

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345420	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ <b>JUN 17 2011</b>	(X3) DATE SURVEY COMPLETED  C 05/25/2011
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NAME OF PROVIDER OR SUPPLIER  ALAMANCE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON STREET BURLINGTON, NC 27217
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F 505 SS=D	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</p> <p>The facility must promptly notify the attending physician of the findings.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and record review, the facility failed to report abnormal laboratory results to the physician for 1 (Resident #4) of 1 sampled resident with stat (immediate) lab orders.</p> <p>Findings include:</p> <p>Resident #4 was admitted to the facility on 9-11-09 with diagnosis to include Failure to Thrive, Dementia, Atrial Fibrillation, and Diabetes Mellitus.</p> <p>Review of the resident ' s medical record revealed a nurses ' note dated 5-20-11 at 2:41pm, that documented the resident was lethargic and pale. The note documented attempts were made to feed the resident and food just fell from the resident's mouth. The nurse documented the Nurse Practitioner (NP) was called and made aware of the resident's condition and the NP gave new orders for <u>stat</u> (immediately) CBC (complete blood count), CMP (comprehensive metabolic panel), HbgA1c (a test that measures blood sugar content), a TSH (thyroid stimulating hormone test), Ammonia, and an In and Out Catheterization for a urine culture and sensitivity. A nurse note written at 2:41pm on 5-20-11 revealed the blood tests were drawn and the urine obtained and the specimens were sent</p>	F 505	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *G. Malinich* TITLE Administrator (X6) DATE 6/14/11

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.

*AP  
M.I.* *X*

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F 505	<p>Continued From page 1 to the hospital laboratory for testing.</p> <p>During an interview on 5-24-11 at 3:50pm with the Nurse #1 who worked on the resident 's unit on 5-20-11 for the 3pm to 11pm shift, the nurse reported she was familiar with Resident #4 even though she didn't work with the resident on a regular basis. The nurse reported she arrived for duty late that day 5-20-11 at 4pm, and got a short report of the unit. The nurse reported she did not remember anything about the resident having stat labs drawn or that there was any problem with the resident.</p> <p>Review of the resident 's medical record revealed the laboratory results of the stat tests ordered on 5-20-11 were not in the resident 's record. Review of the lab results for Resident #4 for 5-20-11 revealed the lab tests were completed by (name of hospital) on 5-20-11. The lab report documented the report was faxed on 5-20-11 at 03:55. Review of the laboratory results indicated there were no critical values. The abnormal test values were as follows: Glucose (amount of blood sugar) 373 (normal range 65-99), Blood Urea Nitrogen (indicator of kidney function) 48 (normal range 7 - 18), Creatinine (indicator of kidney function) 2.94 (normal range 0.60 - 1.30) Potassium 5.7 (normal range 3.5 - 5.1), SGOT (liver functioning test) 82 (normal range 15-37), albumin (blood protein indicator) 3.2 (normal range 3.4 - 5.0), eGFR (glomerular filtration rate, to assess an indication of chronic kidney disease) 16 (normal range greater than 60 milliliters per minute), Hemoglobin A1c (a test for the average amount of blood sugar over a period of 3 months) 6.7 (normal range 4.8 - 6.0), Red Blood Cell Count</p>	F 505	<p><b>F???? How corrective action will be accomplished for each resident found to have been affected by the deficient practice – Resident expired.</b></p> <p><b>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –Nurses will print daily shift reports for oncoming shift. Supervisor will check printer for incoming faxes at the beginning of each shift and as needed. Supervisor will distribute to appropriate nurse for follow up. Nurse will notify supervisor of any expected labs due for their shift.</b></p>	6/19/2011	

