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 02/08/2018

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OAK GROVE HEALTH CARE CENTER	518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #5HRC11.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to clarify physician orders for 1 of 5 sampled residents receiving skin treatments to include the body location for the application site (Resident #111). The findings included: Resident #111 was admitted to the facility on 11/16/17 from the hospital with diagnoses including cellulitis of the right lower extremity, peripheral vascular disease, chronic obstructive pulmonary disease, and hypertension. The hospital discharge medication list dated 11/16/17 included the treatment orders of: *SSD (Silver Sulfadiazine) cream 1% apply daily; and *Hydrocortisone 1% apply topically BID (twice a day)". There was no indication as to where these creams were to be applied on Resident #111's body. The admission physician orders, which included	F 658	F658 SS=D On 2/16/18, an Ad hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure resident treatment orders are accurate and complete, inclusive of application site. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Nursing, Medical Director, Assistant Director of Nursing, Unit Manager, Activities, Dietary, MDS Nurse, and Maintenance Director. Through Root Cause Analysis and based on the findings for Resident #111, it was determined that the facility failed to ensure that licensed nurses verify treatment orders for completeness, inclusive of application site. Resident # 111 discharged from the	3/2/18

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

Electronically Signed | 02/26/2018

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F 658	Continued From page 1 skin treatments were written by the unit manager nurse (UM) on the Treatment Administration Record (TAR) on 11/16/17. These included: *"SSD (Silver Sulfadiazine) cream 1% apply daily to"; and *Hydrocortisone 1% apply topically BID (twice a day)". These orders were also written on the admission physician orders dated 11/16/17 which were signed by the nurse practitioner on 11/17/17. Neither the SSD nor the Hydrocortisone creams included placement of the creams on Resident #111's body on either the physician signed admission orders or the TAR. The admission nursing assessment dated 11/16/17 at 5:10 PM was completed by Nurse #2 and Nurse #3. In the narrative section of this assessment, Nurse #2 wrote on 11/16/17 at 6:40 PM Resident #111's groin was red, excoriation was noted on both buttocks, there were open areas on the back of his thighs and the right lower leg had a surgical area, and the right lower leg had open areas around the leg. This note indicated an order clarification was received for the wound to the right lower leg. Telephone orders dated 11/16/17 at 11:40 PM included Triad cream to the left and right posterior and upper thigh buttocks region for skin tears and shears and groin and pericare excoriation. On 11/16/17 at 11:40 PM, Nurse #3's narrative notes on the admission nursing assessment stated the skin assessment was completed. He had a skin tear to the right posterior upper thigh/buttocks region measuring 0.2 centimeters (cm) by 2 cm by 0.1 cm. Also on this left posterior/upper thigh buttocks region was a skin tear measuring 0.4 cm by 2 cm by 0.1 cm and a sheared are to the left	F 658	facility on 11/19/17. On 2/15/18, the Director of Nursing (DON) completed a quality improvement monitor of 60 resident treatment orders from 1/1/18-2/15/18 to ensure completeness of orders, inclusive of application site. No further discrepancies were identified. On 2/21/18, the DON completed in-service education to licensed nurses on the process for reviewing treatment orders for completeness, inclusive of application site. Education also included the process of verifying by second nurse that all appropriate information is included and accurately transcribed onto the Treatment Administration Record (TAR). Newly hired licensed nurses to be educated upon hire. The licensed nurse receiving treatment orders will ensure completeness of orders, inclusive of application site. A second licensed nurse will then verify for completeness and document acceptance by signature to further ensure that services provided meet professional standards. The Director of Nursing will conduct Quality Improvement monitoring of 5 residents' treatment orders to ensure accuracy and completeness, inclusive of application site. Monitoring to be completed at a frequency of twice weekly for three months, then, once monthly.	

