| 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 _____ | 12/15/2016 |

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

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| F 281 SS=E | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to implement a physician's order for medication administration for 2 of 5 sampled residents (Resident #86 and Resident #71) reviewed for unnecessary medication and failed to implement a physician's order for lab work for 1 of 5 sampled residents (Resident #71) labs reviewed for unnecessary medication.<br><br>Findings included:<br><br>1. Resident #86 was admitted to the facility on 08/28/15 and diagnoses included arthritis, osteoporosis, and degenerative joint disease of multiple joints.<br><br>The most recent quarterly Minimum Data Set (MDS) dated 12/03/16 indicated Resident #86 was cognitively intact. Resident #86 required supervision with bed mobility, transfers and personal hygiene and required limited assistance with dressing and toileting.<br><br>A record review of Resident #86's current care plan with next review date of 03/03/17 revealed an identified problem of alteration in pain/comfort as evidence by complaints of pain and discomfort. An intervention dated 11/01/16 to prevent pain indicated Resident #86 was to receive an application of Bio-freeze (topical analgesic) to the left hip twice a day for arthritic | F 281 | F281<br>SS=E<br><br>1) On 12/14/16, the registered nurse notified the physician and received a clarification order for Resident # 71 to continue potassium chloride 10meq by mouth daily. A medication error report was completed and no harm resulted to the patient.<br>On 12/14/16, the registered nurse notified the physician and received an order to discontinue BioFreeze to left hip for Resident #86. A medication order report was completed and no harm resulted to the patient.<br>On 12/14/16, the registered nurse notified the physician and received a STAT ammonia level lab order for Resident #71 and the results were received timely and within normal limits with no new orders. A medication order report was completed and no harm resulted to the patient.<br><br>2) By 12/30/16, the Director of Clinical Services (DCS) and licensed nurse designees completed a quality monitoring of residents' medications orders from previous 30 days for accurate transcription and administration as ordered by the physician. By 12/30/16, the | 1/12/17 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Electronically Signed | | 01/11/2017 |

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| F 281 | Continued From page 1<br>pain.<br><br>A review of the physician's order dated 11/01/16 revealed Resident #86 was to receive an application of Bio-freeze to the left hip twice a day for arthritic pain.<br><br>A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for November 2016 revealed per nursing documentation on the TAR that Resident #86 received Bio-freeze twice a day to the left hip from 11/01/16 to 11/10/16 and then was written on the TAR as stopped on 11/11/16. The December 2016 MAR and TAR revealed an absence of the physician ' s order to apply Bio-freeze to Resident #86's left hip twice a day for left hip pain.<br><br>On 12/14/2016 at 1:38 PM an interview was conducted with the Unit Manager who verified the physician's order for Bio-freeze for Resident #86 was written on 11/01/16 and indicated Bio-freeze was to be applied to the left hip twice a day for arthritic pain. The Unit Manager verified that the new order for Bio-freeze did not get transcribed to Resident #86's November TAR accurately and was completely missed from being transcribed onto the December TAR. The Unit Manager verified due to a transcription error Resident #86 had not received Bio-freeze as ordered to the left hip twice a day since 11/10/16. The Unit Manager verified that Resident #86 had missed receiving 66 applications of Bio-freeze to the left hip as ordered by the physician.<br><br>On 12/14/2016 at 1:42 PM an interview was conducted with the Wound Care Nurse (WCN) who stated she received the physician's order for | F 281 | DCS and licensed nurse designees also completed a quality monitoring of resident lab orders from previous 30 days for accurate completion as ordered by the physician. No discrepancies were identified.<br><br>3) By 12/30/16, the Director of Clinical Services and registered nurse designee re-educated licensed nurses on regulation 483.2(k)(3)(i) and policy regarding accurate medication administration and transcription onto the Medication Administration Record (MAR) and Treatment Medication Record (TAR) and accurate processing of ordered labs. Newly hired licensed nurses will be educated at hire.<br><br>Licensed nurse who receives medication orders will accurately transcribe new orders onto the MAR/TAR for administration per physician order. Licensed nurse will also send new order to the pharmacy and remove any discontinued/ changed medications from medication/treatment cart as appropriate. The licensed nurse who receives lab orders will accurately transcribe order request onto lab form and fax to lab for routine processing. STAT labs will be called into lab indicating urgent request to be processed timely. The licensed nurse who receives the results will validate labs ordered agree with labs drawn and will then report these results to the ordering physician and receive new orders to process as appropriate. Any identified discrepancies will be reported to the | |

