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

MAY 21 2013

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345374	A. BUILDING _____ B. WING _____	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27856

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain and operate 2 of 3 clothes dryers in a safe manner free of lint; the facility failed to maintain 2 (Resident #33 and #54) of 2 Geri chairs free of tears and 1(Resident #27) of 1 wheelchair free of cracks and fraying edges, and the facility failed to maintain 1 of 1 feeding pumps in clean condition for Resident # 40 Findings included: An observation of the drum for Dryer #2 on 4/25/13 at 5:45 PM revealed areas throughout the drum had a build up hardened brown matter. The tumble bars in the drum had a buildup of hardened brown matter at the bases. An observation of Dryer #3 revealed the dryer was being run with laundry to be dried. The upper half of the dryer drum revealed areas of dried brown matter. A quarter and a penny were stuck in dried brown matter against the drum. An interview was conducted with the Laundry Director at 5:50 PM on 4/25/13 regarding the clothes dryers drums. The Director reported she had worked on trying to scrap some of the matter out of Dryer #3, but wasn't able to remove much of it because it had been there for so long. The Director stated she requested Maintenance to clean them "a while back" but did not know if or what the Maintenance department did. She	F 253	Preparation and/or execution of this plan of correction does not constitute admission or agreement by Universal Healthcare - Nashville of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of state and federal law. F253 • 1. During the annual state survey on 4/25/13 the surveyor observed buildup in the drum of 2 of the 3 dryers in the laundry room. The surveyor also noted that after interviews with staff and observations the surveyor felt the facility failed to maintain some of the dryers in a safe manner free from lint. Immediate action was taken to clean the dryer drums and lint traps. All debris noted by the surveyor has been removed from the drum. • Laundry staff have been trained that they are to wipe down the dryer drum daily to prevent build up of possible debris. If staff notices that the dryer drum is collecting build up that can't be wiped out or if something is melted to the drum, they will put in a maintenance request to have the debris removed.	4/25/13 5/21/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daniel [signature]	Administrator	5/18/13

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.

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F 253	Continued From page 1 further reported she has not asked anyone to clean the drums for her recently. The Laundry Aide stated she didn't clean the inside of the drums and had not requested maintenance to clean them. The Director reported the drums were dirty and needed cleaned and the lint filters had a lot of lint of them and expected they were cleaned every 2 hours. The Administrator observed the dryer filters on 4/25/13 at 5:50 and reported the drums were expected to be clean. 2) An observation of Resident #33 on 4/22/13 at 4:58 PM revealed the resident was seated in a Geri-chair and the head rest was split at the seam 3/4 across the chair and gaped open 4 inches and exposed the padding. The foot rest was tattered across the bottom edges on 3 sides. The arm rest on the right side, toward the back, was torn 2 inches exposing the padding, the right outer edge was tattered. A flap from the chair between the seat and the foot rest was torn and hanging, and a bar support of the footrest was hanging down on the left side. An observation was made of Resident #33 Geri-chair with the Director of Nursing (DON) on 4/24/13 at 3:20 PM. The resident's Geri-chair was torn at the seam at the top at the headrest, the arm rests were torn, the bar underneath the footrest remained disconnected on one side, and the banding of the footboard of the bed remained loose and edges of particle board exposed. An interview was conducted with the DON at that time and the DON stated the resident shouldn't be using the Geri chair with the tears and the footboard should have been reported. The DON stated staff completed rounds daily and those are some of the things they should have been reporting	F 253	• To ensure the deficient practice will not recur; the Housekeeping Supervisor will observe the laundry drums and lint traps on a weekly basis for three months. If there are no discrepancies the Supervisor will observe the laundry drums and lint traps at least monthly. The Supervisor will address any inconsistencies to the procedure as they arise. • Any discrepancies found during the daily checks by the laundry staff or by the Housekeeping Supervisor will be brought to the Quality Assurance Committee meeting for the first three months and quarterly thereafter until there have been three consecutive quarters without problems to report. • 2. – 4. The surveyor noted that Resident #33 and #54 were in Geri-chairs that had tears or cracks in them, and Resident #27 was in a wheelchair with cracks and fraying edges. Resident #33, #54, and #27 have been moved into chairs that don't have tears, cracks or fraying edges. It was also noted that the banding of the footboard in Resident #33's room was loose. The footboard has been fixed.	5/21/13 6/27/13 (Next QA Meeting) & Ongoing 4/26/13

