

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345374	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/13/2013
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/NASHVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to ensure a medication error rate of 5% or less, as evidenced by 4 errors (2 omissions, 1 without order and 1 wrong dose) in 27 opportunities resulting in a 14.81% error rate for 3 out of 12 residents (#5, #6, #10) observed during the medication pass. The findings included:</p> <p>1a. Resident #6 was admitted to the facility on 7/03/2013. Resident #6 had diagnoses including depression and psychotic disorder. Resident #6 had a physician 's order dated 7/3/2013 Depakote 125mg (milligrams) one capsule daily at 12:00 noon.</p> <p>On 8/13/2013 at 12:02 pm, during medication pass for Resident #6, Medication Aide #1 accompanied by Nurse #1, was observed preparing and administering medications that did not include Depakote 125mg (milligrams). Medication aide #1 prepared and administered Carbidopa-Levodopa 10/100 mg (milligrams) one tablet, Hydralazine 25mg (milligrams) one and a half tablet for a total of 37.5 mg (milligrams), and liquitears drops one drop to both eyes.</p> <p>In an interview with Nurse #1 on 8/13/2013 at 2:10pm, he stated " She must have forgotten. I will give it now. " Nurse #1 further indicated the</p>	F 332	<p>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.</p> <p><u>F332</u></p> <ul style="list-style-type: none"> During the complaint state survey conducted on 8/13/13 the surveyor observed four medication errors: Resident #6's Depakote was administered by nurse #1 as soon as the omission was identified by the surveyor. The Depakote was ordered to be given at 12:00 pm, and the first shift nurse (nurse #1) administered the medication prior to 3:00 pm. Resident #6 received a MD order for PRN Liquitears on the same day the error was identified. Resident #5's Calcium acetate was received from back up pharmacy and given the same day the omission was identified. Resident #10 reported he believed he had already taken neomycin 1000 mg (2 x 500 mg tablets); therefore the resident refused an additional 500 mg tablet. 	8/13/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Jared V. Carter

TITLE

Administrator

(X6) DATE

8/28/2013

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

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FORM APPROVED
OMB NO. 0938-0391

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F 332	<p>Continued From page 1</p> <p>medication was not signed for on the medication administration record for the 12:00 noon dose.</p> <p>During an interview with the Director of Nursing (DON) on 8/13/2013 at 5:27 pm, she indicated she expected the nurses or medication aides to always go back and double check the Medication Administration Record (MAR) and verify that they have given everything that is ordered.</p> <p>1b. Resident #6 was admitted to the facility on 7/3/2013. Medical diagnoses for Resident #6 included dry eyes. Resident # 6 had a physician 's order dated 7/3/2013 for Liquitears eye drops instill one drop into both eyes twice daily, scheduled for 9am and 9pm.</p> <p>On 8/13/2013 at 12:02 pm, during medication pass for Resident #6, Medication Aide accompanied by Nurse #1 was observed preparing and administering medications including Liquitears eye drops. Medication Aide stated " She already had them one time this morning but she is just feeling extra dry. " Medication Aide further indicated resident usually asks for the eye drops a few times throughout the day.</p> <p>During an interview with Nurse #1 on 8/13/2013 at 2:10 pm, he stated " I thought she had a prn (as needed) order for the eye drops. " Nurse #1 further added " I will take care of that. " Nurse #1 further indicated he could not locate an order for an as needed dosage on the current Medication Administration Record.</p> <p>On 8/13/2013 at 5:27 pm, during an interview with the Director of Nursing (DON), she indicated her expectation was for the staff to notify the</p>	F 332	<ul style="list-style-type: none"> All nurses and medication aides were educated by the pharmacy nurse educator on medication administration, medication error prevention, the 6 rights of medication administration, and how to obtain medications that are "unavailable" in the medication cart. To ensure the deficient practice will not recur; the Director of Nursing or designee will complete a medication pass audit twice a week. Any nurse or medication aide having errors on the medication pass audit will be re-educated and appropriate disciplinary action will be taken as indicated. <p>Nurse #1, nurse #2, and Medication Aide #1 will be put on a temporary probationary period until they have been audited three consecutive medication passes with 0% error rate. The audits will take place within 30 days from the day of the survey (9/13/13); and after the three staff members have had three consecutive error free medication pass audits they will be removed from temporary probation.</p>	8/20/13 8/30/13 9/13/13	

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F 332	<p>Continued From page 2</p> <p>physician because he may consider a prn (as needed) dose. DON further indicated the doctor had been notified and an order was obtained for a prn (as needed) dose for the liquitears eye drops.</p> <p>2. Resident #5 was admitted to the facility on 7/30/2013. Medical diagnoses for Resident #5 included End Stage Renal Disease. Resident #5 had a physician ' s order for Calcium Acetate 667mg (milligrams) one gelcap by mouth three times a day with meals.</p> <p>On 8/13/2013 at 11:54am, during medication pass for Resident #5, Medication Aide accompanied by Nurse #1 was observed preparing to administer medications. Medication Aide #1 stated she did not have the Calcium Acetate medication for Resident #5 so she could not administer it to her. She circled the medication order on the Medication Administration Record and informed Nurse #1 that she was going to order the medication from the pharmacy. Nurse #1 provided the Medication Aide with the reorder form. Medication Aide #1 indicated the Calcium Acetate was not available in the emergency kit.</p> <p>On 8/13/2013 at 5:27 pm, in an interview with the Director of Nursing, she indicated she expected the staff to utilize the emergency kit on hand to obtain the medication if it is available. The DON further indicated she expected the staff to obtain the medication from the backup pharmacy if the medication is not available on hand. The DON stated she would ensure medication was obtained from the backup pharmacy today.</p> <p>3. Resident #10 was admitted to the facility on 8/2/2013. Resident #10 had medical diagnoses</p>	F 332	<ul style="list-style-type: none"> Any discrepancies found during the bi-weekly medication pass audits will be brought to the Quality Assurance Committee meeting monthly for the first three months and quarterly thereafter until there have been three consecutive quarters without problems to report. 	8/29/13 & Ongoing	

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F 332	<p>Continued From page 3 including pneumonia. Resident #10 had a physician 's order dated 8/2/2013 for Neomycin 1 gram by mouth three times a day.</p> <p>On 8/13/2013 at 12:44 pm, during medication pass for Resident #5, Nurse #2 was observed preparing and administering medications including Neomycin 500mg (milligrams). Nurse #2 was observed administering one tablet of Neomycin 500mg (milligrams) and one tablet of Propranolol 10mg.</p> <p>In an interview with Nurse #2 on 8/13/2013 at 2:20 pm, he indicated he thought he gave two tablets of Neomycin. Nurse #2 further indicated later that medical doctor (MD) had been called and MD gave instructions to go ahead and give the additional 500mg (milligram) tablet to ensure correct dosage had been given.</p> <p>During an interview with the Director of Nursing (DON) on 8/13/2013 at 5:27 pm, she indicated she expected the nurses or medication aides to always go back and double check the Medication Administration Record (MAR) and verify that they have given everything that is ordered.</p>	F 332			