

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

PRINTED: 05/22/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/17/2014
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 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 observation, staff interview, record review and facility policy review, the facility failed to check the placement of a feeding tube by auscultation prior to administering medications through the tube for 1 (Resident #41) of 1 resident with a feeding tube observed during medication pass. The findings included:</p> <p>Resident #41 was admitted to the facility on 1/3/14. Diagnoses included dysphagia.</p> <p>A facility policy, revised April 2007, entitled, "Administering medications through an Enteral Tube Level III" read in part, "17. For nasogastric, esophagostomy, or gastrostomy tubes, check placement and gastric contents: a. Attach 50 to 60 ml (milliliter) syringe containing approximately 10 cc (cubic centimeters) air. B. Auscultate the abdomen (approximately 3 inches below the sternum) while injecting the air from the syringe into the tubing. C. Listen for "whooshing" sound to check placement of the tube in the stomach. D. Pull back gently on the syringe to aspirate stomach content."</p> <p>On 4/16/14 at 10:20 AM, Nurse #4 was observed to approach Resident #41 to administer medications via the feeding tube. Nurse #4 first put the formula that was infusing on hold, then aspirated the feeding tube and obtained 10 cc of tan color liquid similar to the color of the formula.</p>	F 281	<p>Nurse #4 was educated on proper feeding tube placement and the ADON observed Nurse #4 during an accurate return demonstration of the procedure. Resident #41 was assessed by the ADON and there were no negative outcomes after Nurse #4 administered the medication. 4/17/14</p> <p>All nurses will be re-educated by the DON/ADON on the proper procedure for administering medications through a feeding tube. Nurses unable to attend the in-service will be educated prior to returning to the floor. 5/15/14</p> <p>The DON/ADON will assess each resident's feeding tube site during their observations of the nurse return demonstration of the procedure. Following the education each nurse must complete an accurate return demonstration for administering medication through a feeding tube. 5/15/14</p> <p>To ensure this deficient practice does not recur, the DON/ADON will complete a random skills check monthly on each shift. Re-education will be provided on an individual basis if necessary. 5/15/14</p>	5/15/14	

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

TITLE

(X6) DATE

Electronically Signed

05/09/2014

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	Continued From page 1 The nurse then instilled the aspirate back into the stomach. Next the nurse removed the syringe from the feeding tube, pulled back on the plunger of the syringe to the 30 cc (cubic centimeter) mark, then reconnected the syringe to the feeding tube and pushed the air into the tube. The nurse had no stethoscope. During an interview on 4/16/14 at 2:17 PM, Nurse #4 stated she had forgotten about using a stethoscope for Resident #41. The nurse indicated she should have been listening with a stethoscope while injecting the 30 cc of air into the feeding tube. During an interview on 4/16/14 at 3:41 PM, the Assistant Director of Nursing indicated she expected nurses to check feeding tube placement prior to administration of medications by listening with a stethoscope while injecting 10 cc of air into the stomach.	F 281	Any discrepancies found during the monthly skills check will result in re-education for the individual nurse. Discrepancies 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. 5/29/14 (Next QA)		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to clean and trim fingernails for 1of 3 residents for nail care. (Resident #19).	F 312	Nurse #5 assisted Resident #19 with proper nail care during the annual state survey. 4/16/14 A nail care audit for all residents will be	5/15/14	

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F 312	<p>Continued From page 2</p> <p>The findings included:</p> <p>Resident #19's Quarterly Minimum Data Set (MDS) Assessment dated 02/17/2014 revealed current active diagnoses in part as Heart Failure, Diabetes Mellitus, Non- Alzheimer's Dementia, Anxiety Disorder, and Chronic Obstructive Pulmonary Disease.</p> <p>Resident #19's Brief Interview for Mental Status (BIMS Score) documented that Resident #19 was unable to complete the interview. The MDS revealed Resident #19's functional status for activities of daily living (ADL's) was total dependence with two person physical assist.</p> <p>On 4/15/14 at 4:45p.m., Resident # 19 was observed lying in bed leaning towards his left side. Resident #19's fingernails on the right hand were elongated past the fingertips. All nails on the right fingers were jagged. Two fingernails, including the thumbnail had debris under the nails. The left hand had one jagged fingernail with a portion of this fingernail broken. The fingernail that was broken had an elongated piece of nail sticking up, with a jagged, spear-like edge.</p> <p>On 4/16/2014 at 8:53a.m. Resident #19 was observed sitting up in bed. Resident #19's fingernails on the right hand were elongated past the fingertips. All fingernails were jagged. Two fingernails, including the thumbnail had debris under the nails. The left hand had one jagged fingernail with a portion of this fingernail broken. The fingernail that was broken had an elongated piece of nail sticking up, with a jagged, spear-like edge. In addition, brown staining appeared on the right hand under all fingernails. Additional observations at 10:35 a.m. and 10:57 a.m. revealed that Resident #19's fingernails remained</p>	F 312	<p>completed and any residents in need of nail care will be attended to the day the need is identified. 5/15/14</p> <p>All C.N.A.s and Nurses will be educated on our nail care policy. 5/15/14</p> <p>To ensure this deficient practice does not recur, the DON/ADON will complete weekly nail care audits for 4 weeks. Re-education will be provided on an individual basis if residents are found without proper nail care. Department heads also complete daily rounds and have been instructed to focus on nail care as they are completing their rounds. 5/15/14</p> <p>Any discrepancies found during the 4 weeks of nail care audits will result in re-education for the individual staff member. Discrepancies will be brought to the Quality Assurance Committee meeting. Any discrepancies found in Department Head rounds will be discussed at morning stand-up Monday-Friday. 5/29/14 (Next QA)</p>		

