

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/22/2011
NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE RD CHARLOTTE, NC 28214	
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F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and staff interviews, the facility failed to provide toenail care for one (1) of two (2) sampled residents that were dependent with activities of daily living and toenail care. (Resident # 114)</p> <p>The findings are: A review of Resident # 114's medical record revealed the resident was admitted to the facility on 06/28/11 with diagnoses that included dementia and history of a left ankle fracture. A review of Resident # 114's care plan dated 06/28/11 revealed the resident had the inability to complete activities of daily living tasks due to dementia and a fracture. The care plan further revealed interventions that included the nursing staff would keep Resident # 114's nails trimmed and clean, and provide personal hygiene and grooming as needed. A review of Resident # 114's most recent quarterly Minimum Data Set (MDS) assessment dated 07/05/11 revealed the resident had severely impaired cognition. The MDS further revealed Resident # 114 required extensive assistance with personal hygiene.</p> <p>A review of the facility's monthly list of residents</p>	F 312	<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> <p>How corrective action will be accomplished for each resident found to have been affected by the deficient practice – Resident 114 - toenail was trimmed as close as possible without damaging tissue beneath the nail and an appointment was setup with podiatry appointment. Completed on 09/21/2011.</p> <p>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice – 100% audit of toenails completed in the facility. If long nails were identified they were immediately clipped and added to Podiatry list to be seen by Podiatrist.</p>	9/21/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Todd Barner

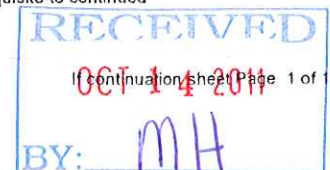
TITLE

Administrator

(X6) DATE

10/11/2011

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 312	<p>Continued From page 1</p> <p>to be seen by the podiatrist dated on 07/10/11, 08/24/11 and 09/21/11 revealed Resident # 114 was not placed on the list by the nursing staff in order for the resident to be seen by the podiatrist to trim her toenails.</p> <p>An observation of Resident # 114 on 09/20/11 at 10:24 AM revealed the resident was observed sitting in her wheelchair with her feet exposed. An observation of Resident # 114's toenails revealed being untrimmed and a half inch long. Further observations of Resident # 114 on 09/21/11 at 9:04AM and 1:15PM revealed the resident's toenails continued to be a half inch long and first toenails on both feet were jagged.</p> <p>On 09/21/11 at 1:38 PM, License Nurse # 3 and the Quality Assurance Nurse were observed trimming Resident # 114's toenails with no difficulty and they trimmed the toenails as short as they were possibly able to, and a podiatry appointment was scheduled for further trimming.</p> <p>An interview with Nursing Assistant (NA) # 1 on 9/21/11 at 1:15 PM revealed she had cared for Resident # 114 for the week. The NA reported the podiatrist had to cut her toenails. The NA stated she reported to the license nurse last week about Resident # 114's long toenails, but she had not mentioned it to the license nurse this week. The NA could recall the license nurse she informed last week about the resident's long toenails. The NA further revealed when the podiatrist visited, she tried to get the podiatrist to do the resident's toenails in case the resident was missed on the podiatrist list, but did not inform the podiatrist today of Resident # 114's long toenails.</p>	F 312	<p>Measures to be put in place or systemic changes made to ensure practice will not re-occur- Nursing and therapy staff in-serviced on steps to take if they identify any resident with long nails. The Charge Nurse, Unit Manager and Unit Secretary to be notified immediately. When personnel are notified, Podiatry Consult Paperwork will be completed and submitted to MD/NP for evaluation to see if patient would benefit from Podiatry Services. Charge Nurses will be responsible for trimming toenails when identified by staff.</p> <p>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All residents will be monitored weekly by Unit Mangers, Supervisor and Director of Nursing x4 weeks then twice monthly x2 months and then monthly x2 months. All audits will be reviewed and reported to QA&A Committee monthly and Quarterly thereafter for continued compliance/revisions to the plan if needed.</p>		

