DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/28/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	345388		B. WIN			C 10/18/2011		
NAME OF PROVIDER OR SUPPLIER HUNTER WOODS NURSING AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 620 TOM HUNTER RD CHARLOTTE, NC 28256				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENCY		ON SHOULD BE COMPLET E APPROPRIATE DATE		
F 333 SS=D	SIGNIFICANT MED ERRORS		F	333	Preparation and/or execution of t	hic plan of		
	The facility must ensure that residents are free of any significant medication errors.				correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer Lorazepam concentrate (A medication used for anxiety.) as ordered by the physician for one (1) of four (4) sampled residents (Resident #1).				prepared and/or executed because it is required by provision of Federal and State regulations.			
	The findings are:							
	11/23/08 with diagno Stage Lewy Body D Minimum Data Set of	mitted to the facility on oses which included End ementia. The most recent lated 7/18/11 assessed were cognitive impairment and						
	included Lorazepan	an's order dated 6/29/11 a oral concentrate 2mg/1ml, y mouth of sublingual every 6 anxiety.						
	physician notificatio during the day shift.	note dated 9/3/11 revealed n of Resident #1's lethargy A physician's orders dated e Lorazepam to 0.25 mg eded for anxiety.			000 S VON	2011 2011		
1	Medication Adminis documentation of 0	ember 2011 and October 2011 tration Records revealed 25 mg Lorazepam 12/11, 10/8/11, and 10/11/11.				<i></i>		

