

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

PRINTED: 04/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345374	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING APR 29 2011	(X3) DATE SURVEY COMPLETED C 04/07/2011
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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / NASHVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1022 EASTERN AVENUE NASHVILLE, NC 27856
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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews, the facility failed to maintain privacy and confidentiality while discussing medical information for 1 of 4 residents (Resident # 1). Findings included: Resident #1 was admitted to the facility on</p>	F 164	<p>F 164</p> <p>Resident # 1 no longer resides in the facility.</p> <p>Residents residing in the facility may be affected by the deficient practice.</p> <p>The facility is providing privacy to the residents to include meetings and visitation.</p> <p>Confidential meetings between residents and staff are being held in a private area that is agreeable to the resident.</p> <p>The Administrator and department heads were in-serviced on the resident's right to privacy on 4-27-11 by the Area office on Aging Regional Ombudsman.</p> <p>The facility will monitor compliance through resident council meetings monthly and individual resident interviews conducted by the Social Service Director five times weekly for 4 weeks. The QA committee will review findings monthly for 3</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Judy A Carter</i>	TITLE NHA	(X6) DATE 4-27-11
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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 164	Continued From page 1 2/22/11 and readmitted on 3/12/11 with cumulative diagnoses that included Pain, Anxiety and Depression. The Minimum Data Set (MDS) completed on 3/12/11 indicated the resident was cognitively intact. The MDS further indicated the resident verbalized pain as severe and almost constantly. The resident daily activities were identified as limited due to pain interference. The MDS further indicated the resident experienced anxiety and depression. The hospital discharge instructions receipt dated 2/23/11 revealed the resident was diagnosed with opiate dependence at the hospital. Documentation revealed the nursing facility was notified of the diagnosis on 2/23/11 at 12:40 AM. Social worker (SW) documentation dated 3/22/11(un-timed) revealed the social worker and the administrator met with the resident (morning hours) to discuss weekend events. The SW documentation indicated, "Staff concerned with resident not having his Percocet with him upon return to facility; this medication is considered a scheduled narcotic. Administrator and SW informed resident of need to be responsible while on LOA (Leave of Absent-when away from the facility with family/friends)." Administrator documentation on 3/22/11 at 9:45 AM revealed upon entry into the resident's room the administrator inquired from the resident if it would be okay to talk with him about being responsible with his medications, when on leave of absent from the facility. The resident responded "Yeah, ok." The administrators note indicated, "I explained to him (the resident) we do not let anyone reside here that uses drugs that are illegal. "The administrator's statement further revealed she "Offered the resident psychological services for his illegal drug use" at the conclusion of the discussion.	F 164	F 164 Resident # 1 no longer resides in the facility. Residents residing in the facility may be affected by the deficient practice. The facility is providing privacy to the residents to include meetings and visitation. Confidential meetings between residents and staff are being held in a private area that is agreeable to the resident. The Administrator and department heads were in-serviced on the resident's right to privacy on 4-27-11 by the Area office on Aging Regional Ombudsman. The facility will monitor compliance through resident council meetings monthly and individual resident interviews conducted by the Social Service Director five times weekly for 4 weeks. The QA committee will review findings monthly for 3	

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F 164	Continued From page 2 Interview on 4/7/11 at 1:45 PM with the SW revealed Resident #1's roommate was present in the room when she and the administrator discussed with the resident the need to be responsible with his Percocet medication, when on leave of absent from the facility. The SW indicated the administrator discussed illegal drug use and explained to the resident illegal drugs were not good for his health. The SW indicated she could not recall if the privacy curtain in the resident's room was pulled. She indicated the door was shut. The SW elaborated the administrator did most of the talking. The SW stated she felt uncomfortable with the other resident (roommate) present in the room. She indicated she did not voice being uncomfortable to the administrator and continued throughout the discussion. She further indicated it was obvious the roommate was engaged in on the discussion due to he appeared to be listening to what was said. The SW concluded Resident #1 appeared to be uncomfortable due to a furrowed eyebrow throughout the discussion. Interview on 4/7/11 at 2:15 PM revealed the administrator indicated the resident gave her permission to talk about the concerns she had. She indicated the resident's roommate was present during the discussion. The administrator indicated she used a low voice tone when talking with the resident. She further indicated she told the resident he was "Irresponsible" that he did not keep up with his meds. Regarding the illegal drugs, she indicated she informed the resident the meds in his system were illegal and she would not allow that in her building. Additionally, the administrator indicated the curtain was completely pulled during the conversation. She also indicated "I probably could have delayed the conversation but rationalized the curtain was	F 164	months and will assess and amend the plan as indicated. Compliance date: 4-27-11	

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F 164	Continued From page 3 pulled and even though the other resident was present in the room, it was still appropriate to have the conversation." The administrator stated "The resident did not get out of the bed that day and I needed to address the concerns with him. I didn't want to wait because I wanted it to stop right there. I wanted to keep drugs out of the building." She concluded the resident had "Never brought drugs into the facility, had never used illegal drugs at the facility, and to date had not been confirmed with illegal drugs on his personal possession or observed having used illegal drug while in the facility." Interview on 4/7/11 at 2:50 PM with The Director of Nursing (DON) revealed it was decided by administration that two staff members (one being the social worker) would talk to the resident together regarding concerns when he went home over the weekend. She concluded her practice when discussing sensitive issues with residents, was not to discuss in a setting where the conversation could be overheard by another resident or visitor. She concluded if the resident felt he did not want to talk about certain issues during the discussion he could have indicated. Interview on 4/12/11 at 4:45 PM with Resident #1 revealed he did not give the administrator or social worker permission to discuss his medical information in the presence of his roommate. He stated the administrator mentioned sensitive information related to his urine drug test obtained at the hospital. Wherein, he tested positive for illegal drugs. He stated he did not foresee the administrator was going to talk about such personal information. He concluded she violated his privacy due to his roommate being present and heard his personal information. Interview on 4/12/11 at 5:20 PM with Nurse #3 revealed when she approached the resident's	F 164		

