

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 346471	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2012
--	--	--	--

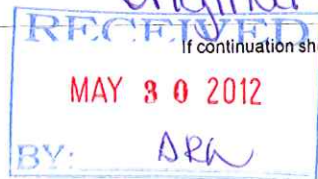
NAME OF PROVIDER OR SUPPLIER MECKLENBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2416 SANDY PORTER ROAD CHARLOTTE, NC 28273
--	--

(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 review, the facility failed to monitor a Digoxin level for 1 of 1 resident (Resident #104)</p> <p>The findings are: Resident #104 was admitted 7/2/2010 with multiple diagnosis including congestive heart</p>	F 329	<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>F-329</p> <p>How corrective action will be accomplished for resident affected:</p> <ol style="list-style-type: none"> Physician for resident #104 was notified that ordered digoxin level was not obtained. Received order to obtain lab. Lab obtained on 4/30/12. Results were within normal limits. 	5/25/12
---------------	--	-------	---	---------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sharyn Nathan</i>	TITLE <i>Administrator</i>	(X6) DATE 5/28/12
---	-------------------------------	----------------------

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.

Original signature

 If continuation sheet Page 1 of 5
 5/10/12
 mh

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

PRINTED: 05/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345471	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MECKLENBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273
--	--

(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	<p>Continued From page 1</p> <p>failure, and atrial fibrillation. The resident is currently taking Digoxin 125mcg by mouth daily. Review of a physician order revealed the resident was to receive Digoxin 125 mcg (micrograms) by mouth daily.</p> <p>A second physician order dated 2/17/12 stated to add a Digoxin level to labs that were sent to the laboratory on 2/16/12. If the laboratory was unable to add the digoxin level, the order stated to draw the level on the following Monday. Further review revealed no documentation of the Digoxin level being completed on 2/17/12 or on the following Monday.</p> <p>In an interview with Nurse #8 on 4/26/12 at 9:30 am, she stated the Digoxin level was not completed on 2/17/12 or on the following Monday.</p> <p>In an interview with Unit Manager #1 on 4/26/12 at 9:45 am, she stated that the Digoxin level was not completed on 2/17/12 or on the following Monday.</p> <p>In an interview with the Director of Nursing (DON) on 4/27/12 at 12:00 who stated it is her expectation that labs be drawn as ordered.</p>	F 329	<p>F- 329 Continued</p> <p>How corrective action will be accomplished for those residents with potential to be affected:</p> <p>2. A. 100% chart audit completed on 5/2/12. This audit included all residents in the facility. All lab orders from March 1st thru current were reviewed.</p> <p>B. Obtained Digoxin levels on remaining patients based on recommendation of pharmacist and physicians.</p> <p>Measures in place to ensure practices will not occur:</p>	
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p>	F 428	<p>3. A. Nursing Staff have been re-educated by SDC/DON on processing lab orders.</p> <p>B. Lab orders will be reviewed and verified by off-going/on-coming nurse to ensure labs are accurately placed in the lab book.</p>	

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

PRINTED: 05/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345471	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2012
NAME OF PROVIDER OR SUPPLIER MECKLENBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	
(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 428	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility consultant pharmacist failed to identify and report the missing laboratory result to monitor medication for 1 of 10 residents (Resident #104) The findings are: Resident #104 was admitted 7/2/2010 with diagnoses of congestive heart failure and atrial fibrillation. Medical record review revealed that a Digoxin level for Resident #104 was ordered on 2/17/2012. The order stated to add a Digoxin level to labs that were sent to the laboratory on 2/16/12. If the lab was unable to add the digoxin level, the order stated to draw one on the following Monday. Further review revealed no documentation of the Digoxin level being completed on 2/17/12 or the following Monday. Further medical record review revealed that the pharmacist reviewed the resident 's medications on 3/2/12 and 4/4/12. The pharmacist documented that the medications were reviewed with no additional comments or recommended changes. On 4/27/12 at 1140 am, a phone call was made to the consulting pharmacist, who was not available.	F 428	<u>F-329 Continued</u> C. The third shift charge nurses will do 24 hour chart checks to ensure lab orders are carried out as ordered. D. The Unit Manager/Designee will review new lab orders on the next business day. The DON/Designee will randomly audit lab orders 5 x week x 2 weeks, 2 x weeks x 2 weeks, monthly x 2 months and then randomly. How the facility plans to monitor to ensure correction is achieved and sustained: 4. The DON/Designee will report results of findings to the QA&A Committee quarterly x 3 quarters for continued compliance/revision to plan.	
F 465	483.70(h)	F 465		

