		, ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED 12/15/2016		
345464			B. WING _				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI			
				518 OLD US HIGHWAY 221			
OAK GRO	VE HEALTH CARE C	ENTER		RUTHERFORDTON, NC 2813	9		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG		ACTION SHOULD BE TO THE APPROPRIATE	COMPLETION	
F 281 SS=E	483.20(k)(3)(i) SEI PROFESSIONAL	RVICES PROVIDED MEET STANDARDS	F 2	281		1/12/17	
		ded or arranged by the facility ional standards of quality.					
	This REQUIREME	NT is not met as evidenced					
	facility failed to imp	eview and staff interviews the plement a physician's order for stration for 2 of 5 sampled		F281 SS=E			
	residents (Resider	t #86 and Resident #71)		1) On 12/14/16, the regis	stered nurse		
	reviewed for unner	cessary medication and failed		notified the physician an			
		sician's order for lab work for 1		clarification order for Res			
		ents (Resident #71) labs		continue potassium chlo			
		cessary medication.		mouth daily. A medication completed and no harm			
	Findings included:			patient. On 12/14/16, the registe			
		as admitted to the facility on noses included arthritis,		the physician and receiv discontinue BioFreeze to			
	Ŭ	degenerative joint disease of		Resident #86. A medical			
	multiple joints.			was completed and no h the patient.			
	The most recent q	uarterly Minimum Data Set		On 12/14/16, the registe	ered nurse notified		
		3/16 indicated Resident #86		the physician and receiv			
		act. Resident #86 required		ammonia level lab order			
		ed mobility, transfers and		and the results were rec	•		
		and required limited assistance		within normal limits with			
	with dressing and			medication order report and no harm resulted to			
	A record review of	Resident #86's current care			patont		
		ew date of 03/03/17 revealed		2) By 12/30/16, the Direc	ctor of Clinical		
		em of alteration in pain/comfort		Services (DCS) and lice			
	as evidence by co	mplaints of pain and		designees completed a			
		rvention dated 11/01/16 to		of residents' medications			
		ated Resident #86 was to		previous 30 days for acc			
		tion of Bio-freeze (topical		transcription and admini			
	analgesic) to the le	eft hip twice a day for arthritic		ordered by the physician	By 12/30/16 the		

01/11/2017

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.

Electronically Signed

					(X3) DATE SU	938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345464	B. WING		12/15	/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
OAK GRO	VE HEALTH CARE CEN	TER		518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	OF CORRECTION CTION SHOULD BE O THE APPROPRIATE NCY)	(X5) COMPLETIC DATE		
F 281	Continued From page	e 1	F 28	31			
	pain.			DCS and licensed nurse	designees also		
				completed a quality mon			
		cian's order dated 11/01/16		lab orders from previous			
	revealed Resident #8	36 was to receive an eze to the left hip twice a day		accurate completion as of physician. No discrepand			
	for arthritic pain.			identified.			
		cation Administration Record		3) By 12/30/16, the Direc			
		t Administration Record		Services and registered			
	. ,	2016 revealed per nursing e TAR that Resident #86		re-educated licensed nur	-		
		wice a day to the left hip		483.2(k)(3)(i) and policy accurate medication adm			
		0/16 and then was written		transcription onto the Me			
	on the TAR as stoppe			Administration Record (N			
		R and TAR revealed an		Treatment Medication Re			
	absence of the physic	cian ' s order to apply		accurate processing of o	rdered labs.		
	Bio-freeze to Resider for left hip pain.	nt #86's left hip twice a day		Newly hired licensed nur educated at hire.	ses will be		
		8 PM an interview was		Licensed nurse who rec			
		nit Manager who verified the		orders will accurately tra			
		Bio-freeze for Resident #86 /16 and indicated Bio-freeze		orders onto the MAR/TA administration per physic			
		the left hip twice a day for		Licensed nurse will also			
		it Manager verified that the		to the pharmacy and rem			
		eze did not get transcribed to		discontinued/ changed m	2		
		mber TAR accurately and		medication/treatment car			
		ed from being transcribed		The licensed nurse who			
		AR. The Unit Manager		orders will accurately tra			
		scription error Resident #86		request onto lab form an			
		freeze as ordered to the left		routine processing. STAT			
		11/10/16. The Unit Manager		called into lab indicating	•		
		t #86 had missed receiving p-freeze to the left hip as		be processed timely. The who receives the results			
	ordered by the physic	-		ordered agree with labs			
		5ian.		then report these results			
	On 12/14/2016 at 1:4	2 PM an interview was		physician and receive ne	-		
		Jound Care Nurse (WCN)		process as appropriate.			
		ved the physician's order for		discrepancies will be rep			