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F 164	Continued From page 4 room the door was not shut all the way. She proceeded to enter the room because she needed to give the roommate his scheduled medication. Upon entry into the room, she indicated the administrator/social worker were present. She further indicated the administrator proceeded to talk about Residents #1's urine drug test that tested positive for illegal drugs. Additionally, she indicated she could see the administrator, the social worker and the resident from where she was standing (roommate side of the room) as the privacy curtain that separated the space (between the two residents) was not pulled for privacy. She concluded she tried to interrupt the conversation due to being uncomfortable with the details that were discussed with the roommate present. However, the administrator indicated, "Not right now" and proceeded with her discussion related to the resident's urine drug test being positive for illegal drugs.	F 164	F 241 Resident # 1 no longer resides in the facility. Residents residing in the facility have the potential to be affected by the deficient practice. The facility is promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Resident information is communicated in a way that protects the confidentiality of the information and the dignity of the residents.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews, the facility failed to address a resident in a manner that maintained his dignity and respect for 1 of 4 residents (Resident # 1). Findings included: Resident #1 was admitted to the facility on 2/22/11 and readmitted on 3/12/11 with	F 241	Confidential meetings between residents and staff are being held in a private area that is agreeable to the resident. The Administrator and department heads were in-serviced on promoting each resident's dignity on 4-27-11 by the area office on Aging Regional Ombudsman. The facility will monitor	

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F 241	Continued From page 5 cumulative diagnoses that included Pain, Anxiety and Depression. The Minimum Data Set (MDS) completed on 3/12/11 indicated the resident was cognitively intact. The MDS also indicated the resident verbalized pain as severe and almost constant. The resident daily activities were identified as limited due to pain interference. The MDS further indicated the resident experienced anxiety and depression. Nurse's notes on 3/22/11 at 12:00 PM revealed the resident complained to Nurse #3 he was anxious and upset. He indicated he would talk to her about it later. Nurse's notes on 3/22/11 at 1:15 PM revealed the resident indicated to Nurse #3 he was upset because someone (did not indicate who) called him a drug addict. Thereafter, at 1:20 PM the resident was sent to the emergency room due to hurting around his pacemaker. The emergency room record on 3/22/11 at 3:15 PM revealed the resident presented to the emergency department with a chief complaint of pain around his pacemaker. He indicated the pain started at noon. The resident stated, "The pain began after the nursing home director yelled at him in front of everybody about his drug use." The resident was discharged from the emergency room to the nursing facility with chest pain-unknown etiology (cause). Interview on 4/7/11 at 11:05 AM with Nurse #4 revealed the resident indicated to her he felt depressed because Nurse #3 was asked to leave the room by the administrator, during the discussion he had with the administrator and the social worker. Nurse #4 further elaborated the resident indicated to her that Nurse #3 should have been allowed to be present throughout the conversation, but she was asked to leave the room. Nurse # 4 concluded she reassured the	F 241	compliance through resident council meetings monthly, the facility "Ambassador Program" which includes individual resident interviews (conducted by the department Heads) five times weekly for 4 weeks. The QA committee will review findings monthly for 3 months and will assess and amend the plan as indicated. Compliance date: 4-27-11	

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F 241	Continued From page 6 resident of his safety and he was less anxious thereafter. Interview on 4/7/11 at 1:45 PM with the Social Worker (SW) revealed the administrator discussed with the resident concerns related to illegal drug use and being responsible with his Percocet medications when at home, in the presence of his roommate. The SW indicated she felt uncomfortable with the details of the conversation (due to roommate present) but continued throughout the discussion. She concluded Resident #1 appeared to be uncomfortable due to a furrowed eyebrow throughout the discussion. Interview on 4/7/11 at 2:15 PM with the Administrator revealed she told the resident in the presence of his roommate he was "Irresponsible" because he did not keep up with his meds. Regarding the illegal drugs, she indicated she informed the resident the meds in his system were illegal and she would not allow that in her building. She stated she did not wait to address the concerns with the resident more discretely because she didn't want to wait and she wanted it to stop right there. She indicated, "I wanted to keep drugs out of the building and wanted to make sure his friends didn't bring drugs in the building." She concluded the resident had "Never brought drugs into the facility, had never used illegal drugs in the facility, and to date had not been confirmed with illegal drugs on his personal possession, or observed having used illegal drug while in the facility." Interview on 4/7/11 at 2:50 PM with the Director of Nursing revealed her practice when discussing sensitive issues with residents, was to discuss in a setting where the conversation could not be overheard by another resident or visitor. Interview on 4/12/11 at 4:45 PM with Resident #1	F 241			

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F 241	<p>Continued From page 7</p> <p>revealed he felt embarrassed and depressed because his private information had been discussed in the presence of his roommate. He stated the administrator mentioned sensitive information related to his urine test results obtained at the hospital. Wherein, he tested positive for illegal drugs. He stated he did not foresee the administrator was going to talk about such personal information. He concluded he did not think to stop her at the time because he was overtaken by surprise.</p> <p>Interview on 4/12/11 at 5:20 PM with Nurse #3 revealed she tried to interrupt the conversation due to being uncomfortable with the resident personal information discussed in the presence of his roommate. She concluded the administrator indicated, "Not right now" and proceeded with her discussion related to the resident's urine drug test being positive for illegal drugs.</p>	F 241		