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F 253	Continued From page 2 3) An observation of Resident #54 seated in a Geri chair on 4/22/13 at 2:03 PM revealed the right arm rest was torn on outer edge in a 1 inch oblong circle exposing the inner padding. A 1.5 inch tear and another one inch tear were observed on the back of the left arm rest exposing the inner padding. An observation was made with the Administrator for the Geri chair for Resident #54 on 4/25/13 at 4:48 PM. The Administrator observed the tears in the arm rests of the resident's Geri chair and stated she didn't expect the resident to use the chair with torn rests. 4) An observation of Resident #27 seated in a wheelchair on 4/23/13 at 9:48 AM revealed the resident's wheelchair armrests had multiple cracks across on the tops and were frayed on the inner seam of each rest exposing the inner padding. During an observation of wheel chair used by Resident #27, the Administrator stated the tattered arm rests were not expected to be on the resident's chair. The Administrator stated when wheelchair and Geri-chairs were cleaned weekly and she expected housekeeping to report torn or worn equipment for repair	F 253	• Maintenance will complete an audit of all residents' footboards, headboards, wheelchairs and Geri-chairs. Any broken or torn/tattered items will be fixed. • To ensure this deficient practice does not recur maintenance staff or designee will complete an audit weekly of all the resident rooms to check for damaged footboards, headboards, wheelchairs, and Geri-chairs. If there are any damaged items noted, a maintenance request will be submitted and the item will be fixed or replaced. • Any damage or discrepancy found during the weekly audits by maintenance staff or designee will be brought to the Quality Assurance Committee meeting for the first three months and quarterly thereafter until there have been three consecutive quarters without problems to report.	5/20/13 5/23/13 6/27/13 (Next QA Meeting) & Ongoing
	5) During the initial tour of the facility on 4/22/13 at 1:45 PM a feeding pump at the bedside of resident #40 was observed to have multiple areas of dried brown matter on the front, back, sides,		• 5. On 4/22/13 the surveyor observed a feeding pump at the bedside of resident #40 to have multiple areas of brown matter on the pump, pole and legs of the equipment. The pump, pole, legs and cord were all thoroughly cleaned.	4/25/13

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F 253	Continued From page 3 and underside of the pump surface. Dried brown matter was observed on three of the four legs of the rolling pole the feeding pump was attached to. One support pole leg had a quarter sized area of the dried brown matter. The surface of the pole had dried brown matter in a drip pattern scattered up and down the pole. The black electrical cord was observed to have the same dried brown substance along its surface in areas up to 1 inch in length. A second observation of the pole and feeding pump on 4/23/13 at 12:00 PM revealed the pump, rolling pole, and electrical cord had dried brown matter on the surfaces as observed on 4/22/13 at 1:45 PM. Housekeeping was observed mopping the floor at the bedside of Resident # 40 on 4/24/13 at 11:00 AM. The feeding pump was observed at 11:20 AM and the dried matter was still on the pump, pole, and electrical cord. An interview was conducted with the Nursing Assistant (NA) assigned to Resident #40 on 4/24/13 at 11:00 AM The NA stated she did not clean the feeding pumps and poles. She revealed she was not aware of who cleaned them but Nursing Assistants did not. An interview was conducted with the first shift Nurse assigned to Resident # 40. The Nurse stated housekeeping cleaned medical equipment like pumps and poles. During an interview on 4/24/13 at 15:45 PM the second shift Nurse assigned to Resident # 40 stated night shift nurses were responsible for	F 253	• Housekeeping staff ensured that all feeding pump poles were clean and nursing ensured that all feeding pumps were clean. • To ensure this deficient practice does not recur; housekeeping and nursing staff will be trained on the procedure for cleaning the feeding tube pumps and poles. The Housekeeping Supervisor or designee will monitor the cleaning of the poles weekly by doing a Quality Control Inspection. • Any discrepancy or inconsistency in cleaning found during the weekly inspections by the Housekeeping Supervisor or designee will be brought to the Quality Assurance Committee meeting for the first three months and quarterly thereafter until there have been three consecutive quarters without problems to report.	4/26/13 5/21/13 6/27/13 (Next QA Meeting) & Ongoing

