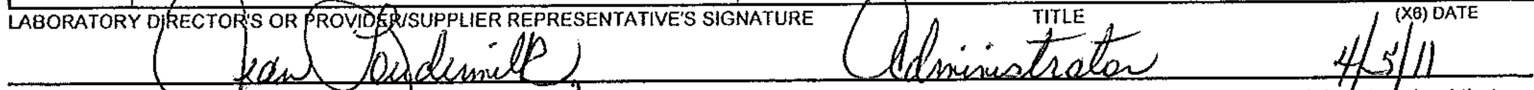
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APR 07 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345183	A. BUILDING ______ B. WING ______	C 03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE & REHAB	430 BROOKWOOD AVE NE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to follow the physician's order for the administration of an antibiotic for 1 of 3 sampled residents with a scheduled stent removal procedure. (Resident #2). Findings included: Resident #2 was admitted to the facility on 1/14/11 with diagnoses which included: cellulitis and abscess; metastatic adenocarcinoma status post colostomy and mucous fistula; a history of hydronephrosis; a history of methicillin-resistant Staphylococcus aureus urinary tract infections; a history of kidney stones; and a history of abdominal pain. The admission's Minimum Data Set (MDS) assessment dated 1/24/11 revealed Resident #2 was cognitively intact. Review of the Physician's Progress Note dated 2/6/11 revealed Resident #2 had a history of nephrolithiasis and the resident was to follow-up with Urology for removal of a stent. The Physician's Order dated 2/14/11 indicated Resident #2 was to receive Bactrim DS (antibiotic) twice each day for five days starting on 3/4/11; which would be three days prior to the stent removal procedure on March 7, 2011.	F 281	A. Corrective action was obtained for resident #2: Physician notified of transcription error and no new order was received to resume antibiotic. Patient was sent to Urologist appointment as instructed by Urologist. FYI:(Stent was not removed because of the transcription error, Urologist wanted to consult Pts. Oncologist and determine how aggressive the patient wants to be) B. This order was a carry over from previous months orders/MAR. Upon completion of order rectification at the end of the month, third shift nurse will compare previous months MARS to current MAR to ensure all orders captured. C. Inservice education completed with nursing staff on transcribing orders and end of month carry overs. Third shift nurse to compare new MARS to old MARS to ensure all orders captured. D. Audit of MARS/TARS completed at beginning of each month to include comparison of MARS; also third shift nurse to sign MAR after audit completed. Results to be reviewed in Monthly QA x 6 Months and then quarterly.	3/7/11 3/31/11 and on-going 3/8/11 and on-going 4/2011 and on-going



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/5/11

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.

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F 281	Continued From page 1 Review of the Medication Administration Record (MAR) for March 2011 indicated Resident #2 did not receive the antibiotic three days prior to her scheduled Urology visit as ordered. During an interview on 3/15/11 at 1:52pm, Resident #2 stated that when she arrived for her scheduled appointment with the Urologist to have the stent removed on 3/7/11, he informed her that the facility notified him (Urologist) of their (facility) failure to give the resident the antibiotic as ordered prior to the resident ' s visit. As of 3/15/11 the stent had not been removed. During an interview on 3/15/11 at 4:16pm, the facility ' s Wound Nurse revealed that on the day of Resident #2's Urology appointment, the hall nurse informed her that the antibiotic ordered by the Urologist to be administered three days prior to the stent removal was not transcribed onto the MAR and therefore was not given to the resident. The Wound Nurse notified the Urologist of the transcription error prior to the appointed time of 10:15am; but also informed the urology office that the resident had received the same antibiotic on 2/17/11-2/25/11 for a urinary tract infection: and, if it was still ok to send Resident #2 her appointment since she didn't receive the antibiotic three days prior. The resident was able to go to her appointment with the Urologist. Upon the resident's return to facility, the resident's family member was upset due to the stent removal procedure was not done because the facility did not administer the antibiotic to the resident.	F 281		