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F 658	Continued From page 2 posterior thigh measuring 2 cm by 1 cm by 0.1 cm. The note revealed that Triad paste would be applied to these areas and to his excoriated groin and periarea. Review of the Nurse Practitioner's initial progress note dated 11/17/17 for Resident #111 indicated that the medication list was reviewed during this encounter, however no clarification for the SSD or Hydrocortisone treatments were noted in the progress note. Review of the completed TAR for November 2017 revealed the SSD cream was administered daily on 11/17/17, 11/18/17 and 11/19/17 by Nurse #1. The Hydrocortisone cream was administered on 11/17/17 by Nurse #1. There was no indication as to where the creams were applied on the body. A telephone interview on 02/08/18 at 6:00 AM was conducted with Nurse #3 who completed the initial skin assessment. Nurse #3 stated she could not recall this resident enough to clarify information. A telephone interview was conducted on 02/08/18 at 9:20 AM with Nurse #2. She was unable to recall details regarding Resident #111. Interview with the UM occurred on 02/08/18 at 2:43 PM confirmed she had transcribed the physician orders including the SSD and Hydrocortisone cream to the TAR. She stated these orders came from the hospital discharge sheet and clarified with the physician. She stated the treatments should have been clarified as to the location for application. She stated she did not personally care for Resident #111.	F 658	Frequency will be adjusted based on findings. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Nursing, and the effectiveness of the monitoring tool will be evaluated and changes will be made if necessary to maintain compliance. The Executive Director is responsible for the implementation and execution of this plan. AOC 3/2/18	

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F 658	Continued From page 3 Unreturned voice messages were left for Nurse #1 who cared for Resident #111 from 7:00 AM to 7:00 PM on 11/17/17, 11/18,17 and 11/19/17 until he discharged on 11/19/17. The Assistant Director of Nursing was interviewed on 02/08/18 at 4:54 PM. The ADON stated the location of the SSD and Hydrocortisone creams should have been clarified. The DON stated during interview on 02/08/18 at 5:11 PM that the orders for the SSD and Hydrocortisone creams should have been clarified to include the location for application on Resident #111's body.	F 658		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		3/2/18

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F 761	Continued From page 4 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove expired medications from 1 of 1 medication room and failed to date an opened multi-dose vial in 1 of 1 medication refrigerator. The findings included: The pharmacy policy, last revised 10/31/16, was reviewed relating to the storage and expiration dates of medications and biologicals which indicated the facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 1. An observation of the medication room on 2/7/18 at 4:00 pm revealed (1) unopened bottle of Calcium Supplement, (1) unopened bottle of Brewers' Yeast, and (1) unopened bottle of Vitamin B-12, available for use, all with expiration dates of 01/18. During an interview with the Assistant Director of Nursing (ADON) at the time of the observation, she verified the medications were expired and should have been removed. She explained the central supply person is responsible for reordering, restocking, and rotating the stock medications. In the process, if any expired medications are found they are to be removed from the medication room and given to her or the	F 761	F761 SS=D On 2/16/18, an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure expired medications are removed and that multi-dose vials are dated upon opening. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Nursing, Medical Director, Assistant Director of Nursing, Unit Manager, Activities, Dietary, MDS Nurse, and Maintenance Director. Through Root Cause Analysis and based on the findings, it was determined the process for discarding expired medications and dating multi t-dose vials was not followed and facility did not have a consistent system in place to check medication carts for expired medications and dating of multi –does vials. On 2/15/18, the Director of Nursing (DON) completed a quality improvement monitor of medications stored in medication room, medication carts, and Storage Room. On	

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F 761	Continued From page 5 Director of Nursing (DON). She stated the expired medications must have been overlooked as the central supply person only works three days per week. The central supply person was unavailable for an interview. 2. An observation of the medication refrigerator on 2/7/18 at 4:20 pm revealed an opened, undated multi-dose vial of Tuberculin Solution. During an interview with the ADON at the time of the observation, she verified the vial was opened and not dated. She explained she would date the vial for the date it was received in the facility, which was 1/29/18. During an interview with the DON on 2/7/18 at 5:00 pm she stated she was unsure of why the bottles of expired medications were in the medication room. She explained the central supply person restocks the stock medications and is expected to remove any expired items and give them to her or the ADON. She expected all nursing staff should check stock medications for expiration dates and any expired stock medications should be removed from the medication room and returned to the pharmacy. The DON also stated any multi-dose vial should be dated when opened and any vials found opened and undated should be discarded. She expected vials of Tuberculin Solution to be dated when opened and discarded after 28 days.	F 761	2/15/18, the DON also completed a quality improvement monitor of multi-use vials to ensure dating upon opening. No further discrepancies were identified. On 2/21/18, the DON completed in-service education to licensed nurses on the process for removing expired medications and proper disposal. On 2/21/18, DON completed in-service education to licensed nurses on process for dating multi-use vials when opening. New hires will be educated upon hire. The Director of Nursing to conduct Quality Improvement monitoring of medications in medication room and nurses carts for expiration, and dating of multi-use vials when opened. Monitoring to be completed at a frequency of three times weekly for four weeks, then twice weekly for two months, then, weekly. Frequency of monitoring to be adjusted based on findings. The results of the Quality Improvement Monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Nursing, and the effectiveness of the monitoring tool to be evaluated and changes to be made if necessary to maintain compliance. The Executive Director is responsible for the implementation and execution of this plan. AOC 3/2/18	
F 842	Resident Records - Identifiable Information	F 842		3/2/18