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F 312	<p>Continued From page 3 the same as the 8:53 a.m. observation.</p> <p>On 4/16/2014 at 11:00 a.m. a record review of a facility document in the front of the Nurse Aides (NA's) documentation binders included a "Nail Care" statement. The statement was written in bold and capitalized. The statement read "Nail Care Must Be Done Daily with a Bath or Directly After. If A Resident Refuses Bath Or Shower, Nail Care Should Still Be Done. All Nails Should Be Trimmed. Nurses Are Responsible For Trimming The Nails For All Residents With Diabetes or Peripheral Vascular Disease (PVD). NA's Can Clean Any Residents Nails but Check with the Nurse Prior to Trimming." Further review of the ADL flow record and nursing notes for April revealed no documented refusal of care for Resident #19.</p> <p>On 4/16/2014 at 11:45 a.m. Nurse Aide (NA) #1 was observed giving Resident #19 a bed bath. Nail care was not included in this bed bath. Upon completion of the bed bath an interview was conducted with NA #1 whom stated, "Yes, we do have a guide in our NA documentation books about nail care and other reminders. What I do for this resident (#19) is nail care on Monday and Thursday, those are the shower days. This resident's nails crack and peel when you cut them, they are fragile and you have to be careful, it is easier to cut them when they are soft after a shower". NA #1 then looked at Resident #19's nails on the right hand and said, "they are jagged; I will look into nail care being done." NA #1 stated, "I am his primary NA today and I know this resident well."</p> <p>On 4/16/2014 at 3:20p.m. Resident #19's fingernails remained the same as the 8:53 a.m.</p>	F 312			

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F 312	Continued From page 4 observation. In an interview on 4/16/2014 at 4:05 p.m. the Director of Nursing (DON) stated she expected NA's to give nail care daily with the resident's bath or shower. The NA's usually do cutting of the nails after showers and the nurse is responsible for trimming the nails of residents who have a diagnosis or peripheral vascular disease or diabetes. NA's can clean any residents' nails, but they have to check with the nurse prior to trimming." On 4/16/14 at 3:30p.m. the DON and Administrator of the facility observed Resident #19's nails. The DON stated, "I see what you are talking about." The DON asked Nurse #5, who was in the room, to "please attend to the resident's fingernails." On 4/16/14 at 4:15p.m. Nurse #5 was observed finishing up nail care, and cleaning Resident #19's hands. Resident #19's fingernails were observed trimmed, neat and clean; without jagged edges.	F 312			
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.	F 314		5/15/14	

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F 314	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with staff, the facility failed to clean a pressure ulcer in a manner that would prevent possible contamination of the wound for 1 of 3 residents observed for wound care (resident # 40). Findings included: Resident # 40 was admitted to the facility 12/24/13 with diagnoses which included paraplegia (loss of voluntary movement of the lower body), Diabetes Mellitus, and a stage 4 decubitus ulcer on the sacrum. The quarterly Minimum Data Set (MDS) dated 1/27/14 revealed the resident was cognitively intact. She required extensive assistance with activities of daily living. The MDS also stated the resident had one stage 4 pressure ulcer. The care plan for resident # 40 revealed she had actual skin breakdown related to a stage 4 sacral decubitus ulcer. The doctor's order dated 4/15/14 stated "clean wound with soap/water, apply silver alginate pad every 2 days until wound vacuum machine available." An observation of the dressing change on 4/17/14 at 11:40 AM by Nurse #3, in the presence of the Assistant Director of Nursing (ADON), revealed Nurse #1 wiped around the buttock then to the open sacral wound with the same surface of the washcloth. During an interview on 4/17/14 at 11:58 AM, Nurse #3 stated she would normally wipe from the clean area to the dirty area. She elaborated by stating she would first clean the skin surrounding the wound then the wound itself. An interview with the ADON on 4/17/13 at 11:59	F 314	Nurse #1 received re-education on the wound cleansing protocol. Nurse #1 was also put back in orientation for a day. 4/18/14 All wounds in the building have been assessed by an RN. There are no infections related to improper wound cleansing. 5/9/14 Nursing staff will be re-educated by the DON/ADON on the proper technique to cleanse a wound. Accurate return demonstration of wound cleansing will be required following the education. 5/15/14 The DON/ADON will review the weekly wound report and randomly conduct a monthly skills check per shift evaluating aseptic technique. 5/15/14 Any discrepancies found during monthly random skills checks will result in re-education for the individual staff member. Discrepancies 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. 5/29/14 (Next QA)		