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

PRINTED: 05/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345471	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MECKLENBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273
---	--

(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 465 SS=D	<p>Continued From page 3</p> <p>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure that one of two automatic ice and water dispensers was clean.</p> <p>The findings are:</p> <p>An observation of the nourishment room located on the two-hundred hall on 4/25/12 at 11:10am revealed an automatic ice and water dispenser with a removable metal rack. Observation further revealed a large amount of a black gelatinous substance around the edges of the dispensing tray under the metal rack. When felt, the gelatinous substance had a slimy feel and was easily removed.</p> <p>Interview with RN Unit Manager #1 on 4/25/12 at 11:15am revealed nursing staff were responsible for checking the nourishment rooms and correcting any concerns. RN Unit Manager #1 was shown the black gelatinous substance around the rim of the dispensing tray under the metal rack in the automatic ice and water dispenser located in the nourishment room on the two-hundred hall.</p> <p>Interview with RN Unit Manager #1 on 4/25/12 at 11:25am further revealed she was informed by</p>	F 465	<p>F-428 How corrective action will be accomplished for resident affected:</p> <p>1. Physician for resident #104 was notified that ordered digoxin level was not obtained. Received order to obtain lab. Lab obtained on 4/30/12. Results were within normal limits.</p> <p>How corrective action will be accomplished for those residents with potential to be affected:</p> <p>2. A 100% chart audit completed on 5/2/12. This audit included all residents in the facility. All lab orders from March 1st thru current were reviewed.</p> <p>B. Obtained Digoxin levels on remaining patients based on recommendation of pharmacist and physicians.</p>	5/25/12
---------------	--	-------	---	---------

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

PRINTED: 05/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345471	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/27/2012
NAME OF PROVIDER OR SUPPLIER MECKLENBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273		
(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 465	Continued From page 4 the Director of Nursing; housekeeping staff were responsible for cleaning the automatic ice and water dispensers located in both of the facilities nourishment rooms. Interview with the Director of Housekeeping on 4/26/12 at 8:25am revealed there was no policy for cleaning the automatic ice and water dispensers. Interview further revealed housekeeping staff were responsible for cleaning the automatic ice and water dispensers in both nourishment rooms. Interview further revealed he expected the ice and water dispensers to be cleaned daily.	F 465	F 428 Continued Measures in place to ensure practices will not occur: 3. Contract pharmacy will continue monthly chart reviews and recommendations, per regulatory guidelines. Pharmacy will provide a list of all residents on Digoxin for Atrial Fibrillation to DON. DON will cross reference pharmacist reviews with the patient list to assure all patients receiving digoxin are reviewed. The recommendations will then be reviewed with MD for review of recommendations for levels and frequency if appropriate, monthly x 3 months and quarterly times 2 quarters. How the facility plans to monitor to ensure correction is achieved and sustained: 4. The Pharmacist/DON/ Designee will report results of findings to the QA&A Committee quarterly times three quarters for continued compliance/revision to the plan.		

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

PRINTED: 05/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345471	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MECKLENBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273
--	--

(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 465 How corrective action will be accomplished for resident affected: 5/25/12

1. Ice Machine was immediately cleaned and sanitized.

How corrective action will be accomplished for those residents with potential to be affected:

2. All other facility ice machines were inspected for cleanliness.

Measures in place to ensure practices will not occur:

3. A. Housekeeping staff educated on the proper cleaning and sanitizing of ice machines required daily .
B. Housekeeping Manager/designee to monitor to assure proper cleaning of the ice machines 5 times each week for two weeks, 3 times each week for two weeks and weekly thereafter as part of routine inspection.

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

PRINTED: 05/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345471	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/27/2012
NAME OF PROVIDER OR SUPPLIER MECKLENBURG HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2415 SANDY PORTER ROAD CHARLOTTE, NC 28273	
(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-465 Continued

How the facility plans to monitor to ensure correction is achieved and sustained:

4. The Housekeeping Mgr./designee will report results to the QA&A Committee quarterly times three quarters for continued compliance/revision to plan.