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F 253	Continued From page 4 feeding pumps. The Nurse revealed night shift changed out the bag, tubing, and syringes for feeding pumps and then wiped down the equipment. The Nurse stated staff had to document on the Medication Administration Record (MAR) when they changed out the bag and tubing but not when they cleaned the equipment. The Nurse stated it was just common sense that if the pole or pump had anything on it you would wipe it off. An observation of the feeding pump for Resident #40 on 4/24/13 at 4:00 PM revealed the pump, pole, and pole legs had been cleaned. A few faint scattered brown specks remained on the pump. The electrical cord was observed to be in the same condition as before. An interview was conducted with a Housekeeper on 4/25/13 at 9:20 AM. She stated it was housekeeping's responsibility to clean the feeding pumps on a daily basis. The Housekeeper revealed she wiped down pumps as a part of her daily cleaning routine and sanitized the pumps after wiping them down. The Housekeeper stated she did not work on Resident #40's hall. The Housekeeper who worked on the hall was not available to interview On 4/25/13 at 3:05 PM an interview was conducted with the Housekeeping Supervisor and the facility Administrator. The Supervisor and Administrator observed the electrical cord of the feeding pump for Resident #40. The Supervisor revealed housekeeping was responsible for cleaning pumps and poles. The Supervisor stated they should be cleaned daily as part of the regular cleaning routine. The Supervisor and	F 253		

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F 253	Continued From page 5 Administrator stated it was their expectation that all feeding pumps, poles, and electrical cords would be cleaned on a regular basis and maintained in a sanitary manner.	F 253		
F 431 SS=B	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F431 • During the annual state survey on 4/25/13 a state surveyor observed four unopened bottles of expired Calcium Acetate in a medical storage room. There was also a vial of unopened Ativan found in the narcotic lock box in the refrigerator for a resident who did not have a current order for the prescription. Both medications were sent back to the pharmacy the same day they were found. • An audit of all of the medication carts and storage room will be conducted by the pharmacy consultant to ensure there are no more expired medication or medication with an out of date orders. • To ensure this deficient practice does not recur; all nursing staff were educated by the pharmacy consultant on May 14, 2013 on the procedure for returning medication to the pharmacy. The Assistant Director of Nursing or designee will bring all telephone orders to the morning huddle and if orders are discontinued or if a resident is discharged the Assistant Director of Nursing or designee will check to ensure all medications were returned to the pharmacy. If something was missed, it would be returned at that time. Also, the pharmacy consultant comes monthly to check medication carts and storage to ensure there are no expired medications.	4/25/13 5/14/13 5/14/13

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F 431	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to discard medication for an expired resident and to return to pharmacy a medication for which there was no order for, 1 of 1 medication storage room reviewed for medication storage. Findings included: On 4/25/13 at 2:40 PM in an observation of the medical storage room four unopened bottles of Calcium Acetate were found. Each bottle was labeled for a resident who had expired on 2/18/13. In an interview on 4/25/13 at 2:42 PM during the medical storage observation, Nurse #2 stated that the resident for whom the Calcium Acetate was prescribed had been discharge to the hospital had sequentially died. On 4/25/13 at 2:50 PM during the medical storage observation, an unopened vial of Ativan was found in the controlled narcotic lock box in the refrigerator. The resident for whom the vial of Ativan was prescribed for did not have a current order for the medication. In an interview on 4/25/13 at 7:15 PM the Director of Nursing (DON) stated that she expected the night nurses to do a weekly check in the medication room for expired medications including controlled narcotics in the lock box. The	F 431	• Any discrepancy found by the Assistant Director of Nursing (designee) or the pharmacy consultant will be reviewed at the Quality Assurance Meeting for the first three months and quarterly thereafter until there have been three consecutive quarters without problems to report.	6/27/13 (Next QA Meeting) & Ongoing

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F 431	Continued From page 7 DON also reported that an in-service was given on 4/25/13 in regards to checking narcotics for expirations and reconciliations of orders.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	F441 • During the annual state survey on 4/24/13 the surveyor observed a nurse completing a wound dressing. Based on the surveyors observation the facility failed to prevent cross contamination during wound care by not establishing a clean area for dressings, ointment and wound cleaner, and failed to ensure soiled gloves and 4x4 pads were disposed of in a manner to prevent the spread of infection. During the surveyor's observation the soiled gloves and 4x4 pads were placed on the resident's mattress. On 4/25/13 when the Director of Nursing (DON) was made aware of the dressing change, the DON immediately re-educated the nurse completing the wound care dressing on proper procedure. • The nurse who completed the wound care will be checked off, step by step, by the Director of Nursing to ensure the nurse is giving proper wound care. • To ensure this deficient practice doesn't happen again, on May 14, 2013 there was training conducted for all nurses on wound care dressings. The training went through step by step what to do for a clean dressing change. Also, the Director of Nursing or designee will spot check a dressing change per month and continue to monitor the infection rate in the building.	4/25/13 5/23/13 5/14/13

