

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

PRINTED: 09/21/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345526</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/13/2012</b>
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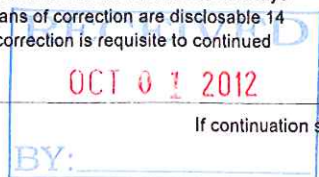
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA REHAB CENTER OF BURKE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612</b>
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F 281 SS=D	<p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to administer a medication as prescribed by the physician to be given sublingually for four days to one of four sampled residents observed during medication administration (Resident #258) and failed to transcribe a physician's order to the Medication Administration Record (MAR) resulting in the failure to follow the order for one of four residents noted during the reconciling of medications (Resident #12).</p> <p>Findings are:</p> <p>1. Resident #258 was admitted to the facility on 09/07/2012 with cumulative diagnoses of red blood cell disorder and anemia.</p> <p>An observation on 09/12/2012 at 8:15 AM showed Nurse #1 administered the medication Vitamin B12 by mouth to Resident # 258 during the morning medication pass.</p> <p>A review of Resident #258's MAR during reconciliation of medications revealed the Vitamin B12 tablet was to be administered by placing the tablet under the tongue (sublingually) and not swallowed whole with water.</p> <p>Interview with Nurse #1 at 9:45 AM on</p>	F 281	<p>Carolina Rehab Center of Burke acknowledges receipt of the statement of deficiencies and proposed this plan of correction to the extent that the summary of findings is factually accurate and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The plan of correction is submitted as a written statement of compliance.</p> <p>Carolina Rehab Center of Burke's response to this statement of deficiencies does not indicate agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Additionally, Carolina Rehab Center of Burke reserves the right to refute any of the deficiencies on this statement of deficiencies through informal dispute resolution, formal appeal procedure, and/or any other administrative or legal proceeding.</p> <p><b>F281</b> How corrective action will be accomplished for the resident affected.</p> <ol style="list-style-type: none"> <li>1. The Vitamin B12 order for patient #258 was changed to oral tablet on 9/12/12.</li> <li>2. For patient #12,             <ol style="list-style-type: none"> <li>a. The order for spironolactone 50 mg for patient #12 was transcribed to the MAR and the spironolactone 100 mg order was discontinued on 9/12/12.</li> <li>b. The medication card for</li> </ol> </li> </ol>	10/1/12 SB
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sheree B. Byrd, MSHL, NHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>09/28/12</i>
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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 281	<p>Continued From page 1</p> <p>09/12/2012 revealed she did not know Resident #258 was to receive her Vitamin B12 sublingually and confirmed she had administered it whole swallowed with water. Nurse # 1 reviewed Resident # 258's MAR and noted according to the MAR she had also administered the Vitamin B12 by mouth on September 8, 10, 11. Nurse #1 provided the medication card from the medication cart and confirmed the MAR and the card both documented the Vitamin B12 was to be given sublingually. Nurse #1 stated " I did not know it was to be administered sublingually".</p> <p>Interview on 09/14/2012 at 3:10PM with the Director of Nursing (DON) revealed she expected nursing staff to administer medications as ordered by the physician and documented on the medication cards and MAR by the pharmacy.</p> <p>2. Resident #12 was admitted to the facility on 08/23/2012 with cumulative diagnoses of edema, ascites, atrial fibrillation and hypertension.</p> <p>An observation on 09/12/2012 at 8:30 AM showed Nurse #1 administered the medication Spironolactone 100 mg to Resident # 12 during the morning medication pass.</p> <p>A review of Resident #12's medical record during reconciliation of medications revealed a physician's order dated 09/11/2012 for Spironolactone to be reduced from 100 milligrams (mg) to 50 mg daily.</p> <p>In an interview on 09/12/2012 at 10:05 AM Nurse #1 confirmed she had given Resident #12 the medication Spiradatlone 100 mg as documented on the MAR and on the</p>	F 281	<p><b>F281 Continued</b></p> <p>spironolactone 100 mg was returned to the pharmacy on 9/12/12.</p> <p>c. Corrective action was given to the nurse who failed to properly transcribe the order remove the card from the cart.</p> <p><b>How corrective action will be accomplished for those residents with the potential to be affected by the same practice.</b></p> <ol style="list-style-type: none"> <li>1. Audit of patients currently receiving sublingual medications was performed on 9/27/2012 to ensure patients are receiving sublingual medications via correct route.</li> <li>2. Audit of patient charts for new orders dated 9/9/12 to present was conducted on 9/12/12. No other missed orders were identified.</li> <li>3. An audit of med cards was performed on 9/12/12 to ensure that active orders matched med cards in the cart.</li> <li>4. The Staff Development Coordinator conducted an in-service for licensed nursing staff on 09/26/12. Topics included:             <ol style="list-style-type: none"> <li>a. Nurses must read entire medication order three times prior to administration of medications and follow orders as written.</li> </ol> </li> </ol>	10/11/2012	

