

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

PRINTED: 11/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/04/2013
NAME OF PROVIDER OR SUPPLIER  CHARLOTTE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1735 TODDVILLE RD CHARLOTTE, NC 28214	
(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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the medical record, the facility failed to notify a family member of an injury of unknown origin regarding</p>	F 157	<p>The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein.</p> <p>To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.</p> <p><b>How the corrective action will be accomplished for each resident found to have been affected by the deficient practice:</b> The resident referenced in the statement of deficiency was/is no longer a resident of the facility. <span style="float: right;">11/4/13</span></p> <p><b>How corrective action will be accomplished for those residents with the potential to be affected by the same practice.</b> Admissions and Medical Records completed a 100% chart audit of all residents in the facility to ensure that face-sheets had contact information on the sheets of someone other than the <span style="float: right;">11/8/13</span></p>	

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

TITLE

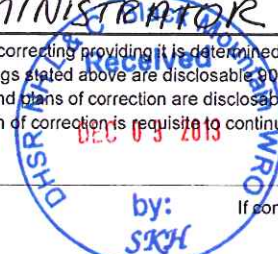
(X6) DATE

*Linda A. Meckling, LNHA*

ADMINISTRATOR

11-29-13

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 157	<p>Continued From page 1</p> <p>right lower extremity bruising and swelling requiring a hospital transfer for 1 of 3 sampled residents reviewed for supervision to prevent accidents. (Resident #1)</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 10/8/13 from the hospital. Diagnoses included cellulitis, acute renal failure, hypoglycemia, severe protein calorie malnutrition, advanced dementia, atrial fibrillation and pressure ulcer.</p> <p>Review of the facility's face sheet revealed Resident #1 was admitted to the facility as his own responsible party and a family member listed as the second contact.</p> <p>A nursing admission assessment dated 10/8/13 assessed Resident #1 as awake, confused, and oriented to name.</p> <p>A nurse progress note dated 10/8/13 revealed Resident #1 was alert but unable to voice needs. The nurse progress note also indicated that information needed for the admission process was received from a family member.</p> <p>A nurse progress note dated 10/12/13 revealed Resident #1 had family visiting.</p> <p>Further medical record review revealed a nurse progress note dated 10/15/13 which recorded that on 10/14/13 around 8:00 PM, Resident #1 was noted with a swollen right leg, severely swollen from the groin to the knee and a bruise which extended from his inner thigh and wrapped towards the back of his leg. His right leg was extremely cold with no pedal pulse palpable to</p>	F 157	<p>resident, if applicable. – audit completed on 11/08/13.</p> <p><b>Measures in place to ensure practice will not occur.</b> Admissions will ensure that all residents entering the building will have a completed face-sheet at the time of admission. A copy of the face-sheet on all new admissions to be given to the administrator too allow for corrections/completion. A log of all new admissions will be kept annotating completion or correction. Nurses in-serviced on checking face-sheet for completeness during admission process and the need to have emergency contact information present. Promptly added to the 24 hour chart check.</p> <p><b>How the facility plans to monitor and to make sure solutions are sustained.</b> The log will be kept for 100% of new admissions for a period of 3 months. Results of trending will be completed by the DON and reported to the QA &amp; A Committee at the quarterly meeting, for continued compliance of the plan or revision if needed.</p>	<p>11-6-13</p> <p>12-6-13</p>	

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F 157	<p>Continued From page 2</p> <p>either leg and +1 edema to his left leg. The on call physician was notified and Resident #1 was sent the emergency room (ER) at 8:45 PM per physician order for further evaluation. The nurse progress note also indicated that there was no family contact information listed on the facility's face sheet.</p> <p>Review of the facility's incident report revealed that on 10/14/13 at approximately 8:20 PM, Resident #1 was noted with an injury of unknown origin and was transferred to the ER for further evaluation. The physician and nurse supervisor were notified. The family visited the facility on 10/15/13 and was made aware at that time of the Resident's hospital transfer.</p> <p>Review of the hospital discharge summary dated 10/15/13 revealed Resident #1 sustained a right hip fracture.</p> <p>Interview with Resident #1's family on 11/4/13 at 10:51 AM revealed the family was not notified of the Resident's hospital transfer on 10/14/13 until the family came to visit Resident #1 in the facility on 10/15/13. The interview revealed that the family was told that the facility did not have family contact information. The family member stated contact information was provided to the hospital prior to the Resident's admission to the facility. The family member also stated that family visited the Resident most days twice a day and that facility staff had previously requested and obtained insurance information, but the facility staff did not request family contact information.</p> <p>An interview with nurse #1 occurred on 11/4/13 at 3:00 PM. Nurse #1 stated that on 10/14/13 during her medication administration, she was</p>	F 157			



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F 157	<p>Continued From page 3</p> <p>summoned to Resident #1's room. When nurse #1 assessed the Resident, she saw his right leg was extremely cold, bruised and swollen and she could not get a pedal pulse in either leg. Resident #1 denied pain and denied having fallen. The on call physician and supervisor were contacted and Resident #1 was transferred to the hospital for further evaluation. Nurse #1 stated there was no family contact information in the Resident's medical record or in the computer and she was unable to notify the family.</p> <p>An interview on 11/4/13 at 5:24 PM occurred with the admissions director (AD). The interview revealed that Resident #1 was admitted to the facility without family contact information due to a glitch in the hospital computer system. The AD further stated that a couple days after Resident #1 was admitted to the facility, staff obtained the Resident 's insurance information, but did not obtain family contact information. The AD stated that under usual circumstances the facility would obtain family contact information from the hospital, or speak with family to obtain contact information, but staff failed to do so for this Resident. The AD stated she remembered seeing family visit Resident #1 during his stay and realized that she should have obtained contact information when she saw the family visiting.</p> <p>An interview on 11/4/13 at 5:46 PM with the director of nursing (DON) revealed that when a resident is admitted to the facility from the hospital the family contact information typically comes from the hospital. If contact information is not available from the hospital, staff try to reach out to the family, but staff failed to obtain this information for Resident #1.</p>	F 157			