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F 505	<p>Continued From page 2</p> <p>3.71 (normal range 3.9 - 5.2), Hemoglobin (an indicator of the blood 's ability to carry oxygen) 11.3 (normal range 12.0 - 16.0),.</p> <p>During an interview with the acting DON on 5-24-11 at 3:52pm, the acting DON stated she had asked the lab scheduler if she had seen the labs of 5-20-11 for Resident #4, and the lab scheduler reported the lab reports were on the fax machine when she came in on Monday (5-23-11). The lab scheduler told the acting DON she put the laboratory reports for Resident #4 in the Medical Records office to be filed because the resident had expired. The acting DON reported when she got the reports from Medical Records (5-24-11), she noticed those lab results had not been reported to the physician, and had begun a staff inservice related to keeping track of laboratory results.</p> <p>During an interview on 5-25-11 at 9am with the lab scheduler, the scheduler reported when she comes in to work in the morning she checked her mail box and the fax machine for any labs that were faxed to the facility. The scheduler reported there were times when the hospital or the lab faxed information to the facility and when she checked the fax, she made a copy of the fax, and took the information to the nurses station and gave it to the nurse for the resident the information belonged. The lab scheduler reported she also faxed a copy to the resident 's physician. The scheduler stated she has been handling faxes this way since May 16, 2011. The lab scheduler stated she wrote her initials on the lab, the date, and the physician 's name, and gave a copy to the unit manager to let them know the lab was faxed. The lab scheduler stated she</p>	F 505	<p><b>Measures to be put in place or systemic changes made to ensure practice will not re-occur-</b> Nurses will print daily shift reports for oncoming shift. Supervisor will check printer for incoming faxes at the beginning of each shift and as needed. Supervisor will distribute to appropriate nurse for follow up. Nurse will notify supervisor of any expected labs due for their shift. Unit Managers will audit 2x weekly x 1 month. Audits and any identified problems will be reviewed in weekly risk management/ QA meetings for further resolution.</p> <p><b>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-</b> Unit Managers will audit 2x weekly x 1 month. Audits and any identified problems will be reviewed in weekly risk management/ QA meetings for further resolution.</p> <p>NOTED: 5/24/2011 2:00PM</p>	6/19/2011	6/19/2011

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F 505	<p>Continued From page 3</p> <p>then put the lab in the resident ' s chart flagged for the doctor. The lab scheduler stated when someone had passed away or was discharged, the faxed lab went to Medical Records to be filed. The lab scheduler state she didn't believe there were any other labs on the fax machine when she came in on Monday.</p> <p>During the interview with the acting DON on 5-24-11 at 3:52pm, the acting DON stated it was her expectation that the supervisor pulled any labs results from the fax machine at the beginning of the shift. The acting DON stated when a nurse was expecting lab results, the supervisor could check periodically for the faxed results throughout the shift. The acting DON reported when the 2nd shift supervisor didn't pick up the lab results at the fax machine, the 3rd shift supervisor was expected to be checking the fax machine also. The acting DON reported when she obtained the labs results of 5-20-11 for Resident #4 from medical records, she reviewed the results and saw there was no documentation on the lab that the physician was informed of the results. The acting DON stated typically the nurse documented on the lab their name, a date, and a fax time the results were sent or called to the physician.. The acting DON stated nurses documented in the nurse notes that the lab results were faxed or called to the doctor and any orders the doctor gave. The acting DON stated she notified Resident #4 ' s physician of the results of the labs that day (5-24-11). The acting DON reported the past weekend (5-21-11 through 5-22-11); the usual supervisor was out of the facility. The acting DON stated she expected nurses on the hall were responsible for checking the fax machine in the supervisor ' s absence.</p>	F 505		

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F 505	Continued From page 4 The acting DON stated the facility had a system is in place and two employees decided not to utilize the system.  During a telephone interview with the the resident's physician on 5-24-11 at 4:16 pm, the physician stated Resident #4 ' s labs were constantly up and down and he didn't get too excited about changes in her labs. The physician stated he has known Resident #4 for over 15 years and her labs have always gone up and down. The physician stated he was unaware of the lab results of 5-20-11 until today and stated the problem was that the staff didn't check for the labs when they were faxed in. The physician stated the resident ' s number one cause of death was listed as " hypertrophy cardiomyopathy " .	F 505			



**June 14, 2011**

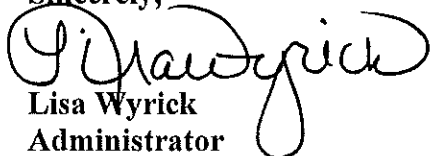
**Ms. Denise Bolin, RN  
Facility Survey Consultant  
2711 Mail Service Center  
Raleigh, North Carolina 27699-2711**

**Dear Ms. Bolin:**

**Please accept the enclosed information as our submitted plan of correction for the complaint survey conducted in our facility on May 23-25, 2011.**

