| 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 07/13/2022 |

| 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 |
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| E 000 | Initial Comments<br><br>An unannounced recertification survey was conducted on 7/11/22 through 7/13/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness, Event ID# O9RE11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification survey and complaint investigation survey was conducted on 7/11/22 through 7/13/22. A total of 17 allegations were investigated and all of them were unsubstantiated: Intakes: NC00185638, NC00186711, NC00187595 and NC00189168. Event ID# O9RE11. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the | F 578 | | 8/9/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/04/2022

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 578 | Continued From page 1<br>facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to maintain accurate advance directives throughout the medical record for 1 of 18 residents reviewed for advance directives (Resident #204).<br><br>The findings included:<br><br>Resident #204 was admitted to the facility on 7/2/22.<br><br>A review of Resident #204's Electronic Medical Record (EMR) indicated a physician's order dated 7/2/22 for Full Code.<br><br>A document entitled, "Advance Directives Discussion Document," dated 7/2/22 in Resident #204's paper chart indicated to withhold | F 578 | F578 (advance directive)<br><br>On 07/13/2022 resident #204 had order written for Full Code. On 07/13/2022 Advance Directives Discussion Document with Medical Order for Scope of Treatment and was placed in the medical record.<br><br>On 07/29/2022 The Director of Nursing and/or Designee performed A Quality Improvement Monitoring of current resident□s code statuses. Any issues identified were addressed.<br><br>On 07/29/2022 through 08/04/2022 current Licensed Nurses were | |

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| F 578 | Continued From page 2<br>cardiopulmonary resuscitation (CPR) and that Resident #204 had a living will. The document was signed by Resident #204's family member and Nurse #1.<br><br>A copy of a written telephone order dated 7/5/22 in Resident #204's paper chart indicated Do Not Resuscitate (DNR). The copy of the order was signed by the Staff Development Coordinator.<br><br>The admission Minimum Data Set (MDS) assessment dated 7/8/22 indicated Resident #204 was cognitively intact.<br><br>An interview with Nurse #1 on 7/13/22 at 11:20 AM revealed she helped with Resident #204's admission on 7/2/22 and discussed Resident #204's advance directive with her family member. Resident #204's family member stated Resident #204 had a living will, but she had left it at home, so Nurse #1 checked the box for withholding CPR on the Advance Directives Discussion Document. Nurse #1 stated she wasn't sure why full code was on Resident #204's EMR and said she didn't enter this information into Resident #204's EMR.<br><br>An interview with the Staff Development Coordinator (SDC) on 7/13/22 at 11:47 AM revealed she had reviewed the Advance Directives Discussion Document for Resident #204 on 7/5/22 and noted that CPR was to be withheld so she wrote a telephone order for DNR and had the physician sign it on his next rounds. The SDC stated she didn't check Resident #204's EMR to make sure it indicated the same advance directive as what was in Resident #204's paper chart.<br><br>An interview with the Social Services Director | F 578 | re-educated by The Director of Nursing and/or designee on obtaining code status orders, Advance Directives Discussion Document and Goldenrod(if applicable) with Medical Order for Scope of Treatment placed in the medical record. Newly hired staff will be educated upon hire.<br><br>Starting on 08/05/2022 the Director of Nursing and/or designee to perform Quality Improvement Monitoring on code status three times a week for four weeks, then two times a week for four weeks, and then one time monthly for three months.<br><br>The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 08/04/22. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings Quality Assurance Performance Improvement Committee monthly for three months.<br><br>AOC Date: August 09, 2022 | |

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| F 578 | Continued From page 3 | F 578 | | |

(SSD) on 7/13/22 at 11:28 AM revealed she was responsible for advance directives but if she wasn't at the facility when a resident was admitted, the nurses were supposed to initiate the discussion about advance directives with the resident and/or family member if the resident was unable to make decisions. The SSD stated she wasn't aware that a MOST (Medical Orders for Scope of Treatment) form wasn't in Resident #204's medical record and that there was inconsistent information about Resident #204's advance directive in the EMR and the paper chart. The SSD stated she usually audited the new admissions on Fridays to make sure a MOST form was in place and that the advance directive information was consistent, but she must have missed Resident #204.

