STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH CARE CENTER	1735 TODDVILLE RD CHARLOTTE, NC 28214

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and medical record review, the facility failed to provide pressure ulcer treatment as ordered for 1 of 3 sampled residents reviewed for pressure ulcers. (Resident #5) The findings included: Resident #5 was admitted 06/14/13. Diagnoses included peripheral vascular disease. Admission skin assessment dated 06/14/13 indicated surgical incision wound to the left leg. The skin assesssment also indicated pressure ulcer to left heel and necrotic pressure ulcer to the left toe fourth digit. Hospital discharge instructions dated 06/14/13 included the following wound care instructions: Apply Bacitracin ointment to left leg and wrap with ace bandage bid (twice daily). Apply Silvadene cream to left heel and toe bid. Review of ulcer and wound record dated 06/14/13 revealed necrotic pressure ulcer to the left toe fourth digit. Pressure ulcer measurements were 0.8cm x 0.8cm. The ulcer and wound record indicated current treatment "wet to dry".	F 314	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. 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. **F314** **How the corrective action will be accomplished for the resident(s) affected.** Resident #5, who was receiving wet to dry dressing changes, had facility physician directed treatment orders added to the EMAR system on 6-19-13 and 6-20-13 with adjustments per ongoing	7-12-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] MSHS, LNHA — TITLE: ADMINISTRATOR — (X6) DATE: 7/5/13

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.

DHSR NH/Black Mountain WRO Received JUL 0 8 2013 by: MMH

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F 314	Continued From page 1 The ulcer and wound record also revealed pressure ulcer to the left heel. No staging of the pressure ulcer was indicated. Pressure ulcer measurements were 1cm x 1cm. The ulcer and wound record indicated current treatment "wet to dry". Observation on 06/19/13 at 12:00 PM revealed Resident #5 lying in bed. The resident's left leg and left foot was observed with no dressing in place. Interview with Resident #5 was conducted at this time. Resident #5 was alert and oriented and responded appropriately. Resident #5 stated wound care treatment to her left leg surgical incision had been completed once since her admission to the facility. Resident #5 stated no dressing change to her left foot had been completed since her admission. Wound care was observed with Nurse #3 on 06/19/13 at 2:10 PM. Nurse #3 cleaned the left leg surgical incision with normal saline and left open to air. Nurse #3 cleaned the left foot and left heel with normal saline. Betadine was applied to all toes on the left foot and left open to air. Skin prep was applied to the left heel and left open to air. Review of June 2013 treatment record revealed wound care was completed as ordered. Review of treatment record indicated no treatment orders from 06/14/13-06/18/13. Following wound care observation an interview was conducted with Nurse #3. Nurse #3 stated she had Resident #5 on her assignment 6/17/13 and 6/19/13. Nurse #3 stated no wound care order was listed on the electronic treatment administration record (TAR) and stated she was not aware the resident required wound care. Nurse #3 stated she also had not received information about wound care from shift change report. Nurse #3 stated she notified the Nurse	F 314	physician orders. The resident has been discharged and is no longer at the facility. The nurse who failed to enter the treatment orders into the EMAR system was counseled. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** An audit of current residents, as of 6-27-13, treatment orders, charts, and wound records were reviewed to validate consistency and accuracy was accomplished on 6-28-13, with immediate corrections as indicated. **Measures in place to ensure practices will not reoccur.** Licensed nursing staff received education from the Director of Nursing (DON) on the processing of new admission orders including treatment orders. Education will be completed by 7-9-13. The Unit Managers will round on residents with wounds and treatments weekly and submit to the Administrator and DON a report of the wounds and treatments	7-12-13

