

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

PRINTED: 06/09/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345436	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 5/25/11 06/25/2011
NAME OF PROVIDER OR SUPPLIER WELLINGTON REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 TANDALL PLACE KNIGHTDALE, NC 27545		
(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 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any 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 reviews, the facility staff administered a sulfa drug (antibiotic) to a 1 of 1 sampled resident who had a documented allergy to sulfa drugs (Resident # 2). Findings include: Resident #2 was admitted to the facility on 08/04/08. The resident's cumulative diagnoses</p>	F 329	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.</p> <p>F-329</p> <ol style="list-style-type: none"> The sulfa drug was discontinued after 1 dose. Resident had no adverse reactions to the sulfa drug. An audit was completed by the RN nurse consultant of current residents' allergies and medications to ensure that they were not receiving a medication which is documented as an allergy in their medical records. All allergy stickers were updated on the resident charts at that time. A sign reminding nurses to check for drug allergies prior to administering drugs from the emergency drug box was posted in all Medication Rooms. Physician's Assistant and Licensed Nurses were re-educated by the administrator or designee to check resident's documented allergies prior to ordering/administering medication to the resident. DON/Designee will conduct Quality Improvement (QI) monitoring of this standard 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. This standard will be monitored by ensuring the 	6/22/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Elizabeth S. Wallace* TITLE *Administrator* (X5) DATE *6/19/2011*

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 30 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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NAME OF PROVIDER OR SUPPLIER WELLINGTON REHABILITATION AND HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 TANDALL PLACE KNIGHTDALE, NC 27545		
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F 328	<p>Continued From page 1</p> <p>Included hypertension, atrial fibrillation, diabetes, and difficulty in walking.</p> <p>According to the most recent Minimum Data Set (MDS) dated 02/22/11, the resident was interviewable.</p> <p>Review of the Medication Record (MR) for the month of March 2011 revealed the resident was allergic to Penicillin, Sulfa (Sulfonamide antibiotics) and Cipro.</p> <p>According to the Lexi-Comp 's Drug Reference Handbook, Geriatric Dosage Handbook, 14th edition, Bactrim DS is a Sulfonamide (sulfa) derivative antibiotics. It is contraindicated to take this medication if the patient is hypersensitive to any sulfa drug.</p> <p>Review of the Physician Telephone Orders dated 03/14/11 revealed an order for Macrobid (antibiotics) 100mg (milligram) 1 tablet by mouth twice a day for 5 days. There was a physician telephone order dated 03/15/11 to discontinue the Macrobid and do a urinalysis and a urine culture and sensitivity test to check for dysuria.</p> <p>Review of the urinalysis done on 03/16/11 revealed the resident showed 2+ bacterial growth and that the urine culture was still pending.</p> <p>Review of the urine culture and sensitivity test results dated 03/16/11 revealed the resident had Providencia stuartii organism. This organism was sensitive to Bactrim.</p> <p>Review of the Physician 's Telephone Order dated 03/18/11 revealed an order to discontinue</p>	F 329	<p>resident has an order for the medication, that the resident was not allergic to the medication ordered, and that the resident did not have a documented allergy to the medication which was administered.</p> <p>4. DON/Designee will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision.</p> <p>5. Date of completion 6-22-11.</p>	6/20/11	

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F 329	<p>Continued From page 2</p> <p>Macrobid and start Bactrim DS 1 tablet (100mg) by mouth twice a day for 7 days. This order was signed by the nurse and the physician assistant (PA).</p> <p>Review of the Medication Records for the month of March 2011 revealed the resident received one dose of Bactrim DS 100mg at 4 PM on 03/18/11.</p> <p>Review of the Nurse's Notes of 03/19/11 revealed the nurse received a call from pharmacy that the resident was allergic to Sulfa. The facility staff called the physician and an order was given to discontinue Bactrim and start the resident on Imipenem 250mg intravenously every 6 hours for 5 days.</p> <p>Review of the Emergency Kit Contents revealed the emergency kit had Bactrim.</p> <p>Interview of the MDS nurse on 05/24/11 at 4:14 PM revealed the resident was put on Macrobid because of dysuria. Since there was no urinalysis, the Macrobid was discontinued waiting for the results of the urinalysis and culture and sensitivity.</p> <p>An interview with Nurse #1 who received the order for Bactrim and administered the dose on 03/18/11 was conducted on 05/24/11 at 3:12 PM. Nurse # 1 stated that she worked on the hall where the resident resided every day except Tuesdays and the weekend. The nurse stated she worked on 03/18/11. She said the order for Bactrim was written by the PA and was flagged in the chart. The nurse said she signed the order and transcribed it to the Medication Records. When the nurse was asked if she checked if the</p>	F 329		

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F 329	<p>Continued From page 3</p> <p>resident was allergic to Bactrim, she said " apparently not ". The nurse said she usually would look at the MR and inside the front cover of the medical record to check for allergies. The nurse said she went to the emergency kit and got the Bactrim and gave it to the resident. The nurse said then she received a phone call from the pharmacy notifying her that the resident was allergic to Bactrim. The resident did not have any allergic reactions or changes.</p> <p>An interview with the PA on 05/24/11 at 10:25 AM revealed that usually when staff called her about a urinalysis test results, she would ask the staff about drug allergies before she gave the order for antibiotics. The PA could not remember about giving the order to give Bactrim to the resident back in March 2011.</p>	F 329			