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F 281	Continued From page 2 medication card stored in the medication cart available for use. Nurse # 1 provided the medication card from the cart that documented Spiradatlone 100mg.  In an interview on 09/12/12 at 3:30 PM Nurse #3, also a Unit Manager, revealed when a nurse takes a physician order and writes noted and faxed it is to confirm an order had been fully processed to include changing the MAR to reflect the new order and pulling the old medication card from the cart to alert nursing staff a change had been made. Nurse #3 reviewed the medication order on Resident # 12's physician orders and MAR and confirmed the order to decrease Resident #12's Spironolactone had not been processed by Nurse #2 who had initialed the order and resulted in the wrong medication dosage being given by Nurse #1.  In an interview on 09/12/2012 at 3:35 PM Nurse #2 revealed she had received the order to decrease Resident #12's medication but had failed to fully process it and did not change the MAR or pull the medication card as facility procedure dictated.  Interview on 09/14/2012 at 3:10 PM with the Director of Nursing (DON) confirmed she expected nursing staff to fully process all physicians' orders and for medications to be administered to residents by nursing staff as ordered.	F 281	<b>F281 Continued</b>  b. New process for order notation: the nurse who notes the physician's order must fully carry out the order (including removal of medication card from med cart), pass to the oncoming shift a copy of the order, and the oncoming nurse will be responsible to perform a double check to ensure that order is fully carried out.  c. Medication cards must be removed from the med cart when the order is changed for that medication.  <b>Measures in place to ensure practice will not occur.</b>  1. DON or designee will complete weekly audit of patients receiving sublingual medications to ensure medications are being given via correct route. Individual education will be given for any errors in route of administration identified during the audits.  2. Oncoming nurse will correct any issues identified during the double check of orders conducted each shift. Shift Supervisor will be notified of any orders that had not been fully carried out, including removal of the	10/11/12 SB	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329			

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F 329	<p>Continued From page 3</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to monitor a resident's laboratory values as ordered by the physician for one (1) of four (4) sampled residents on anticoagulation therapy (Resident #17).</p> <p>The findings are: Resident #17 was admitted to the facility on 6/22/12 with diagnoses that included atrial fibrillation. The admission Minimum Data Set (MDS) dated 6/29/12 specified the resident did</p>	F 329	<p><b>F281 Continued</b></p> <p>medication from the cart, by the nurse who noted the order. Individualized education will be provided to any nurse who fails to carry out the order.</p> <p><b>How the facility plans to monitor and ensure correction is achieved and sustained.</b></p> <p>Results of the weekly Sublingual Administration Audit will be reported by the DON or designee to the Quality Assurance Committee monthly x3, then Quarterly x 3 for continued compliance/revision to plan if needed.</p> <p>Shift Supervisor will report results of the Order Notation Audit to the QA Committee monthly, then Quarterly x 3 for continued compliance/revision to plan if needed.</p> <p><b>F329</b> <b>How corrective action will be accomplished for the resident affected.</b></p> <ol style="list-style-type: none"> <li>1. Patient #17 was discharged on 07/27/12.</li> <li>2. Corrective action was given to nurse who failed to assign the labs order to the correct lab days.</li> </ol>	10/11/12 <i>SB</i>	