Facility ID: 923379

If continuation sheet Page 2 of 8

	S FOR MEDICARE &					0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION G	· · ·	(X3) DATE SURVEY COMPLETED		
		345464	B. WING		12/1	5/2016		
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, 2	ZIP CODE			
OAK GROVE HEALTH CARE CENTER				518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 281	20			
	1							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE JIENCY)	(X5) COMPLETIO DATE		
F 281	Continued From page	e 2	F 28	81				
F 281	Bio-freeze for Reside responsible for transo TAR. The WCN states physician's previous of indicated Bio-freeze w 11/10/16. The WCN states transcribe the new or 11/01/16 to Resident Resident #86 was to day to the left hip for stated because she hiphysician's order for H #86's November TAR transcribed onto Resi The WCN stated because transcribing the physi for Bio-freeze than the that Resident #86 wa Bio-freeze to the left Hipain. The WCN verified not received Bio-freeze physician's order since missed 66 application On 12/14/2016 at 1:5 conducted with the D who stated her expect nurse received the ph Bio-freeze for Reside have been accurately #86's TAR. The DON that Resident #86 wo as per physician's order	nt #86 on 11/01/16 and was cribing the order onto the d she followed the order dated 10/28/16 that was to be stopped on stated she neglected to der for Bio-freeze dated #86's TAR that indicated receive Bio-freeze twice a arthritic pain. The WCN had not transcribed the Bio-freeze onto Resident at the order had not been ident #86's December TAR. ause of the error in ician's order dated 11/01/16 e nurses were not aware s to receive an application of hip twice a day for arthritic ed that Resident #86 had ze to the left hip per the 11/10/16 and she had has of the medication. 6 PM an interview was irrector of Nursing (DON) ctation was that when the hysician 's order for int #86 than the order should v transcribed onto Resident stated her expectation was uld have received Bio-freeze der. The DON stated her	F 28	 physician and DCS by patient will be assessed medication error report and re-education provid disciplinary action giver 4) A quality monitoring medication and lab ord completed for complian RN designee for five (5 per week for three (3) r monthly for nine (9) mo medications are transciadministered per physic labs are drawn timely porder. The DCS/ RN designee results of the quality monthly for twelve (12) committee will recomm revisions to the plan as maintain substantial committee in the plane in	d for safety, will be completed, ded and/ or n as appropriate. of residents' ers will be nee by the DCS/ i) random residents nonths, then onths to ensure that ribed and cians' order and ber physicians' e will report the onitoring at the formance neeting occurring months. The QAPI end and implement is indicated to			
	as per physician's ord expectation was that have been responsibl second nurse check) Bio-freeze had been Resident #86's TAR.							

Facility ID: 923379

If continuation sheet Page 3 of 8

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/12/2017 MAPPROVED). 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED		
345464			B. WING _				12/	15/2016		
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE					
OAK GRO	VE HEALTH CARE CENT	ER			18 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE		(X5) COMPLETION DATE		
F 281	notify the family that F received Bio-freeze a DON stated she was medication error repo administered to Resid physician. On 12/14/2016 at 2:19 conducted with the Ad expectation was that received Bio-freeze at Administrator stated F MARs and TARs wou an investigation would Bio-freeze was misse Administrator stated F physician and family v #86's missed medicat On 12/14/2016 at 4:10 was conducted with th he wrote an order for and expected that the followed by the staff a stated his expectation orders as written. The believe that not apply #86's left hip was a si and further stated his have been followed a stated Resident #86 v scheduled pain medic	Resident #86 had not s per physician's order. The going to initiate a rt regarding Bio-freeze not lent #86 as ordered by the 5 PM an interview was dministrator who stated his Resident #86 would have s per physician's order. The he felt an immediate audit of ld need to be conducted and d occur as to why the d for Resident #86. The he would expect that the would be notified of Resident ion immediately. 6 PM a telephone interview he physician who stated that Bio-freeze for Resident #86 e order would have been as written. The physician is were for staff to follow his e physician stated he did not ing Bio-freeze to Resident gnificant medication error orders for Bio-freeze should s per order. The physician vas receiving other tation. 7 PM an interview was ent #86 who stated she had d staff applied medication to ed with the pain. Resident	F 2	81						