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F 441	Continued From page 8 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to prevent cross contamination during wound care by not establishing a clean area for dressings, ointment and wound cleaner for 1 (Resident #41) of 1 residents observed for wound care; and, failed to ensure soiled gloves and 4 x 4 pads were disposed in a manner to prevent the spread of infection for 1 of 1 observation of soiled gloves and 4 x 4 pads being placed on the resident ' s mattress. Findings include: An observation of wound dressings, on 04/24/13 at 10:10 AM, was made of Resident #41's pressure ulcers on the left and right ischium. When the resident ' s bed covers were removed the resident was laying on top a specialty mattress with a covering that required no use of sheets, the dressings had been removed during bathing and the wounds were visible. Nurse #4 had taken the dressings into the resident's room prior to the treatment. Observed was a number of 4 x 4 pads stacked together on top of the inside of a 4 x 4 wrapper along with a spray bottle of wound cleaner and scissors setting on top of the resident's over bed table. Also, noted on top of the bed mattress were a wrapped ABD pad, a tube of medicated ointment and two wrapped tegaderm dressings. Nurse #4 washed her hands, donned gloves, then sprayed a 4 x 4 with the wound cleaner, wiped the left ischium wound	F 441	• Infection reports and any discrepancies from the Director of Nursing's wound care observation will be reviewed monthly at the Quality Assurance Meeting for the first three months and quarterly thereafter until there have been three consecutive quarters without problems to report.	6/27/13 (Next QA Meeting) & Ongoing

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F 441	Continued From page 9 in a circular outward motion, folded the 4 x 4 and continued to wipe the outer edge of the wound. Nurse #4 was observed to lay the darkly discolored soiled 4 x 4 on the resident's mattress. She then picked up a clean 4 x 4, with her gloved hands that were used to clean the wound, sprayed the wound cleaner onto the 4 x 4, placed the handled bottle back on top the resident's over bed table. She proceeded again to wipe the wound in a circular motion, fold the 4 x 4, wiped the outer edge of the wound and then laid the darkly discolored soiled 4 x 4 on the resident's mattress. Nurse #4 was then observed to pick up the tube of ointment from the resident's mattress, placed a small amount of the medicated ointment on her gloved index finger and applied the ointment over the left ischium wound. She removed the gloves, placed the soiled gloves on the resident's mattress and donned new gloves. Nurse #4 was observed to take a 4 x 4, spray it with the wound cleaner, and wipe the right ischium wound in a circular motion from center outward, she then folded the 4 x 4 and continued the circular motion to the edges of the wound. She discarded the darkly discolored soiled 4 x 4 on the resident's mattress. The nurse was observed to obtain a clean 4 x 4, with her gloves on that were used to clean the wound, sprayed the wound cleaner on the 4 x 4, and placed the bottle back on the resident's over bed table. She rolled the 4 x 4, gently inserted the rolled 4 x 4 into the resident's wound, moved it in a circular motion, removed from the wound and laid the darkly discolored 4 x 4 on the resident's mattress. Nurse #4 was observed to open the calcium alginate, took the scissors from the over bed table and cut an L-shaped piece and with the use of cotton tipped applicator, gently placed the	F 441		

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F 441	Continued From page 10 calcium alginate in to the resident's wound. She opened the ABD pad, using the scissors cut the pad in two pieces, placed one toward one edge of the wound, and placed the second piece overlapping the first to cover the opposite edge of the wound. She then placed transparent dressings over the pads on the wound to secure the dressing. The nurse was observed to remove her gloves, placed them in the soiled dressings on the resident mattress, picked them up and placed them in the trash. She then washed her hands and removed the soiled items. The nurse was then observed to remove the ointment, wound cleaner spray bottle and scissors and placed them back into the treatment cart. An interview, on 04/24/13 at 10:35 AM, was conducted with Nurse #4. When asked if she disinfected the items removed from the room prior to placing them back into the treatment cart, she indicated she had only cleaned the scissors. During the interview a reference was made regarding establishing a clean area to place her dressings, ointment and wound cleaner, she indicated sometimes she did place a plastic bag on the table for her dressings, always wiped the over bed table when she completed the treatment but confirmed she did not do that prior to the treatment. Nurse #4 stated that she usually does bring in a trash bag for the soiled dressings used to clean the wound but failed to do so this date because she was somewhat nervous. On 04/25/13 at 12:45 PM, the Administrator and Director of Nursing (DON) approached and the Administrator indicated Nurse #4 was nervous during the observation and there had been no issues to indicate any problems with wound	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	345374		04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27856