**Should you have further questions regarding this plan of correction, please feel free to contact me at 336-226-9848**

**Sincerely,**

  
**Lisa Wyrick  
Administrator**

*[Faint, illegible text or stamp]*



North Carolina Department of Health and Human Services  
Division of Health Service Regulation  
Nursing Home Licensure and Certification Section  
2711 Mail Service Center, Raleigh, North Carolina 27699-2711  
<http://www.ncdhhs.gov/dhstr/>

Drexdal Pratt, Director

Beverly Eaves Perdue, Governor  
Lanier M. Cansler, Secretary

Beverly Speroff, Section Chief  
Phone (919) 855-4520  
Fax (919) 733-8274

IMPORTANT NOTICE - PLEASE READ CAREFULLY

June 9, 2011

Ms. Lisa Wyrick, Administrator  
Alamance Health Care Center  
1987 Hilton Street  
Burlington, NC 27217

[lisa.wyrick@mfa.net](mailto:lisa.wyrick@mfa.net)

Dear Ms. Wyrick:

On May 23, 2011 to May 25, 2011, a complaint Investigation survey was conducted at your facility by the Nursing Home Licensure and Certification Section of the Division of Health Service Regulation to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs. This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required. (D)

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Based on survey findings, the alleged complaint violations were not substantiated.

Plan of Correction (PoC)

The facility must submit a PoC for the deficiencies within 10 calendar days from the date it receives its Form CMS-2567. Failure to **submit an acceptable PoC by June 19, 2011** may result in imposition of additional remedies by July 9, 2011.

Your PoC for the deficiencies must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice;



Location: 1205 Umstead Drive Dorothea Dix Hospital Campus Raleigh, N.C. 27603  
An Equal Opportunity / Affirmative Action Employer





Ms. Wyrick, Administrator  
June 9, 2011  
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- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.
- Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State.

The Division of Health Service Regulation is allowing you an opportunity to correct your deficiencies prior to recommending imposition of remedies for failure to substantially comply with program requirements. Remedies will be recommended for imposition by the Centers for Medicare & Medicaid Services (CMS) Regional Office, if your facility fails to achieve substantial compliance by the date specified in your Plan of Correction. It should be noted that the latest date in your Plan of Correction should be no later than June 22, 2011. Failure to specify this date can result in your Plan of Correction not being accepted by the State. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the deficiencies may result in a change in the remedy(ies) selected. When this occurs, you will be advised of any change.

The remedies which will be recommended if substantial compliance has not been achieved by June 22, 2011 may include the following:

- Directed Inservice Training
- Directed Plan of Correction
- Civil Money Penalty
- Discretionary Denial of Payment for New Admission

If you do not achieve substantial compliance within 3 months after the last day of the survey identifying noncompliance (August 25, 2011), the CMS Regional Office must deny payments for new admissions.

We are also recommending to the CMS Regional Office that your provider agreement be terminated on November 25, 2011 if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, we will provide you with a separate formal notification of that determination.**

#### Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest scope and severity assessments for deficiencies that resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by June 22, 2011 to Becky Wertz, Nursing Home Licensure and Certification Section at the above listed address. An explanation of why

Ms. Wyrick, Administrator  
June 9, 2011  
Page Three

you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) along with any supporting documentation must be sent and postmarked by July 2, 2011. You must submit 5 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiencies. Additional written material that does not meet these requirements will not be reviewed. This information should be sent to Becky Wertz, Nursing Home Licensure and Certification Section, at the above listed address. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: <http://www.ncdhhs.gov/dhsr/nhlcs/idr.html>.

#### Customer Service Feedback

In order to better serve our customers, and as part of our efforts to provide excellent services, you are being asked to complete a customer service survey. Your opinion is important to us, and will assist us in developing new and better ways to do our job. We have designed the survey to address key expectations of our surveyors and our division regarding the survey process.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you very much for your participation as we strive to improve the services we provide to licensed health care providers across the state of North Carolina

The Customer Service Survey web site: <http://prod.ncsurveymax.com/TakeSurvey.aspx?SurveyID=12K0372>  
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)

If you have any questions concerning the instructions contained in this letter, please contact me.

Sincerely,



Denise Boland, RN  
Facility Survey Consultant

Enclosures  
Statement of Deficiencies

\*\*\*Fax copies of plans of correction will no longer be accepted\*\*\*