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| F 281 | Continued From page 2<br>Bio-freeze for Resident #86 on 11/01/16 and was responsible for transcribing the order onto the TAR. The WCN stated she followed the physician's previous order dated 10/28/16 that indicated Bio-freeze was to be stopped on 11/10/16. The WCN stated she neglected to transcribe the new order for Bio-freeze dated 11/01/16 to Resident #86's TAR that indicated Resident #86 was to receive Bio-freeze twice a day to the left hip for arthritic pain. The WCN stated because she had not transcribed the physician's order for Bio-freeze onto Resident #86's November TAR the order had not been transcribed onto Resident #86's December TAR. The WCN stated because of the error in transcribing the physician's order dated 11/01/16 for Bio-freeze than the nurses were not aware that Resident #86 was to receive an application of Bio-freeze to the left hip twice a day for arthritic pain. The WCN verified that Resident #86 had not received Bio-freeze to the left hip per physician's order since 11/10/16 and she had missed 66 applications of the medication.<br><br>On 12/14/2016 at 1:56 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that when the nurse received the physician ' s order for Bio-freeze for Resident #86 than the order should have been accurately transcribed onto Resident #86's TAR. The DON stated her expectation was that Resident #86 would have received Bio-freeze as per physician's order. The DON stated her expectation was that the Unit Manager would have been responsible to have verified (as the second nurse check) that the new order for Bio-freeze had been transcribed accurately onto Resident #86's TAR. The DON stated she was immediately going to contact the physician and | F 281 | physician and DCS by licensed nurse, patient will be assessed for safety, medication error report will be completed, and re-education provided and/ or disciplinary action given as appropriate.<br><br>4) A quality monitoring of residents' medication and lab orders will be completed for compliance by the DCS/ RN designee for five (5) random residents per week for three (3) months, then monthly for nine (9) months to ensure that medications are transcribed and administered per physicians' order and labs are drawn timely per physicians' order.<br>The DCS/ RN designee will report the results of the quality monitoring at the Quality Assurance Performance Improvement (QAPI) meeting occurring monthly for twelve (12) months. The QAPI committee will recommend and implement revisions to the plan as indicated to maintain substantial compliance. | |

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notify the family that Resident #86 had not received Bio-freeze as per physician's order. The DON stated she was going to initiate a medication error report regarding Bio-freeze not administered to Resident #86 as ordered by the physician.

On 12/14/2016 at 2:15 PM an interview was conducted with the Administrator who stated his expectation was that Resident #86 would have received Bio-freeze as per physician's order. The Administrator stated he felt an immediate audit of MARs and TARs would need to be conducted and an investigation would occur as to why the Bio-freeze was missed for Resident #86. The Administrator stated he would expect that the physician and family would be notified of Resident #86's missed medication immediately.

On 12/14/2016 at 4:16 PM a telephone interview was conducted with the physician who stated that he wrote an order for Bio-freeze for Resident #86 and expected that the order would have been followed by the staff as written. The physician stated his expectations were for staff to follow his orders as written. The physician stated he did not believe that not applying Bio-freeze to Resident #86's left hip was a significant medication error and further stated his orders for Bio-freeze should have been followed as per order. The physician stated Resident #86 was receiving other scheduled pain medication.

On 12/14/2016 at 4:27 PM an interview was conducted with Resident #86 who stated she had pain in her left hip and staff applied medication to her left hip and it helped with the pain. Resident #86 stated she had not been receiving the medication (Bio-freeze) to her left hip and stated

