STATEMENT OF DEFICIENCIES     (X1) PROVIDER/SUPPLIER/CLIA       AND PLAN OF CORRECTION     IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
			A. BUILDING			C	
		345405 B. WING			05/19/2016		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	TE HEALTH & REHABI			17	35 TODDVILLE ROAD		
CHARLOI		LITATION CENTER		CI	HARLOTTE, NC 28214		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SER\ PROFESSIONAL ST	/ICES PROVIDED MEET FANDARDS	F	281			6/16/16
	-	ed or arranged by the facility nal standards of quality.					
	This REQUIREMEN	T is not met as evidenced					
	and physician intervi	view, staff, nurse practitioner, iews the facility failed to			The statements included are not an admission and do not constitute		
	days and delayed ac	Itravenous (IV) antibiotic for 3 Iministration for 1 of 3 or unnecessary medications			agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and		
	(Resident #5). The findings include	d:			federal regulations as outlined. To rem in compliance with all federal and state	ain	
	03/30/16 and discha	mitted to the facility on rged on 04/27/16 with			regulations the center has taken or will take the actions set forth in the followin	g	
		ded osteoarthritis of left knee eview of the most recent			plan of correction. The following plan c correction constitutes the center s	of	
	•	mum data set (MDS) dated			allegation of compliance. All alleged deficiencies cited have been or will be		
	cognitively intact and	d required limited assistance			completed by the dates indicated.		
		for bed mobility, transfers, nd personal hygiene. The			F 281		
	MDS also indicated to days of antibiotic the	that Resident #5 received 3 rapy and received also IV			How corrective action will be accomplished for each resident found the affected by the deficient practice	0	
		locument titled "Outpatient			be affected by the deficient practice. Resident # 5 received antibiotic therapy		
		by Orders" (OPAT) dated t Resident #5 was to receive			as of 4/4/16 with completion of antibioti therapy as of 4/23/16. Resident	С	
		gm) IV every 8 hours until			discharged home in good condition on		
	04/23/16. The docu	mented indicated the location			4/27/16.		
	•	antimicrobial therapy was the					
		y. The document further			How corrective action will be		
		supervising physician with			accomplished for those residents havin	-	
		antimicrobial therapy, delay			the potential to be affected by the same	9	
		ason, any difficulty with IV nb swelling), adverse drug			deficient practice. The Director of Nursing, Unit Manager	or	
	อออออจ (แก่อนนแบ่ง แก่	in sweining), auveise ulug	1		The Director of Nursing, Utilt Manager		1

**Electronically Signed** 

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.

06/06/2016

		MEDICAID SERVICES				<u>NO. 0938-03</u> TE SURVEY
TATEMENT OF DEFICIENCIES     (X1) PROVIDER/SUPPLIER/CLIA       ID PLAN OF CORRECTION     IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
						С
		345405	B. WING		0	5/19/2016
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CODI		
				1735 TODDVILLE ROAD		
CHARLOI	TE HEALTH & REHABIL	LITATION CENTER		CHARLOTTE, NC 28214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 281	Continued From page	e 1	F 28	1		
1 201			F 20		ure that pe	
	symptoms of deep ve	onically signed by the		admissions by 6/16/16 to ensu other medication or physician		
	infectious disease (IE			were missed.		
	,	ation Administration Record				
	dated March 2016 contained no order for			Measures to be put in place o	r svstemic	
	Cefazolin.			changes made to ensure prac	-	
	Review of the Medication Administration Record			reoccur.		
	dated April 2016 revealed an order that was			Newly admitted resident⊡s or	ders will be	
	obtained on 04/04/16 that read Cefazolin			audited within 24 hours of adn	nission by	
		l gm/1000 milliliters (ml).		the Director of Nurses, Unit M	anager, Unit	
		nously every 8 hours for		Coordinator or nurse supervis		
		23/16. The order had been		that no medications were miss	•	
	initialed by the nursing staff indicating the IV medication had been administered starting on 04/04/16 q 8 hours.			admission and that all physicia are followed.	an∐s orders	
	-	Practitioner (NP) on		All nurses will be re-educated	regarding	
	Interview with Nurse Practitioner (NP) on 05/19/16 at 1:08 PM revealed that when she			the importance of administerir		
	arrived at the facility on the morning of 04/04/16			medications per physician	-	
	she found a document in her box that was titled			following a physician s order		
		bial Therapy Orders" that		6/16/16. They will also be re-e		
		or Cefazolin 2 gm IV q 8		contact the prescribing physic		
	hours until 04/23/16.	The staff had circled the		attending physician or NP to c	larify orders	
		te asking if the staff should		as needed.		
		The NP stated that she gave				
		dication as ordered on the		Nurses who do not receive the		
		stated that she would have		re-education will not be allowed		
		call her at the time of the he order and she would have		until they receive the educatio	11.	
		aff to notify the ID doctor per		All newly hired nurses will rec	aive	
	her instructions on th			education at the time of hire of		
		tor on 05/19/16 at 2:07 PM		importance of administering m		
		s not aware that Resident #5		per physician s orders and for		
	did not receive the IV	antibiotics as ordered. The		physician⊡s order. They will a	-	
	ID doctor stated she	would have expected the		educated to contact the presc	ribing	
		ct her if they had questions		physician or the attending phy	sician or NP	
		instead of placing them in ID doctor stated her contact		to clarify orders as needed.		
		ocumented on the "Outpatient		How the facility will monitor co	rrective	
		y Order" document. The ID		action to ensure deficient prac		