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F 329	<p>Continued From page 4</p> <p>not have impaired cognition and had received anticoagulant medication for 7 days. The resident was discharged to the hospital on 7/27/12 for bleeding and elevated PT/INR (prothrombin time / international normalized ratio).</p> <p>Review of Resident #17's medical record revealed a document titled "Clinical Discharge Summary" dated 6/22/12 specified the resident was ordered by the Physician to have her PT/INR checked on 6/23/12. Further review of the medical record revealed Resident #17's PT/INR was not performed on 6/23/12. Additional review of Resident #17's medical record revealed a laboratory results sheet dated 7/13/12 that specified the resident's PT/INR was high. The sheet specified to re-check the PT/INR on 7/17/12. Further review of the medical record revealed Resident #17's PT/INR was not checked on 7/17/12.</p> <p>Licensed nurse (LN) #1 was interviewed on 9/13/12 at 11:00 AM and reported she admitted Resident #17 on 6/22/12 and failed to see the physician's order to check the resident's PT/INR on 6/23/12. She stated that it was an oversight on her part. She added that she wrote on Resident #17's admission orders for her PT/INR to be checked on the next lab day. Resident #17's PT/INR was obtained on 6/25/12 and was within normal limits. LN #1 also stated she obtained the written order to check Resident #17's PT/INR on 7/17/12 and failed to transcribe the order. She reviewed the medical record and revealed Resident #17's PT/INR was not obtained on 7/17/12 as ordered by the Physician. Further review revealed Resident #17's PT/INR was</p>	F 329	<p><b>F329 Continued</b></p> <p><b>How corrective action will be accomplished for those residents with the potential to be affected by the same practice.</b></p> <ol style="list-style-type: none"> <li>1. An audit of patients on Coumadin was performed on 9/13/12, and orders for PT/INR labs were reviewed. No other missed labs were noted.</li> <li>2. The DON conducted an in-service for licensed nursing staff on 09/26/12. Topics included new process for order notation: the nurse who notes the physician's order must fully carry out the order (including assigning labs to be drawn on the correct date due), pass to the oncoming shift a copy of the order, and the oncoming shift will be responsible to ensure that labs are on the lab calendar to be drawn as ordered.</li> </ol> <p><b>F329 Continued</b></p> <p><b>Measures in place to ensure practice will not occur.</b></p> <p>Shift Supervisor will complete a weekly audit for patients receiving Coumadin. Orders for PT/INR will be reviewed to ensure lab was drawn as ordered. Individualized education and/or corrective action will be provided for any areas of non-compliance.</p>	10/11/12 SB	

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F 329	Continued From page 5 drawn on 7/20/12 and was slightly elevated.  Unit Manager #1 was present for the interview on 9/13/12 at 11:00 AM and reported she would expect licensed nurses to transcribe Physician's orders for Coumadin monitoring correctly. She reviewed the medical record and reported that Resident #17's PT/INR had not been monitored as ordered by the Physician.	F 329	<b>F329 Continued</b> <b>How the facility plans to monitor and ensure correction is achieved and sustained.</b>  Shift Supervisor will report results of this audit to the QA Committee monthly x3, then Quarterly x 3 for continued compliance/revision to plan if needed.	10/11/12 SB	
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	<b>F441</b> <b>How corrective action will be accomplished for the resident affected.</b>  On 9/10/12, isolation precaution for patient #221 based on physician order. The room was deep cleaned and both residents were bathed with Hibiclens soap.  <b>F441 Continued</b> <b>How corrective action will be accomplished for those residents with the potential to be affected by the same practice.</b>  On 9/10/12, Physician Assistant was individually educated regarding facility's policy for use of appropriate PPE when entering rooms designated as isolated and proper hand hygiene between residents and upon exiting the room. Medical Director was advised of individual education given to his Physician Assistant. He was provided with a list of all residents on isolation precautions at that time.		