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F 842 SS=D	Continued From page 6 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 7 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Treatment Administration Records (TAR) for 1 of 8 sampled residents reviewed for treatments. Resident #111's TAR had blanks where staff were to indicate if a treatment was administered or an indication that the treatment was not administered with an explanation on the reverse side. The findings included:	F 842	F842 SS=D On 2/16/18, an Ad hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding plan of correction to ensure resident medical records are complete with accurate documentation. QAPI committee	

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F 842	Continued From page 8 Resident #111 was admitted to the facility on 11/16/17 from the hospital with diagnoses including cellulitis of the right lower extremity, peripheral vascular disease, chronic obstructive pulmonary disease, and hypertension. The admission physician orders were written by the unit manager nurse (UM) on the Treatment Administration Record (TAR) on 11/16/17. These included: *Hydrocortisone 1% apply topically twice a day; and *CPAP (Continuous Positive Airway Pressure) to be applied at night and removed in the morning. A telephone order written 11/16/17 at 11:40 PM was for Triad cream to the left and right posterior /upper thigh buttocks region every shift to skin tears and to the excoriation to the groin and periarea until resolved. Review of the completed TAR for November 2017 revealed the Hydrocortisone cream was administered only on 11/17/17 by Nurse #1. Review of the medical record revealed no physician orders which discontinued this ordered hydrocortisone treatment. In addition, the TAR was blank related to the application of the CPAP to Resident #111 on the nights of 11/16/17, 11/17/17 or 11/18/17 (no initials to indicate the CPAP was applied to the resident). The TAR also was blank for the second shift for the application of Triad cream on 11/18/17. Resident #111 was discharged to the hospital on 11/19/17. A telephone interview was conducted on 02/08/18 at 9:20 AM with Nurse #2 who worked the night of 11/16/17. She was unable to recall details	F 842	members in attendance included the Executive Director (QAPI Coordinator), Director of Nursing, Medical Director, Assistant Director of Nursing, Unit Manager, Activities, Dietary, MDS Nurse, and Maintenance Director. Through Root Cause Analysis and based on the findings for Resident #111, it was determined that licensed nurses were not following policy for documenting on treatment administration record (TAR) and facility did not have a system in place to monitor.. Resident # 111 discharged from the facility on 11/19/17. On 2/15/18, the Director of Nursing (DON) completed a quality improvement monitor of 60 resident treatment administration records (TAR) from 1/1/18-2/15/18 to ensure accurate documentation. No further discrepancies were identified. On 2/21/18, the DON completed in-service education to licensed nurses on the process for accurately completing documentation on TAR. Licensed Nurses will initial on the TAR when treatment is completed ensuring accuracy of documentation. Newly hired licensed nurses to be educated during orientation. The Director of Nursing to conduct Quality Improvement monitoring of 5 residents' treatment administration records to ensure accuracy and completeness of documentation. Monitoring to be	

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F 842	Continued From page 9 regarding Resident #111. Nurse Aide (NA) #2, who worked 2:00 PM to 10:00 PM on 11/18/17 was interviewed on 02/07/18 at 2:03 PM and could not recall this resident. NA #1, who worked 2:00 PM to 10:00 PM on 11/17/17, was interviewed on 02/07/18 at 2:18 PM. She could not recall details of this resident's care. NA #3, who worked on 11/19/17 starting at 6:00 AM, was interviewed via phone on 02/08/18 at 6:10 PM. He stated he barely recalled this resident and thought he wore a CPAP at night. Unreturned voice messages were left for Nurse #1 who cared for Resident #111 from 7:00 AM to 7:00 PM on 11/17/17, 11/18,17 and 11/19/17 until he discharged on 11/19/17. A telephone interview on 02/08/18 at 3:29 PM with Nurse #4 who worked 7:00 PM to 7:00 AM on the nights of 11/17/17 and 11/18/17 revealed she was unable to recall details of Resident #111's CPAP. She recalled speaking to the family about it but could not recall if he had a CPAP. The Assistant Director of Nursing was interviewed on 02/08/18 at 4:54 PM. The ADON stated the TAR should have been completed with initials to indicate the Hydrocortisone and the CPAP was applied or indicated the reason they were not. The DON stated during interview on 02/08/18 at 5:11 PM that the TAR should have been completed with initials to indicate the Hydrocortisone and the CPAP was applied or	F 842	completed at a frequency of twice weekly for three months, then, weekly. Frequency of monitoring to be adjusted based on findings. The results of the Quality Improvement Monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Nursing, and the effectiveness of the monitoring to be evaluated and changes to be made if necessary to maintain compliance. The Executive Director is responsible for the implementation and execution of this plan. AOC 3/2/18	