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F 314	Continued From page 6 AM revealed she expected the wound to be cleaned first, then clean the surrounding skin.	F 314			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to have less than a 5% medication administration error rate. There were three errors of omission out of 30 opportunities for error, resulting in a 10 percent error rate (Residents #41 and #100). Findings included: 1. Resident #41 was admitted to the facility on 1/3/14. Diagnoses included chronic kidney disease and hypertension. Review of the April 2014 Physician Orders and Medication Administration Record (MAR) revealed Resident #41 was scheduled to receive fish oil 1000 mg (milligrams) daily at 9:00 AM via gastric tube. On 4/16/14 at 10:20 AM, Nurse #4 was observed administering medications to Resident #41 via gastric tube. The fish oil was not included in the medications administered. During an interview on 4/16/14 at 10:25 AM, Nurse #4 stated she inadvertently missed the order for fish oil on the MAR.	F 332	Nurse #4 and the MAA were both individually re-educated on the proper Medication Administration procedure and observed for accuracy. 4/17/14 Medication Administration education will be provided by the DON/ADON for all Nurses and MAAs. Any Nurse/MAA unable to attend the in-service will be educated prior to returning to the floor. 5/15/14 A random observation of medication administration will be completed per shift by the DON/ADON weekly for 4 week. The pharmacy consultant will conduct two random medication administration observations monthly on different shifts. 5/15/14 Any discrepancies found during monthly random medication administration audits will result in re-education for the individual staff member. Discrepancies will be brought to the Quality Assurance Committee meeting for the first three	5/15/14	

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F 332	Continued From page 7 The Assistant Director of Nursing (ADON) was notified of the omissions at 09:40 AM on 4/16/14. She stated that her expectations were for nursing staff to carefully compare medications pulled from the medication cart against those listed on the Medication Administration Record (MAR), put them into a medication cup and administer them to the resident. They should then document on the MAR that the medications were administered. 2. Medication administration pass was observed with the Medication Administration Aide (MAA) on 4/16/14 at 0900. It was observed that the following 2 medications were not administered to Resident 100 during the pass: a. Metamucil 425 grams by mouth (PO) daily. The physician order dated 4/15/14 indicated that the medication was to be administered at 9 AM. b. Ascorbic acid 500 micrograms PO daily. The physician order dated 4/15/14 indicated that the medication was to be administered at 9 AM. The MAA was questioned about the omissions on 4/16/14 at 9:30 AM to which she indicated that the medications should have been included during the 9 AM medication pass and were not given. She further indicated that Resident 100 was admitted yesterday evening and that she had not yet familiarized herself with all of the resident's medications. The policy on Medication Administration Procedures revised on 11/1/2011 did not address the topic of omissions of medications during administration. The Assistant Director of Nursing (ADON) was notified of the omissions at 09:40 AM on 4/16/14.	F 332	months and quarterly thereafter until there have been three consecutive quarters without problems to report. 5/29/14(Next QA)		

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F 332	Continued From page 8 She stated that her expectations were for nursing staff to carefully compare medications pulled from the medication cart against those listed on the Medication Administration Record (MAR), put them into a medication cup and administer them to the resident. They should then document on the MAR that the medications were administered.	F 332			
F 431 SS=D	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	F 431		5/15/14	