Facility ID: 923379

If continuation sheet Page 4 of 8

		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/12/2017 RM APPROVED O. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345464		(X1) PROVIDER/SUPPLIER/CLIA	• •		E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED		
		B. WING			12	2/15/2016			
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
OAK GRO	VE HEALTH CARE CEN	TER			518 OLD US HIGHWAY 221				
	1				RUTHERFORDTON, NC 28139				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE		
F 281	2. Resident #71 was 11-02-2016 with diag Diabetes. Review of the most ro Minimum Data Set (M revealed Resident #7 functional status reve extensive assistance and transfers. Review of Resident # revealed the resident with etiologies of Cor	admitted to the facility on noses of Heart Failure and ecent comprehensive MDS) dated 11-09-2016 '1 was cognitively intact. The ealed Resident #71 needed with bed mobility, dressing, 471 care plan dated 10-25-16 c had cardiovascular disease ngestive Heart Failure and	F	281					
	ensure medications w monitor labs, and not for any change in cor Nutrition/Hydration da approaches for nursin milliequivalents (meq hypokalemia and rec Review of the medica (MAR) revealed pota daily was started on initialed by nursing st through 12-15-2016 a Review of the chart for MD order dated 11-11 potassium 10 meq ar	heck potassium lab levels. ation administration record ssium 10 meq by mouth 11-03-2016, and had been aff as given from 11-03-2016 at 8:00 AM. or Resident #71 revealed a							

Facility ID: 923379

If continuation sheet Page 5 of 8

STATE MENT OF DEPRETADES AND PLAN OF CORRECTION (X1) DENTIFICATION NUMBER: UDENTIFICATION NUMBER: 346464 (X2) MULTIPLE CONSTRUCTION A BUILING RESULTION NUMBER: 04/10 PREFX (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED NAME OF ROUNDER OR BURPHUER 346464 III WING III VIEW RUTHERFORDTON, NO. 20139 IIII VIEW IIII VIEW RUTHERFORDTON, NO. 20139 OAK GROVE HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, 2P CODE S16 OLD US HIGHWAY 221 RUTHERFORDTON, NO. 20139 IIIII REGULATORY OR SURVEY CARE OF CONTROL ACTION SHOLL DB E (REGULATORY OR ISO DENTIFING MERGANITON) IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/12/2017 // APPROVED). 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE OAK GROVE HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, 2P CODE IMAGE OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST BE PROCEEDED & FULL RESULTORY OR LGC DEPTIFICING INFORMATION) ID PREFIX PROVIDERS PLAN OF CORRECTION (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) COMENTIFICIENCIES (EACH OEARCIVE ACTION SHOULD BE CROS	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,				(X3) DATE SURVEY	
Statute Control (Mail ID Tree SUMMARY STATEMENT OF DEFICIENCIES (CACH DIFFICIENCY MILT OF PERCEPTICE DI YILL RECH CONTRETS TO THE APPROPRIATE DEFICIENCY) PROVIDER'S FLAN OF CORRECTION (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) CONSTRUCTION (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) F 281 Continued From page 5 was written and signed by the Nurse Unit Manager on 11-10-16. F 281 F 281 During an interview with Nurse #1 on 12-14-2016 at 12.29 PM, she acknowledged potassium 10 med, one table by mouth every day scheduled at 8:00 AM was written on the December MAR. Nurse #1 explained the dose step gave Resident #71 was potassium 10 meq one tablet by mouth. F 281 Review of the medication card used to administer the 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. As econd 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 or inform her (the DDD) and the (resident's) family. The same nurse should inform the MD for instructions	345464			B. WING				12/	15/2016
OAK GROVE HEALTH CARE CENTER RUTHERFORDTON, NC 28139 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ORFECTIONY MUST REPECCIED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH ORFECTIONY OT LSC IDENTIFYING INFORMATION) D PREFIX PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH ORFECTION STATION OF DEFICIENCY MUST REPECCIED BY FULL PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH ORFECTION CATION OF DEFICIENCY) CORRECTION (DATE F 281 Continued From page 5 was written and signed by the 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 on etable ty mouth. F 281 Review of the medication card used to administer the potassium 10 meq on etable ty mouth. meq by mouth daily. Review of the medication card used to administer the 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 order should be correctly transcribed to the MAR. Ascond check by nursing staff should be done. The expectation was when a medication error was made. the nurse who discovered the error to inform her (the DN) and the (resident's) family. The same nurse should inform the MD for instructions	NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STAT	TE, ZIP CODE	-	
Preferx Tx3 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX Tx3 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Output Tx3 F 281 Continued From page 5 was written and signed by the Nurse Unit Manager on 11-10-16. F 281 F 281 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. F 281 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. F 281 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 8:32AM, 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 (residents) family. The same nurse should inform the MD for instructions	OAK GRO	VE HEALTH CARE CENT	ER				28139		
 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 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECT CROSS-REFERENC	TIVE ACTION SHOULD B		COMPLETION
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.	F 281	was written and signer Manager on 11-10-16 During an interview w at 12:29 PM, she ack meq, one tab by mout 8:00 AM was written of Nurse #1 explained th #71 was potassium 10 Review of the medica the potassium doses instructions to give on meq by mouth daily. During an interview w on 12-15-2016 at 8:32 order for potassium d transcribed by her to a given to Nurse #2 to th MAR. During an interview w (DON) on 12-15-2016 the MD orders should the MAR. A second cl be done. The expecta error was made, the r the nurse who discover (the DON) and the (re nurse should inform th and/or clarification of During an interview w 12-15-2016 at 12:50 F	ith the Nurse Unit Manager a does she gave Resident of the very day scheduled at on the December MAR. The dose she gave Resident of meq one tablet by mouth. To meq one tablet by mouth. To card used to administer to Resident #71 revealed the tablet of potassium 10 ith the Nurse Unit Manager 2 AM she explained how the ated 11-10-2016 was a MD order sheet and was ranscribe to the November ith the Director of Nursing a t8:43AM, she explained be correctly transcribed to neck by nursing staff should tho was when a medication nurse who made the error or ered the error to inform her seident's) family. The same ne MD for instructions orders. ith the facility MD on PM, he explained the ursing staff was to follow the	F	281				