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| F 281 | Continued From page 4<br>she did not know why she had not received the medication anymore.<br><br>2. Resident #71 was admitted to the facility on 11-02-2016 with diagnoses of Heart Failure and Diabetes.<br>Review of the most recent comprehensive Minimum Data Set (MDS) dated 11-09-2016 revealed Resident #71 was cognitively intact. The functional status revealed Resident #71 needed extensive assistance with bed mobility, dressing, and transfers.<br>Review of Resident #71 care plan dated 10-25-16 revealed the resident had cardiovascular disease with etiologies of Congestive Heart Failure and Diabetes. The approaches for nursing was to ensure medications were given as ordered, to monitor labs, and notify the medical doctor (MD) for any change in condition. The care plan for Nutrition/Hydration dated 11-17-16 included approaches for nursing to give potassium 20 milliequivalents (meq) daily related to hypokalemia and recheck potassium lab levels.<br><br>Review of the medication administration record (MAR) revealed potassium 10 meq by mouth daily was started on 11-03-2016, and had been initialed by nursing staff as given from 11-03-2016 through 12-15-2016 at 8:00 AM.<br><br>Review of the chart for Resident #71 revealed a MD order dated 11-10-16 to discontinue potassium 10 meq and to give Potassium 20 meq by mouth daily related to hypokalemia. The order | F 281 | | |

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was written and signed by the Nurse Unit Manager on 11-10-16.

During an interview with Nurse #1 on 12-14-2016 at 12:29 PM, she acknowledged potassium 10 meq, one tab by mouth every day scheduled at 8:00 AM was written on the December MAR. Nurse #1 explained the dose she gave Resident #71 was potassium 10 meq one tablet by mouth.

Review of the medication card used to administer the potassium doses to Resident #71 revealed instructions to give one tablet of potassium 10 meq by mouth daily.

During an interview with the Nurse Unit Manager on 12-15-2016 at 8:32 AM she explained how the order for potassium dated 11-10-2016 was transcribed by her to a MD order sheet and was given to Nurse #2 to transcribe to the November MAR.

During an interview with the Director of Nursing (DON) on 12-15-2016 at 8:43AM, she explained the MD orders should be correctly transcribed to the MAR. A second check by nursing staff should be done. The expectation was when a medication error was made, the nurse who made the error or the nurse who discovered the error to inform her (the DON) and the (resident's) family. The same nurse should inform the MD for instructions and/or clarification of orders.

During an interview with the facility MD on 12-15-2016 at 12:50 PM, he explained the expectations of the nursing staff was to follow the MD orders as written.

During an interview with Nurse #2 on 12-15-2016

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| F 281 | Continued From page 6 | F 281 | | |

at 1:04 PM, she didn't remember the potassium order, but acknowledges she didn't transcribe the order for potassium to Resident #71 November MAR.

During an interview with the facility Administrator on 12-15-2016 at 1:37 PM, he explained his expectations of nursing staff was MD orders to be transcribed as written/given and residents treated as the MD prescribed.

3. Resident #71 was admitted to the facility on 11-02-2016 with diagnoses of Heart Failure and Diabetes.
Review of the most recent comprehensive MDS dated 11-09-2016 revealed Resident #71 was cognitively intact. The functional status revealed Resident #71 needed extensive assistance with bed mobility, dressing, and transfers.
Review of Resident #71 chart revealed a MD order written on 11-18-2016 at 6:00 PM for nursing to obtain a complete blood count, comprehensive metabolic panel, and an ammonia level. Review of lab records revealed the ammonia level was not obtained.

Review of Resident #71 care plan dated 10-25-16 revealed the resident had cardiovascular disease with etiologies of Congestive Heart Failure and Diabetes. The approaches for nursing was to ensure medications were given as ordered, to monitor labs, and notify the medical doctor (MD) for any change in condition. The care plan dated 11-17-16 for Nutrition/Hydration included approaches for nursing to give potassium 20 meq daily related to hypokalemia and recheck potassium lab levels.

During an interview with the Nurse Unit Manager

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| F 281 | Continued From page 7<br>on 12-15-2016 at 8:32 AM, she explained the nurse filling out the lab sheet must hand write ammonia on the lab sheet and that was not done. It would have been the responsibility of the nurse on duty to check completion of all labs ordered and when the results were received to call those results to the MD.<br><br>During an interview with the DON on 12-15-2016 at 8:43 AM, she explained her expectations was for nurses to follow MD orders. The nurses should check to ensure the correct labs were obtained and the MD was notified.<br><br>During an interview with the facility MD on 12-15-2016 at 12:50 PM, he explained his expectations was for the nursing staff to follow MD orders as written and labs to be drawn as ordered and the MD to be notified of the results.<br><br>During an interview with the facility Administrator on 12-15-2016 at 1:37 PM, he explained his expectations was for nursing staff to transcribe MD orders as written by the MD and residents treated as the MD prescribed. | F 281 | | |