

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

PRINTED: 09/23/2014
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 08/13/2014
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 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to follow the care plan to provide wound treatment as ordered for 1 of 3 residents' care plans reviewed (Resident #1). Findings included:</p> <p>Resident #1 was admitted into the facility on 7/10/14 from the hospital. Diagnoses included Pressure Ulcer, Diabetes, Urinary Tract Infection, End Stage Renal Disease (ESRD), General Muscle Weakness, Lack of Coordination, Feeding Problem and Failure to Thrive.</p> <p>The admission Minimum Data Set (MDS) completed on 7/17/14 indicated Resident #1 had short and long term memory problems. Daily decision making was severely impaired. Extensive assistance of one person was required with bed mobility, personal hygiene and toilet use. Total dependence of one person was needed for transfers and bathing. Bowel and bladder was indicated as always incontinent. The MDS further indicated Resident #1 was at risk for developing pressure ulcers with one stage II pressure ulcer present. The pressure ulcer was not indicated as present upon admission into the facility. The pressure ulcer was described as "epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly</p>	F 282	<p>F282</p> <p>Resident #1 is no longer in the facility.</p> <p>An audit of Current residents was completed to identify any other residents with pressure wounds. Any resident identified was re-assessed by a licensed nurse on 8/15/14 and no infections related to improper wound protocol were noted.</p> <p>Care plans were reviewed by DON/MDS to ensure that current prevention interventions were updated and in place for each resident.</p> <p>Current residents with pressure wounds will have a weekly wound assessment completed which includes documentation of wound measurements, stage, description of wound bed and surrounding skin, and presence or non-presence of odor. Care plans will be updated as appropriate.</p> <p>The DON or designee will monitor the wound documentation weekly during the wound SOC meeting to ensure completion.</p>	9/10/14	

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

TITLE

(X6) DATE

Electronically Signed

09/06/2014

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 282	<p>Continued From page 1</p> <p>pigmented skin, moisture associate skin damage." Rejection of care was not indicated.</p> <p>A review of the weekly wound measurement revealed the following:</p> <ul style="list-style-type: none"> "7/17/14 new opened area stage II to sacrum 1.5 cm (centimeter) length x 1 cm width x 0.5 cm depth." <p>The care plan dated 7/29/14 listed as a problem, an alteration in skin integrity due to needs assistance with activities of daily living with a "stage II pressure ulcer which now appears a unstageable due to slough" related to impaired mobility, ESRD with hemodialysis, and relying on the staff for most of care. Approaches for pressure ulcer care in part read "provide treatment as ordered/protocol."</p> <p>A review of a written statement by the Director of Nursing (DON) in part read "As of 8/1/14 Nurse #1 would no longer be the wound nurse due to poor documentation."</p> <p>A review of the Physician order dated 8/5/14 read "stage II decubitus to coccyx - clean with normal saline and allow to dry, apply santyl, cover with dry dressing daily."</p> <p>A review of the wound measurement log revealed the following:</p> <ul style="list-style-type: none"> "8/6/14 pressure ulcer to coccyx 3 cm length x 3 cm width x 0.3 cm depth." There was no indicated ulcer stage, description of the wound, odor or any needed intervention. <p>A review of the treatment record revealed no</p>	F 282	<p>An IDT Standards of Care meeting is in place to review all residents with pressure wounds weekly for measurements, stages, descriptions, presence or non-presence of odor, current treatment orders, current needs, documentation and notification of MD/RP of any noted changes.</p> <p>Nurse #2, #4 and #7 received counseling and re-education on providing and documenting wound care as ordered by the MD from the DON.</p> <p>Nurse #3 is no longer employed.</p> <p>Licensed staff will receive re-education by the DON and Administrator by 9/10/14 and on-going in-services will take place on care of residents with pressure wounds. Education will include: providing treatment as ordered/protocol, documentation, observation of signs and symptoms in infection including odor, notifying MD of changes noted, notification of DON via the 24 hour report sheet, weekly wound documentation requirements for measurements, stage, description, presence of odor and pressure wound prevention techniques.</p> <p>Current residents will have a skin assessment completed by a licensed nurse weekly. The nurse will note any changes in skin condition, notify MD/protocol for needed interventions, transcribe and implement any orders/protocol, document findings in the</p>		