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F 312	<p>Continued From page 2</p> <p>An interview with Licensed Nurse (LN) # 3 on 09/21/11 at 1:20 PM revealed Resident # 114's toenails were long and the nursing staff should have informed her of the long toenails and should have been able to trim the toenails. LN stated if the staff was not comfortable with trimming the resident's toenails, the podiatrist would have trimmed them. LN # 3 reported Resident # 114 had skin assessments completed every week and the nursing assistants observed her toenails everyday when completing personal care, but license nurse was still not informed about the long toenails. LN # 3 further revealed the podiatrist was in the facility today and could have trimmed Resident # 114's toenails.</p> <p>An interview with the Unit Manager on 09/21/11 at 1:28 PM revealed Resident # 114 was not on the podiatrist list to be seen today and she was not aware that the resident's toenails were long. The Unit Manager reported she would have to investigate why Resident # 114 was missed from being placed on the podiatrist list. The Unit Manager stated the expectation was for the nursing assistants to report to the license nurses when the resident's toenails were long. The license nurse would then place Resident # 114 on the podiatry list and the podiatrist would be aware to see the resident when she came to the facility and would have trimmed the resident's toenails.</p> <p>An interview with the Director of Nursing (DON) on 09/21/11 at 1:38 PM revealed the podiatrist or wound care nurse would have trimmed the toenails, since the podiatrist came to the facility once a month. The DON reported Resident # 114's toenails should have been trimmed and taken care of before because the nursing staff</p>	F 312		

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F 312	Continued From page 3 should have been aware of the long toenails when personal care was provided to the resident and when the skin assessments were completed. The DON further revealed the podiatrist should have been able to trim the toenails today if she was informed about the long toenails. An interview with the Wound Care Nurse (WCN) on 09/21/11 at 3:20PM revealed she completed Resident # 114's weekly skin assessment yesterday on 09/20/11. The WCN reported she did not notice Resident # 114's toenail being long, because she was concentrating more on the resident's heels. The WCN further revealed since she did not notice the long toenails, she did not report to anyone that they were long. A further interview with the Unit Manager on 09/21/11 revealed when the skin assessment was completed on Resident # 114, her toenails should have been assessed as well during the skin assessment. The staff should have reported to the licensed nurse or to her about Resident # 114's toenails in order for the resident's toenails to be trimmed.	F 312			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff interviews the facility failed to have significant error free medication administration for one (1) of twelve (12) residents observed for	F 333	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.	9/22/11	

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F 333	<p>Continued From page 4</p> <p>medication administration. Questran (Cholestyramine) was administered with other medications resulting in a Drug interaction and instruction per the pharmacy label was not accurately followed. (Resident # 170)</p> <p>The findings include:</p> <p>A review of the product literature included from the manufacturer of Qeustran (Cholestyramine Resin) had a boxed warning on Drug interactions and revealed that Cholestyramine can reduce the absorption of numerous medications when used concurrently. The instructions included to give other medications 1 hour before or 4-6 hours after giving cholestyramine.</p> <p>Resident # 170 was readmitted to the facility on 1/20/2011. Resident # 170's diagnoses included Dyslipidemia, Schizophrenia, status post ileostomy, Diabetes Mellitus and Atrial Fibrillation.</p> <p>A review of the physician orders included Cholestyramine and other 14 medications scheduled at 8:00 AM.</p> <p>Resident # 170 was observed for medication administration on 09/21/2011 at 8:54 AM. Licensed Nurse (LN) # 2 was observed administering medications to Resident # 170. Resident # 170 had a total of 15 medications including Cholestyramine 4 gram (Questran) packet, as per physician orders reviewed.</p> <p>LN # 2 dissolved the Cholestyramine 4 gram packet in 4 ounce of water and kept aside and stated that it takes few minutes for it to dissolve. LN # 2 removed all other 14 medications to a</p>	F 333	<p>How corrective action will be accomplished for each resident found to have been affected by the deficient practice – Patient 170 was administered the medication and once identified by surveyor the MD/NP was notified of the medication error. Medication Requirement as indicated on the packaging added to MAR. No harm to patient noted.</p> <p>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice – 100% audit completed by Pharmacy Consultant to identify any other residents on Cholestyramine and recommendation made to give medication 1 hour before other medications and MAR's updated to reflect the recommendation.</p> <p>Measures to be put in place or systemic changes made to ensure practice will not re-occur- Nurses in-serviced on Medication Time Constraints and possible side effects if the medication is given with other medications.</p> <p>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All resident charts will be audited monthly by Pharmacy Consultant for Cholestyramine and patients identified on the medication will be given to DON monthly x4 months and all New Admissions will be audited weekly x4 then monthly x2. Results of the audits will be presented to QA&A Committee monthly and Quarterly thereafter to monitor for continued compliance and revisions as needed.</p>		

