STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on 10/13-10/16/15.	D 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
D 072	10A NCAC 13F .0305(m) Physical Environment 10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure the outside grounds of the facility were maintained in a clean and safe condition related to multiple holes throughout the yard. The findings are: Observation of the center courtyard patio on 10/16/15 at 11:59 a.m. revealed: -Three rabbits were in the courtyard. -Sixteen chunks of bread were on the cemented patio. -Multiple burrows, which were at least one foot deep, were on the side of the building and throughout the yard. -The space under the patio and the ground was six inches or more. -The side of the patio attached to the building was cracked. Confidential interview with a family member	D 072	Universal Healthcare/Nashville contracted vendor, "Adventure Wildlife Services" to remove rabbits. There were 9 domestic rabbits removed from the courtyard. All rabbits have been removed from the courtyard. Choice Health Contractor has completed repairs to the courtyard which included repair of drainage pipe, filling in of holes, reinforcement of concrete patio, and repair any cracked patio areas.	11/2/15 11/12/15

approved
12/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 072	Continued From page 1 revealed: -The facility had multiple rabbits at the facility. -The rabbits had dug multiple burrows in one of the resident smoking areas. -Some of the burrows were under the cement. -The rabbits and burrows had been there since 2014. -The family member was concerned, because of the residents' safety in the smoking area. -The family member did not want their family member to fall in the burrows or did not want the cement to cave in, because of the burrows under the patio. -Nothing had been done to get rid of the rabbits. Interview with a resident on 10/16/15 at 12:00 pm revealed: -The residents raised rabbits. -The residents fed the cats and the rabbits. -The residents would pet the cats. -The residents were not afraid of the animals. Interview with a second resident on 10/16/15 at 12:05 pm revealed: -The resident felt safe going outside onto porch. -The resident had not noticed any animals on the porch. Interview with a resident on 10/16/15 at 12:09 p.m. revealed: -The resident felt safe at the facility. -"I don't go outside too often." -The rabbits had been at the facility for one to two months. -"They tried to catch the rabbits." -The resident did not have a problem with the rabbits. Interview with the Administrator on 10/16/15 at 1:15 pm revealed:	D 072	Facility Administrator will communicate with residents and families (via mailed letters) regarding the importance of not bringing in animals to live at the facility without facility knowledge, this also included information on the pet therapy program guidelines, and the prohibition of feeding stray animals by the residents and family members. Administrator met with residents in small group setting to educate on the reason rabbits were removed, pet therapy program, and requested that they not feed stray animals. The Facility Administrator & Maintenance Director will conduct daily rounds for 30 days, then weekly to ensure that facility grounds continue to be maintained in a clean & safe condition.	11/13/15 11/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 072	Continued From page 2 -The rabbits had been at the facility prior to her working there. -They had family members that would catch the rabbits and take them away. -The residents were angry the rabbits were removed. -The corporate office was aware of the rabbits and the damage they caused by digging. -The corporate office was going to send someone to repair the courtyard by filling holes, leveling the ground and reinforcing the concrete slab.	D 072	Facility has completed an audit of currently occupied rooms to determine what repairs need to be completed. Facility Maintenance Director and Choice Health Management Senior Maintenance Director will perform all repairs including but not limited to repairing cracked tiles in resident rooms and in hallways, patching holes in resident rooms and bathrooms, painting in resident rooms, bathrooms, and hallways, repairing baseboards and caulking/repairing around base of the toilets.	11/30/15