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F 282	<p>Continued From page 2</p> <p>facility staff signature which reflected wound treatment was provided on 8/5, 8/6 and 8/9/14 as ordered "clean stage II decubitus to coccyx with normal saline, allow to dry, apply santyl, cover with dry dressing daily 7am-3pm."</p> <p>A review of the nurses on 8/5, 8/6 and 8/9/14, revealed no indication which reflected wound treatment was provided as ordered or a description of the wound appearance.</p> <p>On 8/12/14 at 2:30 pm, upon entering the room for pressure ulcer observation, a foul wound odor was observed immediately upon entering the room. Upon observing Nurse #2, she removed the wound dressing from Resident #1's sacrum/coccyx area, and the odor became stronger after removal of the dressing. While Nurse #2 performed wound care to the pressure ulcer on the sacrum, the area was observed to be an unstagable pressure ulcer that was opened, covered with thick-stringy yellow slough, with a foul odor and no drainage.</p> <p>On 8/12/14 at 4:14 pm, Nurse #3 stated she was the nurse for Resident #1 on 8/9/14 from 7am-3pm. She indicated she did not perform wound treatment as ordered or observe the resident's wound on 8/9/14. She acknowledged she was aware Resident #1 had a pressure ulcer to the sacrum area. She further indicated she did not recall being informed during her shift on 8/9/14, there was a concern with wound odors, nor did she observe any wound odors throughout the day. Nurse #3 concluded she was hired as the charge nurse on the weekend, and she did not know that she was responsible for doing treatments.</p>	F 282	<p>resident's medical record and on the 24 hour report sheet.</p> <p>All current residents will have the Braden's assessment completed by a licensed nurse quarterly to determine the resident's risk factor for skin breakdown, implement needed interventions, document in the resident medical record, care plan, and on the 24 hour report sheet.</p> <p>The DON will monitor the Treatment Administration Records to ensure treatments are being completed as ordered daily x 4 weeks; then, monthly x 2 months. Results of the monitor will be reviewed by the QA Committee during the monthly meeting x 3 months.</p> <p>Future residents will have a skin assessment completed by a licensed nurse upon admission. The nurse will note any skin conditions needing evaluation, notify MD/protocol for needed interventions, transcribe and implement orders/protocol, document in the resident's medical record, admission care plan, and on the 24 hour report sheet.</p> <p>The admitting nurse will complete the Braden's Assessment to determine the new resident's risk factor for skin breakdown, implement needed interventions, document in the resident medical record, admission care plan, and on the 24 hour report sheet.</p>		

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F 282	<p>Continued From page 3</p> <p>On 8/13/14 at 10:22 am, Nurse #2 acknowledged on 8/5, 8/6/14 she was the nurse for Resident #1 from 7am-3pm and she did not provide wound treatment as ordered by the physician because she was "extremely busy on the medication cart." She stated she reported to Nurse #6 on 8/5/14 and Nurse #4 on 8/6/14 who both worked from 3pm-11pm, treatment needed to be done to the sacral.</p> <p>On 8/13/14 11:54 am, Nurse #5 who is part of the managerial team, in the absence of the DON stated wound care was expected to be provided per the care plan.</p> <p>On 8/13/14 at 1:21 pm, a telephone interview was attempted with Nurse #6 who was the nurse for Resident #1 on 8/5/14 from 3pm-11pm. There was no answer.</p> <p>On 8/13/14 at 1:23 pm, Nurse #4 who was the nurse on 8/6/14 from 3pm-11pm stated she did not recall being notified during shift report on 8/6/14 Resident #1's treatment had not been completed from 7am-3pm. She stated she did not do the wound treatment from 3pm-11pm.</p> <p>On 8/13/14 1:34 pm, Nurse #3 acknowledged she was the nurse on 8/9/14 and she did not provide wound treatment from 7am -3pm. She stated she thought she was only responsible for the medications. She stated she did not know she was responsible for the wound care.</p> <p>On 8/13/14 2:55 pm, Nurse #7 acknowledged she was the primary nurse for Resident #1 on 8/5, 8/6 and 8/9/14 from 11pm-7am. She stated she did not recall providing wound treatment, nor did she notice a wound odor. She indicated she recalled</p>	F 282	The DON or designee will review all newly admitted resident's weekly x 4 weeks; then, monthly x 2 months to ensure Braden's assessment, skin assessment, including pressure areas, have been completed, treatments administrated as order by the MD, and documentation completed.		