A follow-up interview with the SSD on 7/13/22 at 11:59 AM revealed she spoke with Resident #204 and found out that Resident #204 wanted to be a full code. The SSD also stated she found a MOST form that had been initiated on 7/2/22 but it was located in the Medical Records' box.

A review of Resident #204's MOST form dated 7/2/22 indicated to attempt CPR if person had no pulse and was not breathing and to provide full scope of treatment. The MOST form was signed by Resident #204's family member on 7/2/22 and by the Physician Assistant (PA) on 7/12/22.

An interview with the Medical Records Officer (MRO) on 7/13/22 at 1:25 PM revealed Resident #204's MOST form had been in her box since 7/2/22 because they were waiting for the physician or the PA to sign it. After it was signed by the PA on 7/12/22, the MRO had not had a chance to file it on Resident #204's paper chart.

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| F 578 | Continued From page 4<br>The MRO stated she didn't have anything to do with the advance directives except filing them in the residents' charts.<br><br>A follow-up interview with Nurse #1 on 7/13/22 at 2:20 PM revealed she had witnessed Resident #204's family member sign both the Advance Directives Discussion Document and MOST form on 7/2/22 but she didn't notice that the Advance Directives Discussion Document indicated DNR, and the MOST form indicated full code. Nurse #1 stated she remembered Resident #204 stating to her to discuss her advance directive with her family member and to have her sign the necessary forms.<br><br>An interview with the Director of Nursing (DON) on 7/13/22 at 3:32 PM revealed the SSD should have reviewed Resident #204's advance directive on 7/5/22 after her admission to the facility on 7/2/22. The DON stated the SSD should have followed up to make sure the advance direction information in Resident #204's EMR and paper chart were consistent and were based on her preference.<br><br>An interview with the Administrator on 7/13/22 at 3:36 PM revealed he didn't know what happened with Resident #204's advance directive but both the admitting nurses and the SSD were responsible for initiating it and making sure it reflected what Resident #204 wanted. | F 578 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be- | F 657 | | 8/9/22 |

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| F 657 | Continued From page 5<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to update care plans to reflect weight loss for 1 of 2 residents reviewed for nutrition (Resident #39) and failed to update care plans for 1 of 1 resident reviewed for pressure ulcers (Resident #17).<br><br>The findings included:<br><br>1. Resident #39 was admitted to the facility on 3/1/2022 with diagnoses of chronic obstructive pulmonary disease. | F 657 | F657<br><br>1. Resident #39 had care plan update to include weight loss. Resident #17 had care plan updated to include pressure ulcer.<br><br>2. On 07/29/2022 through 08/01/2022 the Director of Nursing and/or Nursing Supervisor performed quality improvement monitoring of current residents with weight loss and current residents with pressure wounds to ensure | |