(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)	(X6) COMPLETION DATE
F 441	Continued From page 11 infections. The DON stated the Nurse #4 was aware of the need to use good technique when providing wound care. A phone interview, on 04/29/13 at 10:00 AM was conducted with the DON, who indicated her expectation was that the wound nurse would have maintained a clean working field, disposed of soiled items in a trash bag as she usually did and cleaned all the items prior to returning them to the cart.	F 441	F465 • During the annual state survey on 4/25/13 based on surveyor observation, the facility failed to maintain the nourishment refrigerator in clean condition. The refrigerator was cleaned on 4/25/13 after surveyor observation. • There has been a new cleaning schedule for the nourishment room refrigerator created.	4/25/13 5/16/13
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain 1 of 1 nourishment refrigerators in clean condition. Findings included: An observation of the nourishment refrigerator on 4/25/13 at 4:10 PM revealed dried tan matter on the top rack, the rack supports on both sides of the refrigerator had a black lint-type debris, and yellow debris splashed on the inner walls. The bottom left of the inside of the door had dried yellow debris on door. The base of the refrigerator had a circle of blackened build up on the right side under the clear fruit/vegetable drawer. The clear bottom drawer on the right	F 465	• To ensure this deficient practice doesn't recur; housekeeping and dietary staff have been educated on the new cleaning schedule. Dietary staff will wipe down the nourishment refrigerator daily and Housekeeping staff will complete a deep clean on the nourishment refrigerator once a week. The nourishment room refrigerator will be check weekly by the Housekeeping Supervisor or designee to ensure proper cleaning. Any inconsistencies will be fixed immediately. • Any discrepancies found during the weekly checks by the Housekeeping Supervisor will be brought to the Quality Assurance Committee meeting for the first three months and quarterly thereafter until there have been three consecutive quarters without problems to report.	5/14/13 6/27/13 (Next QA Meeting) & Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	345374		04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27856

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F 465	Continued From page 12 side of the refrigerator was stuck and could not be pulled out. An observation of the nourishment refrigerator with the Dietary Manager was made on 4/25/13 at 4:45 PM. No changes had been made in the condition of the refrigerator. An interview was conducted with the Dietary Manager (DM) at 4:48 PM. The DM reported dietary and housekeeping took turns cleaning the refrigerator, but there was no cleaning schedule for the refrigerator. The DM stated the refrigerator needed to be cleaned and put on a schedule for regular cleaning. An observation of the nourishment refrigerator with the Administrator on 4/25/13 at 4:45 PM, the Administrator stated the refrigerator was expected to be clean and on a cleaning schedule with someone responsible for monitoring its completion.	F 465		

NASHVILLE 1022 Eastern Avenue, Nashville, NC 27856
Ph. 252-459-3014 Fax. 252-459-5092

VIA Certified Mail

May 18, 2013

North Carolina Department of Health and Human Services
Division of Health Services Regulation
Nursing Home Licensure and Certification Section
2711 Mail Service Center
Raleigh, NC 27699-2711

RE: Universal Healthcare – Nashville
Annual Survey Plan of Correction (PoC)

To Whom It May Concern:

On April 22, 2013 through April 25, 2013, an Annual Licensure Recertification Survey was conducted by the Nursing Home Licensure and Certification Section of the Division of Health Service Regulation at Universal Healthcare - Nashville. As a result of the inspection, the surveyor alleged the Nursing Home's most serious deficiencies to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy. Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Universal Healthcare - Nashville of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Universal Healthcare – Nashville reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies will be taken to Universal Healthcare – Nashville's Quality Assurance/Assessment Committee on June 27, 2013.

Please notify me if you need additional information not included in our plan of correction.