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F 333	Continued From page 5 medication cup which were scheduled at this time. LN # 2 offered the medication cup with medications and gave the dissolved Cholestyramine solution to help Resident # 170 swallow the medications. Observation of the pharmacy label revealed instructions to administer Cholestyramine 1 hour before other medications or 4 hours later. A continued interview with LN # 2 on 09/21/11 at 9:15 AM revealed that she was not aware of the drug interactions of Cholestyramine and stated that she did not read the labeled instructions from the pharmacy related to the timing of administration. LN # 2 confirmed that she had been giving these medications at the same time in the morning and stated evening medications were also scheduled together with Cholestyramine per Medication Administration Records (MAR). LN # 2 stated that she did not get any special instructions from the pharmacy related to the administration of Cholestyramine. An interview with the Director of Nursing on 09/21/2011 at 9:25 AM revealed that all nurses were expected to read both the instructions on the pharmacy label and the instructions on the MAR's. The DON confirmed that she would in-service all nurses related to drug interactions with Cholestyramine and make the changes in the MAR as needed.	F 333		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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F 514	<p>Continued From page 6 accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record and facility record review, the facility failed to document a physician's verbal order to hold lipid administration in the medical record for 1 of 1 sampled resident reviewed for total parenteral nutrition. (Resident # 179)</p> <p>The findings are: Resident # 179 was admitted to the facility August 2011 and received total parenteral nutrition (TPN) on admission. Diagnoses included status post abdominal fistula repair, open abdominal wound, oropharyngeal cancer status post surgical resection with radiation, severe gastroesophageal reflux disease, severe malnutrition, vancomycin resistant interococci infections, fungemia and sepsis. Medical record review revealed a physician's order dated 08/04/11 for TPN and Lipids. The order recorded that Resident # 179 would receive an electrolyte solution of 15% Dextrose and 5% Amino Acids to infuse continuously at 50 ml per hour for one hour and then increase to 85 ml per hour. Additionally, the Resident would receive</p>	F 514	<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> <p>How corrective action will be accomplished for each resident found to have been affected by the deficient practice – Resident # 179 was/is no longer a resident at Charlotte Healthcare Center.</p> <p>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice – 100% audit of all transcripts from Dr. William Long's on call service has been audited by Unit Mangers and Director of Nursing to ensure all verbal orders have been transcribed since 9/19/2011.</p> <p>Measures to be put in place or systemic changes made to ensure practice will not re-occur- Nurses will be in-serviced on the proper technique when taking verbal orders and transcription when calling Dr. William Long's on call service by 10/12/2011</p>	<p>10/17/11</p> <p>10/12/11</p>	