Facility ID: 943091

		MEDICAID SERVICES				D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING			
345405		B. WING			C	
	ROVIDER OR SUPPLIER	343403		STREET ADDRESS, CITY, STATE, ZIP CO		19/2016
	ROVIDER OR SUPPLIER			1735 TODDVILLE ROAD		
HARLOT	TE HEALTH & REHABI	LITATION CENTER		CHARLOTTE, NC 28214		
				-		1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
F 281	Continued From pag	ge 2	F 281			
		at Resident #5 was lucky and		reoccur.		
		V medications did not have a		The Director of Nursing will	report on the	
		outcome and he had done		results of these audits during	•	
	well and had dischar			Assurance meetings once m		
		#1 on 05/19/16 at 2:58 PM		months, then quarterly x 9 m		
	revealed that she admitted Resident #5 and the supervisor had entered the orders into the electronic medical record. Nurse #1 stated that while completing has mediation notes the patient			The QA&A committee will ev		
				reports to determine the effe		
				the plan and make any chan	iges as	
	while completing her medication pass she noticed that Resident #5 had an IV access and reviewed			needed.		
		ned no IV medications. Nurse				
	#1 stated that she had gone to review his discharge orders that had accompanied Resident					
	#5 from the hospital and she noted the document					
		timicrobial Therapy Orders"				
		rder Cefazolin 2 grams (gm)				
		il 04/23/16. Nurse #1 stated				
		o the facility so she took the				
	-	pervisor who instructed Nurse				
	-	iment in the physician box at				
	the facility. Nurse #1					
		d the order and wrote a note tion needed to be given.				
	-	t if she had it to do over again				
		picked up the phone and				
	-	actitioner or physician.				
		rector of Nursing (DON) on				
	05/19/16 at 3:23 PM	I revealed that he was new to				
	-	not aware the Resident #5 did				
		ntibiotics as ordered. The				
		d have expected the staff to				
		P, or ID doctor if they had any				
	· ·	medications that were also expect medications that				
		Iministered as ordered.				
		upervisor on 05/19/16 at 4:21				
		ot recall Resident #5.				
			1	1		1

If continuation sheet Page 3 of 6

		MEDICAID SERVICES				NO. 0938-039	
TATEMENT OF DEFICIENCIES     (X1) PROVIDER/SUPPLIER/CLIA       ND PLAN OF CORRECTION     IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						С	
345405		B. WING			5/19/2016		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
				1735 TODDVILLE ROAD			
CHARLOI	TE HEALTH & REHABI	LITATION CENTER		CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
E 222	Continued From non	- 2					
F 333	1 0		F 33	33			
SS=D	SIGNIFICANT MED	EKKUKS					
	The facility must ensure that residents are free of any significant medication errors.						
	,						
	This REQUIREMEN	T is not met as evidenced					
	by:						
		view, staff, nurse practitioner,		F333			
		ews the facility failed to		How corrective action will			
		us (IV) antibiotic as ordered		accomplished for each re			
		ampled for unnecessary		be affected by the deficient			
	medications (Reside The findings included	,		Resident # 5 received and as of 4/4/16 with completi			
		nitted to the facility on		therapy as of 4/23/16. Re			
		rged on 04/27/16 with		discharged home in good			
		led osteoarthritis of left knee		4/27/16.			
	•	view of the most recent					
		num data set (MDS) dated		How corrective action will	be		
	04/06/16 revealed th	at Resident #5 was		accomplished for those re			
		I required limited assistance		the potential to be affecte	d by the same		
		for bed mobility, transfers,		deficient practice.			
		nd personal hygiene. The		The Director of Nursing, l	-		
		hat Resident #5 received 3		nursing supervisor will au			
	-	rapy and received also IV		admissions by 6/16/16 to other medication or physi			
	therapy. Review of a facility d	ocument titled "Outpatient		were missed.			
	-	y Orders" (OPAT) dated					
		Resident #5 was to receive		Measures to be put in pla	ce or systemic		
		m) IV every 8 hours until		changes made to ensure			
	04/23/16. The docu	ment indicated the location of		reoccur.			
		microbial therapy was the		Newly admitted resident			
		/. The document further		audited within 24 hours of	•		
		supervising physician with		the Director of Nurses, Ur			
		antimicrobial therapy, delay		Coordinator or nurse supe			
		ason, any difficulty with IV b swelling), adverse drug		that no medications were admission and that all phy	-		
	access uncluding lim						
		t then 100.4 degree, or		are followed.			