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F 282	Continued From page 4 having to change the wound dressing around 2:00 am due to the dressing was soiled but she could not recall if it was Saturday or Sunday. She concluded normally if she had to change the resident's dressing from 11pm to 7am; she documented the care provided in the nurse's notes.	F 282			
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. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to assess weekly wound measurements and provide a description of the appearance of a pressure ulcer's progress. The facility also failed to provide wound care for 1 of 3 residents reviewed for pressures ulcers. (Resident #1). Findings included: Resident #1 was admitted into the facility on 7/10/14 from the hospital. Diagnoses included Pressure Ulcer, Diabetes, Urinary Tract Infection,	F 314	F 314 Resident #1 is no longer in the facility and no other corrective action can be completed for this resident. Nurse #2, #4 and #7 received counseling and re-education on assessment, providing and documenting wound care as MD ordered by the DON on 08/15/14. The DON/designee will monitor the	9/10/14	

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F 314	<p>Continued From page 5</p> <p>End Stage Renal Disease (ESRD), General Muscle Weakness, Lack of Coordination, Feeding Problem and Failure to Thrive.</p> <p>A review of the weekly skin check record completed by Nurse #2 on 7/14/14 in part read "Excoriation to the sacrum. No open areas, skin intact."</p> <p>The admission Minimum Data Set (MDS) completed on 7/17/14 indicated Resident #1 had short and long term memory problems. Daily decision making was severely impaired. Extensive assistance of one person was required with bed mobility, personal hygiene and toilet use. Total dependence of one person was needed for transfers and bathing. Bowel and bladder was indicated as always incontinent. The MDS further indicated Resident #1 was at risk for developing pressure ulcers with one stage II pressure ulcer present. The pressure ulcer was not indicated as present upon admission into the facility. The pressure ulcer was described as "epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin, moisture associate skin damage." Rejection of care was not indicated.</p> <p>A review of the weekly wound measurement revealed the following:</p> <ul style="list-style-type: none"> "7/17/14 new opened area stage II to sacrum 1.5 cm (centimeter) length x 1 cm width x 0.5 cm depth." <p>The care plan dated 7/29/14 listed as a problem, an alteration in skin integrity due to needs assistance with activities of daily living with a "stage II pressure ulcer which now appears a</p>	F 314	<p>Treatment Administration Records to ensure treatments are being completed as ordered by the physician daily X 4 weeks; then, monthly X 2 months starting 09/01/14. The DON will follow up with nurses #2, #4, and #7 who fail to administer treatments and/or document timely.</p> <p>Nurse #3 is no longer employed.</p> <p>Current residents received a skin assessment by a licensed nurse on 09/01/14. Any residents with identified pressure wounds were assessed by the DON and wound nurse on 09/02/14 to ensure documented wound measurements were accurate, documentation of Stages were accurate, documented descriptions of the wound appearance were accurate; including signs & symptoms of infection and current treatment orders were reviewed.</p> <p>The DON/designee will monitor the Treatment Administration Records to ensure treatments are being completed as ordered by the physician daily X 4 weeks; then, monthly X 2 months starting 09/01/14. The DON will follow up with nurses who fail to administer treatment and/or document timely. The DON will present the results of the audit to the Quality Assurance Performance Improvement Committee monthly for review and recommendations for 3 months.</p> <p>The DON/designee will monitor all</p>		