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| F 657 | Continued From page 6<br>The admission Minimum Data Set (MDS) dated 3/8/2022 revealed Resident #39 was cognitively intact and weighed 97 pounds.<br><br>Review of the facility's care plan meeting minutes dated 3/9/2022 revealed the facility was aware of Resident #39's history of permanent loss of taste and smell.<br><br>Review of Resident #39's care plan dated 3/16/2022 revealed a focus area for potential for nutritional problem. Interventions included: provide supplements as ordered; provide regular no added salt diet; and Registered Dietician to evaluate and make changes as needed. The care plan did not include a focus for weight loss or information regarding her loss of taste and smell. There were no documented revisions or indications of care plan review after 4/29/2022.<br><br>The quarterly MDS dated 6/8/2022 revealed Resident #39 weighed 86 pounds with no weight loss noted.<br><br>A telephone interview on 7/13/2022 at 2:18 PM with the MDS Coordinator revealed she was responsible for updating care plans following completion of quarterly and annual MDS submission. The MDS Coordinator stated she had not received notification of Resident #39's weight loss and weight loss should have been included in the care plan.<br><br>Interview with the Director of Nursing (DON) on 7/13/2022 at 3:18 PM revealed she expected care plans to reflect the current status of each resident.<br><br>Interview with the facility Administrator on | F 657 | the care plans are updated appropriately.<br><br>3. On 07/29/2022 the Vice President of Nursing provided education to the Director of Nursing on updating Resident□s Care Plans with weight loss and pressure wounds. On 07/29/2022 through 08/03/2022 the Director of Nursing provided education to the Minimum Data Set Nurse, Workforce Manager Nurse and the Unit Manager on updating Resident□s Care Plans with weight loss and pressure wounds. Newly hired staff will be educated upon hire.<br><br>4. Starting on 08/05/2022 the Director of Nursing and/or Nursing Supervisor to perform Quality Improvement Monitoring of Care Plan interventions to include weight loss and pressure wounds three times per week for 12 weeks.<br><br>The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 08/04/22. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings Quality Assurance Performance Improvement Committee monthly for | |

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| F 657 | Continued From page 7<br>7/13/2022 at 3:37 PM revealed he expected care plans to correctly match the resident.<br><br>2. Resident #17 was admitted to the facility on 4/27/22.<br><br>Resident #17's care plan last revised on 5/16/22 indicated Resident #17 had a suspected deep tissue injury to the coccyx. Interventions included to administer treatments as ordered, monitor for effectiveness, and follow facility policies/protocols for the prevention/treatment of skin breakdown.<br><br>A progress note report by the Wound Physician Assistant dated 5/27/22 indicated Resident #17's "wound to coccyx: wound stage had been changed from unstageable to IV for the reason muscle was palpable and tissue depth had changed because curette debridement was completed. (Curette debridement is the surgical removal or cutting away of devitalized tissue, necrosis or slough using a curette).<br><br>A phone interview with the MDS (Minimum Data Set) Coordinator on 7/13/22 at 2:09 PM revealed she didn't update Resident #17's care plan to reflect the stage 4 pressure ulcer to the coccyx because she didn't know about it. The MDS Coordinator stated whoever did wound rounds with the Wound PA should have notified her when Resident #17's pressure ulcer had advanced to a stage 4.<br><br>An interview with the Director of Nursing (DON) on 7/13/22 at 2:58 PM revealed Resident #17's care plan should have been revised to reflect the | F 657 | three months.<br><br>Date of Alleged Compliance is 08/09/2022 | |

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| F 657 | Continued From page 8<br>current stage of her pressure ulcer. | F 657 | | |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
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| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
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| F 641 | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment for a tube feeding for 1 of 3 residents (Resident #4) reviewed for tube feedings.<br><br>The findings included:<br><br>Resident #4 was admitted to the facility on 11/29/21.<br><br>Review of orders revealed Resident #4's percutaneous epigastric (PEG) tube and feedings were discontinued on 2/1/22.<br><br>Resident #4's quarterly Minimum Data Set (MDS) dated 4/5/22 revealed Resident #4 was cognitively intact and was totally dependent of majority of activities of daily living (ADL). The MDS further revealed the resident was coded for tube feeding.<br><br>A phone interview conducted with the MDS Coordinator on 7/13/22 at 2:35 PM revealed Resident #4's MDS should have not been coded for tube feedings since the resident's orders were discontinued on 2/1/22.<br><br>An interview conducted with the Director of Nursing (DON) on 7/13/22 at 3:30 PM revealed Resident #4's MDS should reflect the resident orders and should have not been coded for tube feedings.<br><br>An interview conducted with the Administrator on 7/13/22 at 3:40 PM revealed he expected for residents' MDS to be coded correctly and timely. The Administrator further revealed Resident #4's MDS should have not been coded for tube feeding. |



The above isolated deficiencies pose no actual harm to the residents