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F 842	Continued From page 10 indicated the reason they were not applied.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment an Assurance Committee failed to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in December of 2016. This was for one recited deficiency which was cited in December of 2016 on a recertification survey, cited on a complaint survey in May of 2017 and cited during the current recertification survey. The deficiencies were in the area of professional standards. The continued failure of the facility during three federal surveys of record show an isolated pattern of the facilities inability to sustain an effective quality assurance Program. The Findings included: This tag is cross referred to: 483.21 Services meet Professional Standards: Based on record review and staff interviews, the facility failed to clarify physician orders for 1 of 5 sampled residents receiving skin treatments to include the body location for the application site (Resident #111).	F 867	F867 SS=D On 2/16/18, an Ad hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted by the Executive Director to complete a root cause analysis and to develop corresponding corrective action to ensure resident treatment orders are accurate and complete, inclusive of application site. QAPI committee members in attendance included the Executive Director (QAPI Coordinator), Director of Nursing, Medical Director, Assistant Director of Nursing, Unit Manager, Activities, Dietary, MDS Nurse, and Maintenance Director. Through Root Cause Analysis and based on the findings for Resident #111, it was determined that the process for license nurses to review treatment orders for completeness, inclusive of application site was not followed.. Resident # 111 discharged from the	3/2/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 11 The facility was recited for 483.21 for failure to clarify physician orders for completeness including the location of the application site. 483.21 Services Meet Professional Standards was originally cited during the December 15, 2016 recertification survey for failure to implement physician orders for medication administration and for obtaining laboratory testing. 483.21 was also cited on a complaint survey of May 11, 2017 for failure to transcribe a physician's order for wound care. During an interview with the Director of Nursing (DON) on 02/08/18 at 5:38 PM, the DON stated that she was still continuing with the quality assurance program established which included auditing a sample of new admissions and the physician orders to assure completeness, accuracy and administration. DON further stated that Resident#111's record was not reviewed when she completed her monthly audit on 11/05/17 and he was discharged by the December audit. She also indicated there were no identified concerns with the audits completed.	F 867	facility on 11/19/17. On 2/15/18, the Director of Nursing (DON) completed a quality improvement monitor of 60 resident treatment orders from 1/1/18-2/15/18 to ensure completeness of orders, inclusive of application site. No further discrepancies were identified. On 2/21/18, the DON completed in-service education to licensed nurses on the process for reviewing treatment orders for completeness, inclusive of application site. Education also included the process of verifying by second nurse that all appropriate information is included and accurately transcribed onto the Treatment Administration Record (TAR). Newly hired licensed nurses to be educated upon hire. The licensed nurse receiving treatment orders to ensure completeness of orders, inclusive of application site. A second licensed nurse to then verify for completeness and document by signature to further ensure that services provided meet professional standards. Really new orders should be being checked in Morning Clinical and thru 24 hour Chart Check On 2/23/18, the Regional Director of Clinical Services educated QAPI members, inclusive of Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse, Activities,	

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 02/08/2018

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F 867	Continued From page 12	F 867	Dietary, Human Resources, Housekeeping, Maintenance Director, and Business Office Manager on the facility policy and procedure for maintaining an effective Quality Assurance Performance Improvement Program. The Director of Nursing to conduct Quality Improvement monitoring of 5 residents□ treatment orders to ensure accuracy and completeness, inclusive of application site. Monitoring to be completed at a frequency of twice weekly for three months, then, once monthly. Frequency of monitoring to be adjusted based on findings. The Executive Director to conduct Quality Improvement monitoring to ensure completeness of quality improvement monitoring tools as scheduled and to ensure that Quality Assurance Performance Improvement meetings occur monthly at minimum. The Regional Director of Clinical Services or the Regional Vice President of Operations to attend the QAPI meeting at least quarterly to evaluate the effectiveness of the program. The results of the Quality Improvement Monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Nursing, and the effectiveness of the monitoring tool will be evaluated and changes will be made if necessary to maintain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 13	F 867	The Executive Director is responsible for the implementation and execution of this plan. AOC 3/2/18	