasible, and anticipate resident's needs and provide interventions as necessary.	F 312		

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F 312	Continued From page 7 During initial tour on 05/10/11 at approximately 9:15 AM Resident #11 was observed with multiple white facial hairs approximately one half inch long on the left lower chin and above the left side of her mouth. Additional observations of Resident #11 with visible facial hair, unchanged from original observation, included: 05/11/2011 at 4:00 PM in hallway outside her room 05/12/2011 at 8:30 AM in the dining room for breakfast 05/12/2011 at 10:00 and 10:30 AM participating in an activity in the dining room 05/12/2011 at 1:45 PM in hallway outside her room 05/12/2011 at 2:50 PM in the dining room during an activity The May 2011 daily shower schedules, utilized by Nursing Assistant (NA) staff to document showers, revealed Resident #11 was showered/bathed 05/11/2011. The NA responsible for Resident #11's shower on 05/11/2011 was not available for interview. On 05/12/2011 at 10:30 AM an interview was conducted with NA #1 assigned to Resident #11 on 05/10/2011 and 05/12/2011. During the interview NA #1 observed the facial hair on Resident #11 and stated, during weekly showers and on a daily basis, all NA staff were responsible for grooming their assigned residents which included shaving and/or removal of facial hair. NA #1 stated she did not noticed Resident #11's facial hair and had not provided facial hair removal or shaving on 05/10/11 and 05/12/11.	F 312		

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F 312	Continued From page 8 On 05/12/11 at 12:40 PM an interview was conducted with Resident #11's responsible party. The responsible party reported staff did not always keep Resident #11 free from facial hair and that she (the responsible party) sometimes trimmed the hair to make it less noticeable. The responsible party stated Resident #11 was very particular about her appearance and would be "embarrassed" about having facial hair. During an interview, 05/12/2011 at 2:50 PM, the Director of Nursing (DON) observed Resident #11 and confirmed the resident needed to have facial hair shaved and/or removed. The DON stated all NA staff were responsible for and expected to provide their assigned residents with facial hair removal and/or shaving twice weekly during showers and on a daily basis as needed.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record reviews, the facility failed to apply protective sleeves as ordered for one (1) of six (6) residents at risk for accidents and skin injury. (Resident #1)	F 323		

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F 323	Continued From page 9 The findings are: Resident #1 was admitted 4/3/06 with diagnoses including Alzheimer's Dementia, Congestive Heart Failure, Diabetes and Joint Contractures. The most recent Minimum Data Set (MDS) assessment dated 3/11/11 indicated impairment of memory and cognition and total dependence on staff assistance for all daily care. The Plan of Care dated 6/25/11 addressed the risk for skin impairment with interventions including, "Provide protective and preventative skincare with each shift." Review of the Physician's Orders for May 2011 revealed a 12/8/08 order for geri-sleeves to provide skin protection. Review of the Nursing Assistant (NA) profile sheet used for daily assignments included the entry "geri sleeves." Review of the medical record revealed on 7/16/10, the resident experienced a skin tear to the right forearm. Review of the Treatment Administration Records revealed steri-strip closure and daily treatments were provided for the skin tear. Additional record review revealed the resident experienced skin tears to the right arm and hand on 3/10/11. Investigation of the injuries revealed probable contact with the side rail as the cause of injury. Review of the Treatment Administration Records revealed steri-strip closure and daily treatments were provided for the skin tears. Observations during the initial tour on 5/10/11 at 8:50 a.m. revealed the resident was dressed in a short sleeve gown. No protective sleeves were in place.	F 323	F 323 A. Geri Sleeves were put back on Resident #1 B. No other residents in the facility had an intervention for geri-sleeves. Long sleeves or other measures to prevent skin injuries. C. Staff re-educated on the need to provide intervention prevent skin injuries. Systemic change made to the current system is the requirement of each licensed nurse to note on the 24 hour report each shift that they have checked and ensured the geri-sleeves have been applied as ordered. Monitoring will be to observe 3 residents per week x 4 weeks then 4 residents /month x 11 months By ADON or designee D. Results of the Quality Improvement review will be reported to the QI/RM committee monthly x 12 months to identify trends and need for further education and/or monitoring.	6/9/11

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F 323	Continued From page 10 On 5/11/11 at 9:30 a.m., observation during pressure ulcer treatments and catheter care revealed the resident was dressed in a short sleeve gown with no protective sleeves in place. The Treatment NA (Nursing Assistant) stated the resident's skin on her arms and legs was "very fragile." While assisting with care and treatments, NA #4 stated, "You just touch her and she will bruise or tear." On 5/12/11 at 10:15 a.m., the Assistant Director of Nursing stated she was unaware of the resident wearing geri-sleeves as indicated on the NA assignment sheets. A search in the resident's room revealed the sleeves were in the drawer in the bedside table. The sleeves were applied without difficulty. During an interview on 5/12/11 at 11:15 a.m., NA #1 stated NAs were responsible for the devices listed on their assignment sheets. NA #1 confirmed she routinely took care of Resident #1 but she had not applied the geri-sleeves to the resident and did not recall seeing her wearing the geri-sleeves.	F 323		