Sincerely,

Danielle R. Hellenbrand
Administrator
Universal Healthcare - Nashville

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

PRINTED: 05/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345374	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/17/2013

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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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/17/2013 there were unprotected holes in the rated ceiling of the Mech. / Switch Gear room just out side of the kitchen. 42 CFR 483.70 (a)	K 012	Preparation and/or execution of this plan of correction does not constitute admission or agreement by Universal Healthcare - Nashville of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of state and federal law. K012 • It was identified during the Life Safety survey on 5/17/13 that there were unprotected holes in the rated ceiling of the Mechanical/ Switch Gear Room just outside of the kitchen.	05/17/13
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/17/2013 the magnetic locks could not be tested when the fire alarm was in the silent mode. 42 CFR 483.70 (a)	K 038	• The Maintenance Director or designee will fix the unprotected holes in the rated ceiling of the Mechanical/ Switch Gear Room and they will complete walking rounds of the building to ensure there are no other holes in rated ceilings. If holes are found they will be fixed immediately.	06/03/13
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	K 061	• To ensure the deficient practice will not recur the Maintenance Director or designee will conduct monthly rounds to ensure there are no unprotected holes in rated ceilings.	06/03/13

RECEIVED
JUN 05 2013
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X8) DATE: 5/29/13

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.

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 A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	345374		05/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27856

(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
K 061	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 05/17/2013 the dry sprinkler system did not have a high and low air pressure alarm switch. 42 CFr 483.70 (a)	K 061	• Any discrepancies from the monthly rounds will be reviewed at the monthly Quality Assurance Committee meeting for the first three months and quarterly thereafter until there have been three consecutive quarters without problems to report.	6/27/13 (Next QA Meeting) & Ongoing
			K 038 • During the Life Safety Survey on 05/17/2013 it was identified that the magnetic locks could not be tested when the fire alarm was in the silent mode.	05/17/13
			• On 4/15/13 a Fire Panel inspection was completed by United Fire and Safety Equipment Company and no problems were noted with the silencing of the panel or the magnetic locks. On 05/23/13 a fire drill was conducted, the system was silenced and the magnetic doors were tested by the Maintenance Director and Maintenance Assistant and everything was in working order. On 05/31/13 Pye Barker Fire and Safety will test the fire panel and magnetic locks to ensure good working order. If there are problems, they will be fixed by Pye Barker.	06/17/13

• To ensure the deficient practice will not recur the Maintenance Director or designee will conduct monthly fire panel and magnetic lock inspections during the fire drill. Any problems will be fixed immediately.	06/21/13
• Any discrepancies from the fire drills will be reviewed at the Quality Assurance Committee meeting for the first three months and quarterly thereafter until there have been three consecutive quarters without problems to report.	6/27/13 (Next QA Meeting) & Ongoing

K 061

• It was identified during the Life Safety survey on 5/17/13 that the dry sprinkler system did not have a high and low air pressure alarm switch.	05/17/13
• Century Fire Protection will be installing the high and low air pressure alarm switch to the dry sprinkler system by 06/15/13. Pye Barker will be wiring the switch to the fire panel no later than 06/21/13.	06/21/13

• To ensure the deficient practice will not recur the Maintenance Director or designee will conduct high and low air pressure alarm switch communication testing monthly. The first test will be conducted by Pye Barker when the high and low air pressure alarm switch is replaced.	06/21/13
• Any discrepancies from the monthly testing will be reviewed at the monthly Quality Assurance Committee meeting for the first three months and quarterly thereafter until there have been three consecutive quarters without problems to report.	6/27/13 (Next QA Meeting) & Ongoing

Universal Healthcare

NASHVILLE • 1022 Eastern Avenue • Nashville, NC 27856
Ph: 252-459-3014 • Fax: 252-459-5092

VIA Certified Mail

May 29, 2013

North Carolina Department of Health and Human Services
Division of Health Services Regulation
Construction Section
2705 Mail Service Center
Raleigh, NC 27699-2705

RE: Universal Healthcare – Nashville
Life Safety Plan of Correction (PoC)

To Whom It May Concern:

On May 17, 2013, a Life Safety Survey was conducted by the Construction Section of the Division of Health Service and Regulation at Universal Healthcare - Nashville. As a result of the inspection, the surveyor alleged the Nursing Home's most serious deficiencies to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, whereby corrections are required. Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Universal Healthcare - Nashville of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Universal Healthcare – Nashville reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies will be taken to Universal Healthcare – Nashville's Quality Assurance/Assessment Committee on June 27, 2013.

Please notify me if you need additional information not included in our plan of correction.

Sincerely,

Danielle R. Hellenbrand
Administrator
Universal Healthcare - Nashville