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F 514	<p>Continued From page 7</p> <p>Lipids to infuse at 25 ml per hour for 12 hours, from 5 PM - 5 AM.</p> <p>The medical record revealed a nursing note dated 08/05/11 at 8:18 AM which recorded the following regarding a hold on lipid administration, "TPN electrolytes @ (at) 85 ml/hr continuous via PICC (peripherally inserted central catheter for intravenous access) in R (right) arm. Lipids held d/t (due to) IV (intravenous) pump malfunctioning. Pharmacy called for backup; awaiting delivery as of 7 AM." Additionally, a nursing note dated 8/14/11 at 6:45 PM also recorded a hold on lipid administration, "RT IV pump for lipids malfunctioned on second shift. Follow up to contact pharmacy in the morning d/t the pharmacy not available at this time."</p> <p>Continued review of the medical record revealed there was no telephone order from the physician to document that lipid administration was ordered to be held by the physician on 08/05/11 or 08/14/11.</p> <p>On 09/21/11 at 3:48 PM, the facility's consultant dietitian stated in interview that he was not aware that the IV pump for the lipids malfunctioned on 8/5/11 and 8/14/11 for Resident #179 and that lipid administration was held until pharmacy could replace the pump.</p> <p>On 09/22/11 at 10:25AM Licensed Nurse (LN) # 1 stated in interview that the unit manager initiated the TPN for Resident # 179 on 08/05/11 because LN #1 had not been trained and initiating TPN was the responsibility of a registered nurse (RN). LN # 1 stated she observed the procedure. She further added that when the TPN was started</p>	F 514	<p>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Call log form Dr. William Long's On Call service will be monitored Monday- Friday (Mondays log review encompasses the weekend) by Unit Mangers, Supervisor and Director of Nursing daily x4 weeks then every two weeks x2 months and then monthly x1 months. All audits will be reviewed and reported to QA&A Committee monthly and Quarterly thereafter for continued compliance/revisions to the plan if needed.</p>		

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F 514	<p>Continued From page 8</p> <p>there was a problem with the pump for lipid administration, the pump malfunctioned. LN # 1 stated she received a verbal physician's order from the unit manager to hold lipid administration until pharmacy provided a replacement the next day.</p> <p>On 09/22/11 at 2:30 PM an interview with second shift unit manager revealed that on 08/05/11 and 08/14/11 the TPN pump for Resident # 179 was infusing and the lipid pump malfunctioned, so the lipid pump was held. The unit manager stated he was pretty certain the physician was contacted, but he could not say definitively. The unit manager also stated that the nurse was busy and since he could not remember if he received the order or if the nurse received the order, he had no explanation as to why the verbal physician's order to hold lipid administration was not documented in the Resident's medical record. He confirmed that lipids were administered by 5 PM the next day as ordered.</p> <p>On 09/22/11 at 3:50 PM an interview with the Resident's physician confirmed that his office was notified of the need to hold lipid administration for Resident # 179 since lipids could not be administered for this Resident without the pump. The physician stated that as best he could remember, the physician on-call was contacted, but the verbal order was not documented by the nurse in the facility. The Physician stated the verbal order should have been documented.</p> <p>On 09/22/11 at 4:50 PM the Director of Nursing (DON) was interviewed. She stated that a verbal physician's order to hold lipid administration for Resident # 179 was not documented in the</p>	F 514			

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F 514	<p>Continued From page 9</p> <p>Resident's medical record and this should have been documented. The DON further stated that verbal physician's orders should be documented as a telephone order and given to the physician for signature. She confirmed that the facility did not have have a written policy regarding documenting physician telephone orders, but she expected verbal physician's orders to be documented in the medical record prior to being implemented.</p> <p>The Quality Assurance Nurse was interviewed on 09/22/11 at 5:00 PM and revealed that she identified a problem in September 2011 with nursing staff receiving physician's orders verbally from another nurse and not documenting the order as a telephone order before the order was implemented. She was in the process of providing licensed nurses in-services, but had not in-serviced all licensed nurses to date.</p>	F 514			