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the walls and floors in the residents' bathrooms, rooms and in hallways were kept clean and in good repair. The findings are: Observation on 10/13/15 at 3:05 pm of resident room 242 revealed: -The bathroom floor was sticky. -There was a strong odor of urine. -There was a dried, brown ring on the floor around the toilet bowl which extended out approximately 1-2 inches. Observation on 10/13/15 at 3:15 pm of resident	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 074	Continued From page 3 room 236 revealed: -There was a dried, brown ring on the floor around the toilet bowl. -There was a large dried, yellow stain around the toilet bowl base. -There were dried, yellow spots located on the wall adjacent to the toilet. -There was a 5-inch by 3-inch rectangular hole in the wall under the bathroom sink. -There was peeling paint behind the sink faucet. Observation on 10/13/15 at 3:30 pm of resident bathroom 228 revealed: -There was rubber floor molding peeling away from the wall on 3 of 4 walls. -The toilet was leaking at the base. -A wrench was found beside the toilet drain pipe. Interview with the Maintenance Supervisor on 10/13/15 at 3:45 pm revealed: -He was working on the toilet in room 228. -He was unaware that there was a hole in the wall in the bathroom of room 236. -He speculated that the hole may have been a previous leak to be repaired. -He was going to patch the hole as soon as possible in room 236. -The facility had received an estimate for the walls to be painted in a few weeks. Interview with a resident on 10/15/15 at 8:50 am revealed: -The resident cleaned the bathroom. -The housekeeping staff does not clean the bathroom. -The housekeeping staff checked the bathrooms only. -The resident used soap from the wall dispenser and wiped down the sink and the toilet.	D 074	A tool has been developed to be used to record any needed repairs. This tool, "Maintenance Work Order," will be placed at nurse's station, housekeeping carts and special care unit. Facility staff has been in-serviced by the Administrator on the use of the Maintenance Work Order Form. In-service included the location of forms & timeliness of reporting any needed repairs. Facility Maintenance Director and/or Administrator will be conducting daily rounds Mon-Fri to ensure resident's rooms are in clean and good repair. If any issues are identified repairs will be completed as soon as possible. Choice Health Management Senior Maintenance Director conducted in-services with housekeepers, floor tech, and maintenance director on the use of floor care chemicals and how to properly clean residents rooms and bathrooms	11/20/15 11/16/15 11/17/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 074	Continued From page 4 Observation on 10/15/15 at 8:58 am revealed that the door to the bathroom in room 230 was locked. Interview with a resident in room 230 on 10/15/15 at 8:58 am revealed: -The room was cleaned every day. -Housekeeping scrubbed, mopped and dusted. -The bathroom door had been locked for 24 hours for the toilet to be repaired. -The resident went down the hall to the shower room to use the bathroom. Observation on 10/15/15 at 9:05 am of the 200 hallway fire doors between rooms 234 and 236 revealed unleveled cracked tiles with dried brown stains. Interview with Housekeeper on 10/15/15 at 9:20 am revealed: -The Maintenance Supervisor was her supervisor. -She cleaned every resident room daily. -There were two housekeepers everyday between the hours of 7am-5pm. -She dusted the bedroom. -She wiped the toilet and sink. -She mopped the floors in the bathroom and the bedroom. -The facility did not have a cleaning schedule. -There was no way to remove stains on floor tiles. Observation of bathroom shared between room #222 and #223 on 10/13/15 at 3:52 p.m. revealed: -Three baseboards, around the sink and the toilet were loosen from the walls and had dark brown stains. -The seal around the base of the toilet was stained, brown, and three tiles on the right side of the toilet toward the sink had dark brown stains. -The bathroom tile behind the toilet by the wall	D 074		
		D 074	Choice Health Management Senior Maintenance Director created a facility cleaning schedule and in-serviced housekeepers and facility maintenance director on how to use the schedule. Facility maintenance director will collect cleaning schedules daily to verify completion and review all explanations of variations (i.e. resident refusals, etc.). Administrator and facility maintenance director will review cleaning schedules at the morning meeting and follow-up with residents and families as needed.	11/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 074	Continued From page 5 was loosen, dirty and had dark brown stains. Observation of resident room #222 on 10/13/15 at 3:58 p.m. revealed: -One large, dark brown tile by the entrance door of the bedroom in the corner by the closet was broken. -Two tiles near the nightstand and bed were broken. Observation of the hallway, between the two double doors, by rooms #225 and #227 on 10/14/15 at 3:39 p.m. revealed six cracked tiles, which were across one side of the hall to the other side of the hall. Observation of the hallway by room #234 on 10/15/15 at 8:40 a.m. revealed the entire floor strip of the hallway had dark stains, was cracked, and had multiple chipped areas. Observation of the nurse's station across from the conference room on 10/15/15 at 8:43 a.m. revealed: -One large broken tile at the entrance of nurse ' s station. -The half wall around the nurse's station across from conference room had pealed paint. Review of the state building inspection report dated 6/29/15 revealed "paint all walls throughout building where paint is required." Observation of 22 resident bathrooms revealed each bathroom had an area of approximately 6" x 12" of unpainted bare brown-colored drywall with 2 wall anchors still in place in the unpainted area. Observation of resident's room 215 in the Special Care Unit at 1:35pm revealed a 6"x2" hole in the	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 074	Continued From page 6 far wall. Interview with Adminsitrator on 10/14/15 at 3:00pm revealed: -The facility had removed all older soap dispensers for a new soap dispensers approximately 8 months ago. -The dispenser removals caused the unpainted drywall areas on all walls in the rooms. -The state report had noted the same areas of paint need. -The facility had not painted the walls nor patched the holes where previous soap dispensers had been. -"We had put in a request to have the current dispensers replaced with yet another brand in the next few weeks." -"We had not painted the existing walls after the state report because we will be repainting again with the new soap dispensers." -She had the new dispensers for several months. -She did not have an explanation why the facility did not repaint the bare areas after the removal of the old dispensers 8 months ago. -She did not have a contract or time of arrival for the new soap dispensers. -The new dispensers would be here "in a few weeks." Interview with Maintenance Supervisor on 10/14/15 at 4:00pm revealed: -He was aware of the unpainted areas throughout the facility. -He learned sometime in September 2015 that the facility is changing the soap dispensers again in a few weeks. -He did not feel the need to paint the walls if they were going to replace the dispensers again. -He could not explain why the walls remained	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 074	Continued From page 7 unpainted for approximately 4 months prior to the September knowledge that the facility would be changing dispensers. -He does not know when the new dispensers will arrive. -The hole on room 215 hole was caused by a dresser anchor that was ripped from the wall. -The hole in room 215 is now repaired. -The hole in room 215 had been there two weeks.	D 074		
D 163	10A NCAC 13F .0504(c) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (c) Competency validation of staff, according to Paragraph (a) of this Rule, for the licensed health professional support tasks specified in Paragraph (a) of Rule .0903 of this Subchapter and the performance of these tasks is limited exclusively to these tasks except in those cases in which a physician acting under the authority of G.S. 131D-2(a1) certifies that non-licensed personnel can be competency validated to perform other tasks on a temporary basis to meet the resident's needs and prevent unnecessary relocation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure non-licensed staff were competency validated to apply a unna boot to a resident's foot and leg for 1 of 5 sampled residents (Resident #3). The findings are:	D 163	Residents will be evaluated by a RN for LHPS tasks within 30 days of admission and/or upon receiving orders for LHPS tasks. Any LHPS task that is not one of the 28 approved tasks will be referred to a licensed health professional, such as a home health agency. Administrator will conduct an audit to determine which current nursing home personnel have up-to-date LHPS Task competency validations. Any non-licensed staff without LHPS task competency validation will not be allowed to perform LHPS tasks until competency is validated by a RN or appropriate licensed professional	11/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 163	Continued From page 8 Review of Resident #3's current FL-2 dated 3/31/15 revealed: -Diagnoses included hypertension, hyperlipidemia, schizoaffective disorder, hypothyroidism, dementia, chronic kidney disease, anemia and renal disease. Review of the resident registry dated 4/3/15 revealed the date of admission was 4/3/15. Review of Resident #3's nurse's notes dated 9/21/15 at 2:45 pm revealed: -Resident #3 had swelling of right ankle and foot. -There was a large, weeping blistered area on top of the right foot. Review of Resident #3's nurses notes dated 9/21/15 at 5:00 pm revealed: -The Primary Care Physician wanted Resident #3 sent to the local emergency department (ED) for evaluation of right foot. Review of ED discharge instructions for Resident #3 dated 9/21/15 revealed: -The resident was to follow up with the local wound clinic and primary care physician within 2 days. Review of physician's order for Resident #3 dated 10/1/15 (no time) revealed: -Calcium alginate and unna boot to right