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F 441	<p>Continued From page 6</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow facility Infection Control Policies by not donning Personal Protective Equipment (PPE) as posted signage indicated for one of seven rooms with isolation signs, and failed to wash hands between two residents residing together in an isolation room. (Resident #221 and #48).</p> <p>The findings are:</p> <p>1. Review of a policy dated 12/18/2009 titled "Infection Control Policies and Procedures, Section: Precautionary Measures, Isolation Precautions-General Practice" revealed: " The health care team and visitors will be instructed on the importance and necessity of maintaining isolation precautions before entering the resident's room ". In addition under #5: "Fundamental protective measures must be maintained. Hand washing is the single most important measure to reduce the risks of transmitting microorganisms from one person to another or from one site to another on the same resident " .</p>	F 441	<p><b>F441 Continued</b></p> <p>Hanging isolation bags were removed and carts were placed outside the room to provide better visual reminder that room has been designated as having isolation precautions in place.</p> <p><b>Measures in place to ensure practice will not occur.</b></p> <p>Facility-wide education was completed on 9/10/12: Topics included:</p> <ol style="list-style-type: none"> <li>1. Policies regarding hand hygiene between residents and prior to exiting the room.</li> <li>2. Policies regarding isolation precautions and appropriate PPE.</li> <li>3. Educated staff to report to infection control nurse incidences of non-compliance with infection control policies.</li> </ol> <p>On 9/19/12, all staff were re-educated during monthly All-Staff Meeting regarding expectation for compliance with isolation precaution and hand hygiene policies.</p> <p>Infection Control nurse or designee will make rounds 5x/wk and observe for compliance with PPE and hand hygiene.</p>	10/11/12 <i>EB</i>	

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F 441	Continued From page 7  Medical record review revealed Resident #221 was re-admitted to the facility on 08/09/2012 from an acute care hospital. Review of the medical record revealed a laboratory report dated 08/24/2012 that documented Resident #221 had vancomycin resistant enterococcus and contact precautions were required for patients in healthcare settings. In addition the report stated: "Place patient in contact precautions in healthcare setting by entering type of isolation in computer and placing sign outside patien's door". Review of the Treatment Administration Record (TAR) documented the infectious wound was located on the right foot and toe area. Further review of the medical record revealed no documentation or physicia's orders that stated Resident #221 was no longer infectious and could be removed from contact precautions.  Medical record review revealed Resident #48 was admitted to the facility on 07/20/2012 from an acute care hospital with diagnoses including acute renal failure and atrial fibrillation.  On 09/10/12 at 9:53 AM a contact precaution sign was observed on Resident #221 and #48's door along with an equipment holder that contained gowns and gloves.  On 09/10/2012 at 9:55 AM the facility Physician Assistant (PA) was observed entering Resident #221and #48's room without donning either a gown or the gloves available hanging on the door. The PA went to Resident #221 in the first bed, greeted her by shaking her hand and talking with her as he assessed her. The PA was then observed to greet and assess the Resident #48 in	F 441	<b>F441 Continued</b> <b>How the facility plans to monitor and ensure correction is achieved and sustained.</b>  Infection Control nurse will report results of infection control rounds to the QA Committee monthly x3, then Quarterly x 3 for continued compliance/revision to plan if needed.	10/11/12 <i>EB</i>	



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F 441	<p>Continued From page 8</p> <p>the second bed palpating (touching by pressing) her for swelling. The PA did not wash his hands between these two residents.</p> <p>The PA was interviewed immediately when he exited the room at 10:05 AM and revealed he was uncertain which resident in the room was on contact precaution but had seen the contact precautions sign on the door with gowns and gloves available for use. The PA stated he should have followed the facility policy and put on the Personal Protective Equipment (PPE, gown and gloves) before entering. The PA also confirmed he was supposed to wash his hands between residents and when he exited the room but just had not done it.</p> <p>Interview at 10:57AM on 09/10/2012 with the Unit Manager Nurse #3 revealed she expected the PA and all medical staff to don PPE as indicated if posted on a resident's door when going into a room and to wash their hands between residents and when they exited.</p> <p>Interview on 09/12/12 at 8:40 AM with the Medical Director and facility Physician revealed he expected all medical staff to follow precaution signs when posted and put on PPE as directed and wash their hands between residents.</p> <p>Interview on 09/13/12 at 1:20 PM with the Infection Control nurse revealed her desire was for anyone entering a room with a precautions sign to follow the facility protocol and don the PPE as indicated by the sign on the door. She also confirmed that anyone coming out of the rooms were to wash their hands to include residents, visitor and staff. She noted she goes</p>	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345526</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA REHAB CENTER OF BURKE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612</b>		
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F 441	Continued From page 9 over Isolation Precautions on orientation with all new staff and annually with current staff but had not in serviced the Physician Assistant.  Interview on 09/14/2012 at 3:10 PM with the Director of Nursing (DON) revealed she expected when staff entered a room they were to don the PPE as indicated on the door, remove it before they exited and wash their hands.	F 441		