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F 431	<p>Continued From page 9</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations of two of two medication carts, policy review, and staff interviews the facility failed to: keep adhered the pharmacy-generated label onto a Lantus pen which would ascertain to whom the medication belonged and other legally required information; denote the date of medication expiration and/or date of opening on the same Lantus pen; clean an oral syringe for phenytoin suspension between medication administrations; and refrigerate an unopened Novolog insulin vial as per manufacturer recommendations.</p> <p>Findings included:</p> <p>An inspection of the medication storage areas was conducted on 4/15/14 at 2:00 PM. One medication storage room and 2 medication carts were inspected.</p> <p>The facility policy regarding "Medication Storage in the Facility" (revised on 1/20/2014) was reviewed and stated:</p> <p>"Medipack Pharmacy dispenses medication in containers that meet legal requirements, including requirements of good manufacturing practices. Medications are kept in these containers."</p> <p>"Outdated, contaminated, or deteriorated medications and those in containers that are</p>	F 431	<p>The Lantus pen, unopened Novolog insulin vial, and the used oral syringe attached to the Phenyton liquid were all disposed of following proper procedure. 4/16/14</p> <p>The pharmacy consultant completed an audit of the medication carts to ensure all medications were labeled and stored appropriately. Disposable oral syringes were purchased to ensure used oral syringes would not be stored with the medication. 4/16/14</p> <p>To ensure this deficient practice does not recur, nurses and MAAs will be educated by the DON/ADON on disposable syringe use, storage and labeling of medication. 5/15/14</p> <p>Third shift nurses will conduct a weekly audit of the medication carts and medication storage. The DON/ADON will review the audit and conduct random checks for accuracy weekly for four weeks. The pharmacy consultant will conduct a monthly check of the medication carts and medication storage. 5/15/14</p> <p>Any discrepancies found during the four</p>		

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F 431	<p>Continued From page 10</p> <p>cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy if a current order exists."</p> <p>"Medications requiring "refrigeration" or "temperatures between 2 degrees C (36 degrees F) and 8 degrees C (46 degrees F)" are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage "in a cool place" are refrigerated unless otherwise directed on the label."</p> <p>The following discrepancies were found in two of two medication carts (referred to as the lower East medication cart and the upper East medication cart):</p> <ol style="list-style-type: none"> 1. An opened and used Lantus pen was found (in the lower East medication cart) without any sort of documentation which indicated to whom the device belonged (the device contained neither a legally required pharmacy-generated label nor a facility produced generic label). It was noted that 40 units of insulin were missing from the device. 2. The same Lantus pen did not have a date marked when opened or date marked when the medication expired after opening the device. 3. A Phenytoin liquid suspension (in the upper East medication cart) had a used oral syringe still attached to the loop of the drug container cap. The syringe was unclean, with orange liquid caking at the tip of the syringe, and not stored in a manner that prevented further contamination within the medication cart. 	F 431	<p>weeks of random audit checks will result in re-education for the individual staff member. Discrepancies will be brought to the Quality Assurance Committee meeting. Any discrepancies found during the monthly pharmacy consultant training will result in re-education and 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.</p> <p>5/29/14(Next QA)</p>		

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

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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 04/17/2014
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 431	<p>Continued From page 11</p> <p>4. An unopened Novolog insulin vial was found (in the upper East medication cart) unrefrigerated as per manufacturer recommendations. It was unknown when the vial was taken out of the refrigerator and was warm to the touch.</p> <p>An interview was conducted at 4/14/14 at 2:20 PM with Nurse 1 who was using the lower East medication cart. She indicated that this was her first week of working at the facility and could not say why the Lantus pen was unlabeled or for which resident it was being used, as she had not used it or witnessed it being used in the past week.</p> <p>An interview was conducted on 4/14/14 at 2:25 PM with Nurse 2 who was using the upper East medication cart. He indicated that he used the oral syringe, provided by pharmacy with the medication, for medication administration. He acknowledged that he had not cleaned the oral syringe after using it. He further stated that he did not know why or how long the Novolog vial has been out of the refrigerator.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 4/15/14 at 2:25 PM indicated what her expectations were in reference to the above mentioned findings:</p> <ol style="list-style-type: none"> 1. Proper Lantus pen storage is to clean the device after use and replace it in the bag containing the pharmacy-generated label containing resident and other legally required information 2. Lantus pens should have a label unto which the staff should document when the device was opened and when the medication expired 	F 431			

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F 431	Continued From page 12 3. Oral syringes should be cleaned between uses and stored in a bag to prevent contamination. Moreover she said that she will order additional oral syringes from pharmacy to be stored in the medication carts so that each syringe can be disposed of after each use for better sanitary control 4. Novolog should be stored in the refrigerator until opened as per manufacturer recommendations. Furthermore, each vial should also be labeled as to when the medication was opened and when it expired Moreover, the ADON indicated that the current practice is to conduct monthly cart checks for expired medications by both pharmacy and nursing staff. She expressed the need to reinforce to staff to audit the medication carts for other medication storage issues as well, especially in reference to medication labels, insulin, and oral syringes.	F 431			