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F 314	<p>Continued From page 6</p> <p>unstageable due to slough" related to impaired mobility, ESRD with hemodialysis, and relying on the staff for most of care. Approaches for pressure ulcer care in part read 1) "provide treatment as ordered/protocol and 2) observe for signs and symptoms of infection including odor - notify physician for interventions."</p> <p>A review of a written statement by the Director of Nursing (DON) in part read "As of 8/1/14 Nurse #1 would no longer be the wound nurse due to poor documentation."</p> <p>Review of the medical record revealed no completed wound measurements or description of the skin's appearance of the stage II pressure ulcer to the sacrum from 7/20/14 to 8/5/14, with exception of the care plan dated 7/29/14, which reflected a change from a stage II pressure ulcer to an unstageable due to slough present.</p> <p>A review of the Physician order dated 8/5/14 read "stage II decubitus to coccyx - clean with normal saline and allow to dry, apply santyl, cover with dry dressing daily."</p> <p>A review of the wound measurement log revealed the following:</p> <ul style="list-style-type: none"> "8/6/14 pressure ulcer to coccyx 3 cm length x 3 cm width x 0.3 depth." There was no indicated ulcer stage, description of the wound, odor or any needed intervention. <p>A review of the treatment record revealed no facility staff signature which reflected wound treatment was provided on 8/5, 8/6 and 8/9/14 as ordered "clean stage II decubitus to coccyx with normal saline, allow to dry, apply santyl, cover</p>	F 314	<p>residents with pressure wounds weekly for measurements, stages, descriptions, presence or non-presence of S&S of infection, current treatment orders, documentation and notification of MD/RP of any noted changes during the weekly IDT Wounds Standard of Care meeting starting 09/03/14. The DON will follow up with the wound nurse for any noted omissions. The DON will present the results of the audit to the Quality Assurance Performance Improvement Committee monthly for review and recommendations for 3 months.</p> <p>Licensed nurses received re-education by the DON and Administrator 9/10/14 on providing treatments as ordered/protocol, documentation, observation of signs and symptoms in infection including odor, notifying MD of changes noted, notification of DON via the 24 hour report sheet, weekly wound documentation requirements for measurements, stage, description, S&S of infection, weekly skin assessments and pressure wound prevention techniques.</p> <p>New hires will receive the in-services during orientation.</p> <p>New residents will have a skin assessment completed by a licensed nurse upon admission. The admitting nurse will complete the Braden's Assessment to determine the new resident's risk factor for skin breakdown, document in the resident medical record, the admission care plan, and on the 24</p>		

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F 314	<p>Continued From page 7 with dry dressing daily 7am-3pm."</p> <p>A review of the nurses on 8/5, 8/6 and 8/9/14, revealed no indication which reflected wound treatment was provided as ordered or a description of the wound appearance.</p> <p>On 8/12/14 at 2:02 pm, Resident #1 was observed in the bed positioned at a 75 degree angle on her back. A faint wound odor was present in the room.</p> <p>On 8/12/14 at 2:30 pm, upon entering the room for pressure ulcer observation, a foul wound odor was observed immediately upon entering the room. Upon observing Nurse #2, she removed the wound dressing from Resident #1's sacrum/coccyx area, and the odor became stronger after removal of the dressing. While Nurse #2 performed wound care to the pressure ulcer on the sacrum, the area was observed to be an unstagable pressure ulcer that was opened, covered with thick-stringy yellow slough, with a foul odor and no drainage.</p> <p>On 8/12/14 at 2:35 pm, Nurse #2 stated she did not notice a foul odor during treatment to the unstageable pressure ulcer. She further indicated care to the wound was to be provided daily. She indicated she had not notified the physician with any concerns related to the pressure ulcer because she had not assessed any problematic concerns to date and she performed the treatment as ordered. Nurse #2 further revealed on 8/6/14 she was informed by the DON she would be responsible for performing Resident #1's wound treatment/measurements weekly. She revealed prior to her becoming responsible for wound treatments/measurements, Nurse #1</p>	F 314	<p>hour report sheet. The nurse will note any skin conditions needing evaluation, notify MD/protocol for needed interventions, transcribe and implement orders/protocol, document in the resident's medical record, admission care plan, and on the 24 hour report sheet.</p> <p>The DON/designee will review all newly admitted residents weekly X 4 weeks; then, monthly X 2 months to ensure Braden's assessment and skin assessment have been completed; treatments administered as ordered by the MD and documentation completed. The DON will follow up with nurses who fail to complete new admission assessments and documentation timely. The DON will present the results of the audit to the Quality Assurance Performance Improvement Committee monthly for review and recommendations for 3 months.</p> <p>All corrective action will be completed on or before 09/10/14.</p>		