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

Event ID:7/SW11

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

PRINTED: 10/28/2011 FORM APPROVED OMB NO. 0938-0391

SASSES S. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
HUNTER WOODS NURSING AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (PSCHIPFICIENCY WIST DE PRECIDED BY PLUL TAG) PRECINATION OF CORRECTION (PSCHIPFICIENCY WIST DE PRECIDED BY PLUL TAG) PROVIDERS PLAN OF CORRECTION (PSCHIPFICIENCY) PROVIDERS PLAN OF CORRECTION (PSCHIPFICIENCY) PROVIDERS PLAN OF CORRECTION (PSCHIPFICIENCY) PRECINATION (PSCHIPFICIENCY) PROVIDENCE (PSCHI			345388						
F 333 Continued From page 1 Review of the controlled record sheet for Lorazepam revealed directions to administer 0.125 mt in order to administers 0.725 m in the amount column from 9/3/11 to 10/18/11, 10/13/11 and 10/17/11), 0.725 and 10/13/11, 0.725 and 29,00 etc) with the final 10/17/11 amount listed as 27 mt. On 10/18/11 at 7:30AM, the documentation thread of 12 doses of 0.50 mg administered totaled 12 doses of 0.50 mg administered totaled 12 doses of 0.50 mg administered totaled 12 doses of 0.50 mg diministered instead of 12 doses of 0.50 mg administered instead of 9/7/11 of 30 mt with directions to administer 0.125 mt in order to administer 0.25 mg dose. Review of the Lorazepam concentrate administered of 13 mt. direction of the spilled 3 mt, the amount of Lorazepam concentrate administered of 13 doses of 0.50 mg administered instead of 12 doses of 0.50 mg. (The amount remaining would be 25.5 mt.) if 12 doses (1,5 mt.) of the 0.25 mg were administered instead of 12 doses of 0.50 mg. (The amount remaining would be 25.5 mt.) if 12 doses (1,5 mt.) of the 0.25 mg were administered instead of 12 doses of 0.50 mg. (The amount order to administer) of 0.50 mg. (The mount of 0.50 mg.) of the 0.25 mg were administered instead of 12 doses of 0.50 mg. (The mount of 0.50 mg.) of the 0.25 mg. (The mount of 0.50 mg.) of the 0.25 mg. (The mount of 0.50 mg.) of the 0.25 mg. (The mount of 0.50 mg.) of the 0.25 mg. (The mount of 0.50 mg.) of the 0.25 mg. (The mount of 0.50 mg.) of the 0.25 mg. (The mount of 0.50 mg.) of the 0.25 mg. (The mount of 0.50 mg.) of 0.50 mg. (The mount of 0.50 mg.) of 0.50 mg.) of 0.50 mg. (The mount of 0.5	NAME OF PROVIDER OR SUPPLIER HUNTER WOODS NURSING AND REHAB			,	STREET ADDRESS, CITY, STATE, ZIP CODE 620 TOM HUNTER RD CHARLOTTE, NC 28256				
Review of the controlled record sheet for Lorazepam revealed directions to administer 0.125 mf in order to administer a 0.25 mg dose. Review of the controlled record revealed documentation twelve times of '0.25' in the amount column from 9/3/11 to 10/18/11 (on 9/12/11, 9/17/11, 9/30/11, 10/2/11, 10/8/11, 10/17/11, 10/3/11 and 10/17/11, 10/25 amount subtracted twelve times from the initial volume of 30 ml with each dose (e.g. 29.75, 29.50, 29.25 and 29.00 elc.) with the final 10/17/11 amount listed as 27 ml. On 10/18/11 at 17:30AM, the documentation included 3 ml listed as spilled leaving a volume of 24 ml. After subtraction of the spilled 3 ml, the amount of Lorazepam concentrate administered lotaled 12 doses of 0.56 mg administered instead of 12 doses of 0.56 mg administered instead of 12 doses of 0.56 mg administered by the physician for current residents. Review of the Lorazepam concentrate pharmacy label revealed a dispense date of 9/7/11 of 30 ml with directions to administer 0.125 ml in order to administer a 0.25 mg dose. Observation on 10/18/11 at 1:30PM revealed 24 ml of Lorazepam available for administration. The medication dropper's separate lines designated .25 ml, .50 ml, .75 ml and 1.00 ml. Interview with LN#1 on 10/18/11 at 1:35PM revealed \$he documented the .25 as the dose and thought the .25 ml of the dropper meant mg.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	PREFIX (EACH CORRECTIVE ACTION SHI TAG CROSS-REFERENCED TO THE APP		OULD BE	COMPLETION	
LN #1 pointed to the line designated .25 ml to	F 333	Review of the control Lorazepam revealed 0.125 ml in order to a Review of the control documentation twelvamount column from 9/12/11, 9/17/11, 9/3 10/10/11, twice on 10/13/11 and 10/17/subtracted twelve tim 30 ml with each dose and 29.00 etc.) with disted as 27 ml. On documentation include aving a volume of 2 the spilled 3 ml, the aconcentrate administer one (The amount re 12 doses (1.5 ml) of administered.) Review of the Loraze label revealed a disp with directions to administer a 0.25 mg. Observation on 10/1 ml of Lorazepam av. The medication drop designated .25 ml, .3 Interview with I.N #1 revealed she document thought the .25	directions to administer administer a 0.25 mg dose. Illed record revealed etimes of "0.25" in the 9/3/11 to 10/18/11 (on 0/11, 10/2/11, 10/8/11, 10/11/11, twice on 10/12/11, 11). A 0.25 amount nes from the initial volume of et (e.g. 29.75, 29.50, 29.25 the final 10/17/11 amount 10/18/11 at 7:30AM, the ded 3 ml listed as spilled 24 ml. After subtraction of amount of Lorazepam tered totaled 12 doses of dinstead of 12 doses of 0.25 maining would be 25.5 ml if the 0.25 mg were epam concentrate pharmacy pense date of 9/7/11 of 30 ml minister 0.125 ml in order to g dose. 8/11 at 1:30PM revealed 24 allable for administration. oper's separate lines 50 ml, .75 ml and 1.00 ml. on 10/18/11 at 1:35PM mented the .25 as the dose ml on the dropper meant mg.	F	333	and new orders were give adverse effects were note resident. 2. Quality Assurance roundi conducted within the faci visualize no other areas o identified as related to the failing to administer Lora concentrate as ordered for residents. 3. Current licensed nursing educated on the facility p procedure for medication administration as to provi proper administration of I concentrate as ordered by physician for current resi DON/Designee will cond Improvement (QI) monite standard 5 x weekly for 4 then 3 x weekly for 4 weeks, an monthly for 9 months. 4. DON/Designee will report QI monitoring to the Rish Management /Quality Im Committee monthly x 12 continued compliance an revision.	n. No d to the ng was lity to f concern facility zepam current staff was olicy and de the Lorazepam the dents. uct Quality bring of this weeks, eks, then 1 d then 1 x rt results of provement months for d/or	11-15-11	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/28/2011 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES			OMB NO	0. 0938-0391	
AND PLAN OF CORRECTION IDENTIFICATI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 10/18/2011	
		345388					
NAME OF PROVIDER OR SUPPLIER HUNTER WOODS NURSING AND REHAB				62	REET ADDRESS, CITY, STATE, ZIP CODE 20 TOM HUNTER RD CHARLOTTE, NC 28256	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	OULD BE COMPLETION	
F 333	indicate the amount g Interview with LN #2 or revealed she administ as a mistake. She wa Lorazepam bottle con mi which would be the mi) had been administ Interview with Resider 10/18/11 at 3:00 PM r of 0.5 mg instead of 0 an adverse effect. Interview with the Direct 3:15 PM revealed st	on 10/18/11 at 2:55 PM tered 0.125 ml but wrote .25 as unable to explain why the stained 24 ml instead of 25.5 a volume if 0.25 mg (0.125 stered. Int #1's physician on revealed the administration 0.125 mg would not cause ector of Nursing on 10/18/11 she expected staff to	F	333			