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F 314	Continued From page 2 Practitioner (NP) for wound care orders 06/19/13 after the surveyor requested to observe wound care. An interview was conducted on 06/19/13 at 4:30 PM with Nurse #2. Nurse #2 stated she completed Resident #5's admission orders on 06/14/13. Nurse #2 stated she did not transcribe wound care orders from the hospital discharge instructions into the system because she thought the physician would review the treatment orders when making rounds to see what type of treatment was needed. Nurse #2 stated she completed the skin assessment on admission, applied a dry dressing to the left leg, and applied the wet to dry dressing to the left heel and left toe. Nurse #2 stated she documented this information on the ulcer and wound record. An interview was conducted with Nurse #4 on 06/19/13 at 4:57 PM. Nurse #4 stated he had Resident #5 on his assignment 06/16/13. Nurse #4 stated he was not aware of any wound care treatment because there was no treatment order on the TAR. Nurse #4 stated he observed a dressing to the left leg that appeared out of date. Nurse #4 stated he cleaned the left leg surgical incision and applied a dry dressing. Nurse #4 stated he applied skin prep to the left heel and left the foot open to air. Nurse #4 stated he did not document wound care on the TAR or in his nurses notes. An interview was conducted on 06/19/13 at 5:15 PM with the Unit Manager (UM). The UM stated she used a checklist to verify new admission orders to ensure all orders were entered accurately. The UM provided no explanation why wound care treatment orders were not entered on the TAR and was unable to provide documentation that orders were verified.	F 314	confirming that the treatment orders and wound sheets match with the physician/NP's directed course. **How the facility plans to monitor and ensure correction is achieved and sustained.** Any deviation will be addressed, at the time of the occurrence. Results of monitoring will be reported to the QA & A Sub-Committee for wounds weekly x 12 weeks and reviewed monthly by the QA & A committee for continued compliance/revision to the plan.	7-12-13

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F 314	Continued From page 3 An interview was conducted on 6/19/13 at 5:40 PM with the Director of Nursing (DON). The DON stated she expected the UM to verify new admission orders to ensure wound care treatment was completed as ordered.	F 314	**F333** **How the corrective action will be accomplished for the resident(s) affected.** The physician was called on 5-28-13 upon recognition of the omission and resident #2 was given medication immediately as presented during survey. The resident also continued to have other insulin coverage during the omission period, as presented during survey. The resident is no longer at the facility. The nurse who failed to enter the insulin order into the EMAR system was counseled.	7-12-13
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 medical record review and staff interviews, the facility failed to administer insulin as ordered for 1 of 3 sampled residents with medications reviewed. (Resident #2) The findings included: Resident #2 was admitted 05/23/13. Diagnoses included diabetes. Admission orders dated 05/23/13 included order for Levemir 18 units sq (subcutaneous) hs (bedtime). Novolog sliding scale insulin coverage was ordered with accuchecks before meals and at bedtime. Record review revealed accuchecks were monitored as ordered. Accucheck results from 05/24/13-05/28/13 revealed blood sugars ranged from 152-472. Novolog sliding scale coverage was given as ordered for elevated blood sugars. Review of May 2013 electronic medication administration record (MAR) did not list 05/23/13 admission order for Levemir. Further review of May 2013 MAR revealed physician orders for Levemir 18 units sq qhs with start date 05/28/13. An interview was conducted on 6/20/13 at 5:00 PM with Nurse #3. Nurse #3 stated she	F 333	**How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** An audit of current residents with insulin orders, as of 7-5-13, who were admitted from 5-23-13 to 6-23-13, were reviewed to validate consistency and accuracy in order transcription was accomplished on 7-5-13 with immediate corrections as indicated. **Measures in place to ensure practices will not reoccur.** Licensed nursing staff received education from the DON on	

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F 333	Continued From page 4 monitored Resident #2's blood sugars and notified the Nurse Practitioner (NP) of the elevated results. Nurse #3 stated new orders dated 05/28/13 were obtained for Levemir 18 units sq qhs and stated the medication was given as ordered. An interview was conducted on 06/20/13 at 2:40 PM with the Unit Manager (UM). The UM stated she verified Resident #2's admission orders and used a checklist to ensure all orders were entered accurately. The UM provided no explanation why the medication order for Levemir was not transcribed to the electronic MAR and was unable to provide documentation that orders were verified. An interview was conducted on 06/20/13 at 2:50 PM with the Director of Nursing (DON). The DON stated she expected the UM to verify new admission orders to ensure medications were given as ordered.	F 333	the processing of new admission orders completed by 7-9-13. Licensed nursing staff will verify the suggested transferring facility orders with the MD/NP and then transcribe those orders to the EMAR system for the resident, noting any changes or discontinuations of hospital orders. A second nurse will review and verify an accurate transcription to the EMAR system. Nursing leadership will review the admission within 48-hours of the patient entering the facility, using an auditing tool, to verify the admission process and order transcription. **How the facility plans to monitor and ensure correction is achieved and sustained.** The DON will report audit results to the Administrator for review weekly, for tracking and trending of concerns, for a period of 12 weeks and then monthly x3. Any deviations will be addressed. The QA & A committee will review monthly x 6 months and determine if further education or systemic changes are needed or recommend the continuation of audits as deemed necessary for further compliance.	7/12/13