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F 314	<p>Continued From page 8</p> <p>was the treatment nurse. Nurse #2 stated she would report her current assessment findings of the unstageable pressure ulcer to the physician for any further treatment.</p> <p>On 8/12/14 at 2:45 pm, NA #1 stated she worked with Resident #1 on a daily basis from 7 am-3pm. She indicated on 8/9/14, while providing incontinence care to the resident, she "smelled a bad odor coming from the resident's bottom." She indicated the resident had not had a bowel movement and she notified Nurse #3 of her findings.</p> <p>On 8/12/14 at 3:00 pm, Nurse #4 stated she was the primary nurse for Resident #1 from 3pm-11pm and she last performed treatment to the pressure ulcer to the coccyx on 8/2/14 during the 3pm-11pm shift. She indicated while providing care she observed no odor, pain, or drainage to the sacral/coccyx area.</p> <p>On 8/12/14 at 3:30 pm, NA #2 stated she provided care to Resident #1 on 8/8/14 from 3pm-11pm and did not notice any odors in the room while providing care to the resident.</p> <p>On 8/12/14 at 4:14 pm, Nurse #3 stated she was the nurse for Resident #1 on 8/9/14 from 7am-3pm. She indicated she did not perform wound treatment as ordered or observe the resident's wound on 8/9/14. She acknowledged she was aware Resident #1 had a pressure ulcer to the sacrum area. She further indicated she did not recall being informed during her shift on 8/9/14, there was a concern with wound odors, nor did she observe any wound odors throughout the day. Nurse #3 concluded she was hired as the charge nurse on the weekend, and she did</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>not know that she was responsible for doing treatments.</p> <p>On 8/13/14 at 10:22 am, Nurse #2 acknowledged on 8/5, 8/6/14 she was the nurse for Resident #1 from 7am-3pm and she did not provide wound treatment as ordered by the physician because she was "extremely busy on the medication cart." She stated she reported to Nurse #6 on 8/5/14 and Nurse #4 on 8/6/14 who both worked from 3pm-11pm, treatment needed to be done to the sacral.</p> <p>On 8/13/14 11:54 am, Nurse #5 who is part of the managerial team, in the absence of the DON stated wound care was expected to be completed weekly. She indicated the hall nurse on duty was responsible for ensuring Resident #1's wound treatment was completed.</p> <p>On 8/13/14 at 1:21 pm, a telephone interview was attempted with Nurse #6 who was the nurse for Resident #1 on 8/5/14 from 3pm-11pm. There was no answer.</p> <p>On 8/13/14 at 1:23 pm, Nurse #4 who was the nurse on 8/6/14 from 3pm-11pm stated she did not recall being notified during shift report on 8/6/14 Resident #1's treatment had not been completed from 7am-3pm. She stated she did not do the wound treatment from 3pm-11pm.</p> <p>On 8/13/14 1:34 pm, Nurse #3 acknowledged she was the nurse on 8/9/14 and she did not provide wound treatment from 7am -3pm. She stated she thought she was only responsible for the medications. She stated she did not know she was responsible for the wound care.</p>	F 314			

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

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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 08/13/2014
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 314	Continued From page 10 On 8/13/14 2:55 pm, Nurse #7 acknowledged she was the primary nurse for Resident #1 on 8/5, 8/6 and 8/9/14 from 11pm-7am. She stated she did not recall providing wound treatment, nor did she notice a wound odor. She indicated she recalled having to change the wound dressing around 2:00 am due to the dressing was soiled but she could not recall if it was Saturday or Sunday. She concluded normally if she had to change the resident's dressing from 11pm to 7am; she documented the care provided in the nurse's notes. The DON was not available to be interviewed. Nurse #5 was appointed to speak in absence of the DON.	F 314			