

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

PRINTED: 06/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/01/2012
NAME OF PROVIDER OR SUPPLIER WILORA LAKE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6001 WILORA LAKE ROAD CHARLOTTE, NC 28212	
(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 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, and record review the facility failed to provide honey thickened liquids as ordered for 1 (one) of 2 (two) sampled residents with aspiration precautions. (Resident #10)</p> <p>The findings are:</p> <p>Resident #10 was admitted to the facility September 2011 with diagnoses of Osteoarthritis and Dysphasia. The quarterly minimum data set (MDS) dated 05/1/12 assessed the Resident as cognitively intact for decision making. Further review of Resident #10's MDS revealed that Resident #10 had a swallowing disorder.</p> <p>Review of Resident #10's Care Plan updated on 05/2/12 revealed the following goal: No aspiration or dehydration requiring hospitalization thru next review. Interventions included: Do not place thin liquids at bedside.</p> <p>Review of the medical record revealed the following: a physician's order dated 05/2/12 which discontinued Resident #10's regular diet and</p>	F 309	<p>This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the Facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.</p> <p>A. Resident #10 was immediately assessed for any signs and symptoms of aspiration or respiratory distress. Resident #10 did not exhibit adverse effects related to ingesting thin liquids. The Physician was updated on resident's condition. Licensed Nurse was re-educated on following physician orders.</p> <p>B. Current patients on thickened liquids were audited to assure that no thin liquids were present at the bedside.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

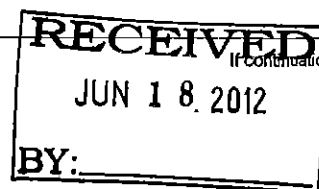
(X6) DATE

Gene Jackson

Administrator

6-15-12

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.



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F 309	<p>Continued From page 1</p> <p>changed it to mechanical soft with honey thickened liquids. Resident #10's medication administration record (MAR) for the month of May 2012 also documented the discontinuation of a regular diet on 05/2/12 and the addition of a mechanical soft diet with honey thickened liquids. The Speech Therapy Discharge summary dated 05/16/12 also documented that Resident #10 would remain on a mechanical soft diet with whole bacon and honey thickened liquids due to the Resident remaining at risk for aspiration.</p> <p>Observation of the 100 and 200 hall nursing stations on 05/29/12 4:43 PM revealed an orange sign in a clear sheet protector stating: Resident's on Thickened Liquids. Behind the orange sheet was a list of names that included Resident #10.</p> <p>Observation of Resident #10's bedside tray table on 05/29/12 at 2:58 PM revealed a 6 oz. cup containing thin water. Resident #10 shared that she got thin water when she was given her medicine by the nurse. She was unable to give an exact time she received the thin water but shared it was probably at 2:00 PM because she received a pain pill at that time. Resident #10 stated that staff stopped giving her a water cup for thin liquids once her diet was changed to thickened liquids.</p> <p>During an interview with Licensed Nurse #1 (LN #1) on 5/29/12 at 4:00 PM, the nurse confirmed that she gave Resident #10 a cup of thin water during a 2:00 PM medication pass. After reviewing the MAR, LN #1 stated that she was off the past four days and had not been informed the Resident was to receive honey thickened liquids per physician order. LN #1 stated she saw the</p>	F 309	<p>C. All staff were educated on current thickened liquid policy and identifiers for patients receiving thickened liquids. DON/Designee to QI monitor patients on thickened liquids to assure proper identifiers are present and no thin liquids are at the bedside 3 times weekly for four weeks, one time weekly for four weeks and monthly thereafter for ten months.</p> <p>D. Results of QI monitoring will be reported to RM/QI Committee monthly for 12 months. The Committee will assure compliance and make revisions to the plan as necessary.</p> <p>E. Completion Date 6/24/2012.</p>		

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F 309	Continued From page 2 physician's order for honey thickened liquids on the MAR for Resident #10, but she was not aware it was a current order. Observation of Resident #10's bedside table at 4:15 PM on 05/29/12 revealed thin water was still in a cup on the Resident's bedside tray table. LN #1 confirmed that it was the cup of water that she had given with the Resident's 2:00 PM medication pass. Interview with Resident #10 on 05/30/12 at 8:45 AM revealed that on yesterday she did not tell the nurse that she was supposed to get thickened liquids with her medications because she thought that if the nurse gave it to her then her diet may have been changed.	F 309		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441	A. Licensed Nurse immediately cleaned glucometer with designated wipes prior to administration of next finger stick blood sugar. B. All Licensed Nurses were re-educated on the Blood Glucose Monitoring policy. Glucometers will be cleaned after each use with a dilute bleach solution of 1:10 or per manufacturer instruction following each resident use. Each Resident requiring finger sticks has been assigned an individual glucometer.	

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F 441	<p>Continued From page 3</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their 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 disinfect a glucometer (used for blood sugar monitoring) before proceeding to obtain a finger stick blood sugar for one (1) of three (3) sampled residents observed for medication administration. (Resident #28)</p> <p>The findings are:</p> <p>The facility policy titled "Blood Glucose Monitoring" dated 3/2012 reads in part: "Cleanse glucometer after each resident use with a dilute bleach solution or utilize approved disinfectant wipes per manufacturer instructions."</p> <p>On 05/30/12 at 4:25PM Licensed Nurse (LN) #2</p>	F 441	<p>C. DON/Designee to QI monitor that glucometers are cleaned per policy following each resident use. DON/Designee will randomly QI monitor cleaning of glucometers following each resident use, three times weekly for four weeks, one time weekly for four weeks and monthly thereafter for ten months.</p> <p>D. Results of QI monitoring will be reported to RM/QI Committee monthly for 12 months. The Committee will assure compliance and make revisions to the plan as necessary.</p> <p>E. Completion Date 6/24/2012.</p>		

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F 441	<p>Continued From page 4</p> <p>was observed during medication administration completing a finger stick blood sugar. LN #2 exited the resident's room and placed the glucometer on top of the medication cart without disinfecting the unit.</p> <p>On 05/30/12 at 4:28 PM LN #2 prepared to obtain a fingerstick blood sugar for Resident #28. LN #2 picked up the glucometer from the top of the medication cart and placed a test strip, lancet, and alcohol wipe in her hand. LN #2 turned away from the medication cart and began to enter Resident #28's room to obtain a finger stick blood sugar. LN #2 was stopped prior to utilizing the contaminated glucometer.</p> <p>LN #2 was interviewed at the time of this observation. LN #2 confirmed the glucometer intended for use on Resident #28 was not disinfected after use on the previous resident. LN #2 stated her usual practice was to disinfect the glucometer with disposable germicidal wipes stored on her medication cart after each resident use but she was nervous and had forgotten to clean the glucometer.</p> <p>On 05/31/12 at 12:15 PM an interview was conducted with the Director of Nursing (DON). The DON stated that nurses were expected to disinfect the glucometers with disposable germicidal wipes before and after each resident use. The DON stated she also conducts staff development inservices and reported that this procedure was included as part of the infection control training.</p>	F 441			