Facility ID: 943091

If continuation sheet Page 4 of 6

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	A. BUILDING				
	345405					С	
			B. WING		c	05/19/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
	TE HEALTH & REHABIL	ITATION CENTER		1735 TODDVILLE ROAD			
UNAREO				CHARLOTTE, NC 28214			
(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 EACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE	
F 333	Continued From page	2 4	F 33	33			
	document was electro		1 00	All nurses will be re-ed	ucated regarding		
	infectious disease (ID			the importance of admi			
	,	ation Administration Record		medications per physic	-		
	dated March 2016 co			following a physician			
	Cefazolin. Review of the Medication Administration Record dated April 2016 revealed an order that was			6/16/16. They will also	be re-educated to		
				contact the prescribing			
				attending physician or	NP to clarify orders		
	obtained on 04/04/16			as needed.			
		gm/1000 milliliters (ml).					
	Use 2000 mg intravenously every 8 hours for septic knee until 04/23/16. The order had been			Nurses who do not rec			
				re-education will not be			
	-	g staff indicating the IV administered starting on		until they receive the e			
	04/04/16 every 8 hou			All newly hired nurses	will receive		
	Interview with Nurse			education at the time o			
		revealed that when she		importance of administ			
		on the morning of 04/04/16		per physician □s orders			
		nt in her box that was titled		physician □s order. The	•		
	"Outpatient Antimicro	bial Therapy Orders" that		educated to contact the	e prescribing		
		or Cefazolin 2 gm IV every 8		physician or the attend	ing physician or NP		
		The staff had circled the		to clarify orders as nee	ded.		
		te asking if the staff should					
	•	The NP stated that she gave		How the facility will mo			
		lication as ordered on the		action to ensure deficie	ent practice will not		
		tated that she would have call her at the time of the		reoccur.	will report on the		
		ne order and she would have		The Director of Nursing results of these audits			
	-	iff to notify the ID doctor per		Assurance meetings of			
	her instructions on the			months, then quarterly			
		tor on 05/19/16 at 2:07 PM		The QA&A committee			
		s not aware that Resident #5		reports to determine th			
	did not receive the IV	antibiotics as ordered. The		the plan and make any			
		would have expected the		needed.			
	-	ct her if they had questions					
		instead of placing them in					
		expected the IV antibiotics to					
		red as ordered. The ID					
		tact information is well					
	aocumented on the "	Outpatient Antimicrobial				1	

Facility ID: 943091

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		MEDICAID SERVICES	(X2) MEILTIPI	E CONSTRUCTION		O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	COMPLETED	
345405					С		
		B. WING	0	5/19/2016			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E		
	TE HEALTH & REHABI			1735 TODDVILLE ROAD			
CHARLOI		LITATION CENTER		CHARLOTTE, NC 28214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 333	Continued From pag	e 5	F 333				
1 000			F 330	5			
		ument. The ID doctor also #5 was lucky and the					
		edications did not have a					
		outcome and he had done					
		ged home on 04/27/16.					
	Interview with Nurse	#1 on 05/19/16 at 2:58 PM					
	revealed that she ad	mitted Resident #5 and the					
	· ·	ed the orders into the					
		cord. Nurse #1 stated that					
		medication pass she noticed					
		I an IV access and reviewed					
		ed no IV medications. Nurse					
	#1 stated that she ha	-					
	-	t had accompanied Resident and she noted the document					
	-	imicrobial Therapy Orders"					
		der Cefazolin 2 grams (gm)					
		il 04/23/16. Nurse #1 stated					
		the facility so she took the					
		ervisor who instructed Nurse					
	#1 to place the docu	ment in the physician box at					
	the facility. Nurse #1	stated she took the					
	document and circle	d the order and wrote a note					
	U U	ion needed to be given.					
		if she had it to do over again					
		picked up the phone and					
		ctitioner or physician.					
		rector of Nursing (DON) on					
		revealed that he was new to not aware the Resident #5 did					
	-	tibiotics as ordered. The					
		d have expected the staff to					
		P, or ID doctor if they had any					
		medications that were					
	· ·	lso expect medications that					
		ministered as ordered.					
						1	
	Interview with the Su	pervisor on 05/19/16 at 4:21					

Facility ID: 943091

If continuation sheet Page 6 of 6