If continuation sheet Page 6 of 8

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/12/2017 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED				
	345464					_	12/	15/2016
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, ST	TATE, ZIP CODE		
OAK GRO	VE HEALTH CARE CEN	ſER			3 OLD US HIGHWAY 221 ITHERFORDTON, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 281	order, but acknowledg order for potassium to MAR. During an interview w on 12-15-2016 at 1:37 expectations of nursir transcribed as written as the MD prescribed 3. Resident #71 was a 11-02-2016 with diagn Diabetes. Review of the most re dated 11-09-2016 rev cognitively intact. The Resident #71 needed bed mobility, dressing Review of Resident # order written on 11-18 nursing to obtain a co comprehensive metal ammonia level. Revie the ammonia level wa Review of Resident # revealed the resident with etiologies of Con Diabetes. The approa ensure medications w monitor labs, and not for any change in con 11-17-16 for Nutrition, approaches for nursir daily related to hypok potassium lab levels.	t remember the potassium ges she didn't transcribe the o Resident #71 November with the facility Administrator 7 PM, he explained his ng staff was MD orders to be //given and residents treated admitted to the facility on noses of Heart Failure and ecent comprehensive MDS realed Resident #71 was a functional status revealed extensive assistance with g, and transfers. 71 chart revealed a MD 3-2016 at 6:00 PM for omplete blood count, bolic panel, and an ew of lab records revealed as not obtained. 71 care plan dated 10-25-16 had cardiovascular disease gestive Heart Failure and aches for nursing was to vere given as ordered, to ify the medical doctor (MD) odition. The care plan dated /Hydration included ng to give potassium 20 meq alemia and recheck	F 28	31				
	During an interview w	vith the Nurse Unit Manager						

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/12/2017 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
345464		B. WING		12	/15/2016	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
OAK GROVE HEALTH CARE CENTER				518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28	139	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 281	nurse filling out the la ammonia on the lab s It would have been th on duty to check com and when the results results to the MD. During an interview w at 8:43 AM, she expla for nurses to follow M should check to ensu obtained and the MD During an interview w 12-15-2016 at 12:50 I expectations was for MD orders as written ordered and the MD t During an interview w on 12-15-2016 at 1:37 expectations was for	2 AM, she explained the b sheet must hand write sheet and that was not done. The responsibility of the nurse pletion of all labs ordered were received to call those with the DON on 12-15-2016 ained her expectations was ID orders. The nurses re the correct labs were was notified. With the facility MD on PM, he explained his the nursing staff to follow and labs to be drawn as to be notified of the results. With the facility Administrator 7 PM, he explained his nursing staff to transcribe by the MD and residents	F 28			

If continuation sheet Page 8 of 8