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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING _____ B. WING _____	C 10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. 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). The findings are: Resident #1 was admitted to the facility on 11/23/08 with diagnoses which included End Stage Lewy Body Dementia. The most recent Minimum Data Set dated 7/18/11 assessed Resident #1 with severe cognitive impairment and wandering behavior. Review of a physician's order dated 6/29/11 included Lorazepam oral concentrate 2mg/1ml, give 0.5 ml (1 mg) by mouth of sublingual every 6 hours as needed for anxiety. Review of a nursing note dated 9/3/11 revealed physician notification of Resident #1's lethargy during the day shift. A physician's orders dated 9/3/11 decreases the Lorazepam to 0.25 mg every 8 hours as needed for anxiety. Review of the September 2011 and October 2011 Medication Administration Records revealed documentation of 0.25 mg Lorazepam administration on 9/12/11, 10/8/11, and 10/11/11.	F 333	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. NOV 3 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/1/11

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 333	Continued From page 1 Review of the controlled record sheet for Lorazepam revealed directions to administer 0.125 ml 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, 10/10/11, twice on 10/11/11, twice on 10/12/11, 10/13/11 and 10/17/11). A 0.25 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 etc.) with the final 10/17/11 amount listed as 27 ml. On 10/18/11 at 7:30AM, 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 totaled 12 doses of 0.50 mg administered instead of 12 doses of 0.25 mg. (The amount remaining would be 25.5 ml if 12 doses (1.5 ml) of the 0.25 mg were administered.) 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 she documented the .25 as the dose and thought the .25 ml on the dropper meant mg. LN #1 pointed to the line designated .25 ml to	F 333	1. MD was notified of medication error and new orders were given. No adverse effects were noted to the resident. 2. Quality Assurance rounding was conducted within the facility to visualize no other areas of concern identified as related to the facility failing to administer Lorazepam concentrate as ordered for current residents. 3. Current licensed nursing staff was educated on the facility policy and procedure for medication administration as to provide the proper administration of Lorazepam concentrate as ordered by the physician for current residents. 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. 4. DON/Designee will report results of QI monitoring to the Risk Management /Quality Improvement Committee monthly x 12 months for continued compliance and/or revision. 5. Completion date 11-15-11.	11-15-11

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F 333	Continued From page 2 indicate the amount given. Interview with LN #2 on 10/18/11 at 2:55 PM revealed she administered 0.125 ml but wrote .25 as a mistake. She was unable to explain why the Lorazepam bottle contained 24 ml instead of 25.5 ml which would be the volume if 0.25 mg (0.125 ml) had been administered. Interview with Resident #1's physician on 10/18/11 at 3:00 PM revealed the administration of 0.5 mg instead of 0.125 mg would not cause an adverse effect. Interview with the Director of Nursing on 10/18/11 at 3:15 PM revealed she expected staff to administer and record the physician ordered amount of Lorazepam.	F 333		