

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

PRINTED: 04/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/30/2012
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NAME OF PROVIDER OR SUPPLIER WILLOWBROOKE COURT SC CTR AT P	STREET ADDRESS, CITY, STATE, ZIP CODE 701 PLANTATION ESTATES DR MATTHEWS, NC 28105
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(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
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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff interviews the facility failed to accurately transcribe and document the physician order to Medication Administration Records for one (1) of one (1) resident observed receiving intravenous (IV) antibiotic therapy. The accurate duration of IV antibiotic Ampicillin was not documented. (Resident #50)</p> <p>The findings include:</p> <p>Resident #50 was admitted to the facility on 3/23/2012. The admitting diagnoses included Urinary Tract Infections (UTI), Bacteremia and Sepsis related to polymicrobial infections and Diabetes Mellitus. A review of physician orders included to administer Ampicillin 2 Grams in 100 ml (milliliter) Normal Saline intravenously through Peripherally Inserted Central Catheter (PICC) line every 6 hours for 13 days:</p> <p>'Ampicillin 2 gm (gram) IV (intravenously) q (every) 6 (hours x (times) 13 days' .</p> <p>Resident #50 was observed for medication administration on 3/28/12 at 11:36 AM. Licensed Nurse (LN) #1 was observed administering Ampicillin appropriately. A further review of the Medication Administration Record for the month of March 2012 revealed the Ampicillin 2 Grams</p>	F 281	<p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as matter of compliance with federal and state law."</p> <p>Resident #50 medication order for Ampicillin 2 Grams was clarified by the physician and the clarification order was written.</p> <p>Current residents medication administration records were reviewed to ensure orders were transcribed correctly.</p>	
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APR 20 2012
BY: DRW

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4-19-12
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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 281	<p>Continued From page 1</p> <p>order was scheduled at 12:00 noon and was transcribed as 14 days instead of 13 days as ordered by the physician.</p> <p>An interview with LN #1 on 3/28/12 at 11:50 AM revealed that MAR transcription was done by a week end nurse supervisor who was not available for the interview. LN #1 also stated that two nurses always checked for the accuracy in transcriptions. The interview revealed that the medication order and MAR transcription for Resident #50 was done by two different nurses which might have caused the error in transcription. LN #1 had not noticed the error in the entries and stated would get a clarification order.</p> <p>An interview with the Director of Nursing (DON) on 3/28/12 at 4:30 PM confirmed that all physician orders were checked and signed off by two licensed nurses and her expectation was the physician orders were accurate.</p>	F 281	<p>Full time, part time and PRN nursing staff were re-educated by Nursing Supervisor/DON that two nurses are required to verify re-written orders that are transcribed on to the medication administration record to ensure correct transcription.</p> <p>DON/Designee will conduct QA monitoring of the above stated standard weekly x12 weeks, then monthly x 6 months of all residents. DON/Designee will report results of QA monitoring to QA committee quarterly for further compliance and/or revision.</p>	4-27-12
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