dorsal foot. Change every 3-4 days. Call wound care as needed. Keep legs elevated during the day. -A Medication Aide (MA) signed for receiving the order at 11:50 am. -There was a signature from the primary care physician. Review of Resident #3's treatment record for October 2015 revealed:	D 163		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 163	Continued From page 9 -Calcium alginate and unna boot to the right dorsal foot. Change every 3-4 days. -Wound care was provided by MA on 10/5/15 at 10:00 am. -Wound care was provided by a second MA on 10/8/15 and 10/13/15 at 10:00 am. -The staff was to call wound care as needed. Observation of Resident #3 on 10/13/15 at 3:15 pm revealed there was a bandage on the right lower leg and foot. Interview with a MA on 10/14/15 at 11:00 am revealed: -Resident #3 was a diabetic. -She noticed the resident's right foot was swollen and was scaly. -The resident had a history of wounds on the resident's feet. -The wound was a small spot on the top of the resident's right foot. -Any MA could change the unna boot. -She had changed the unna boot on 10/5/15. -She was not taught at the facility. -She learned how to apply an unna boot by watching someone else. -She removed the old unna boot, washed the resident's leg and foot, cut the calcium alginate to fit the wound and applied the new unna boot. Interview with the Administrator on 10/14/15 at 12:00 pm revealed: -She was unaware of any skin issues with Resident #3. -She was unaware that Resident #3 had a bandage on the right leg and foot. -The Resident Care Coordinator (RCC) would know about any wound care Resident #3 had received.	D 163		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 163	Continued From page 10 Interview with the RCC on 10/14/15 at 12:20 pm revealed: -A Nurse Aide (NA) noticed Resident #3 had swelling of the right leg and reported it to her on 9/21/15. -She had noticed weeping fluid coming from the foot and faxed the primary care physician on 9/21/15 at 2:45 pm. -She obtained an order and the resident was sent to the ED for evaluation on 9/21/15 at 5:00 pm. -The ED had ordered the resident to follow up with the wound clinic and primary care physician. -The resident was seen by the wound clinic on 10/1/15. -The order for the unna boot was from the wound clinic. -The resident's primary care physician was made aware of the order. -She was unaware that a MA could not apply a unna boot. -There was no licensed nurse that performed wound treatments for the facility. -The facility has a registered nurse (RN) that completed the Licensed Health Professional Support. -The RN had instructed some classes (unknown). -There was a previous resident in the facility that had unna boots ordered and the staff had applied in the past. -The facility was previously a skilled nursing facility and changed over in July. -Home health was usually consulted to perform duties that required a licensed professional. -There was no training provided to staff for application of the unna boot. -She had only been the RCC for 6 weeks. Telephone interview on 10/14/15 with the Program Assistant at the Wound Clinic at 3:55 pm revealed:	D 163		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 163	Continued From page 11 -Resident #3 was seen there on 10/1/15. -She was given an order for calcium alginate and unna boot. -The primary care provider was to continue care of the wound. -She was to return to the wound clinic as needed. Telephone interview with Resident #3's primary care physician on 10/14/15 at 4:00 pm revealed: -He had been the resident's physician for approximately 10 years. -He was unaware the facility did not have licensed staff. -He was aware the facility recently changed from skilled nursing into only assisted living. -If the facility was unable to perform the wound care, he would have liked to have been notified so that other arrangements could have been made. -He would have ordered home health or had the resident continue to follow up with the wound clinic. -He was going to contact the facility immediately. -He was going to have the facility bring the resident tomorrow (10/15/15) so he could apply a new unna boot. -He was going to assess wound for any problems related to unna boot application at appointment on 10/15/15. Telephone interview with Resident #3's responsible party on 10/14/15 at 4:50 pm revealed: -She visited the facility every couple of days. -She was aware of Resident #3's wound. -She had gone with the resident to the wound clinic. -She was aware there was a treatment order for the resident's leg. -She had seen the MA apply the unna boot on	D 163		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 163	Continued From page 12 Resident #3. -She was unware the facility should not perform the wound care. -She would have wanted Resident #3 to have received home health to change wound dressing. Interview with Resident #3 on 10/14/15 at 5:30 pm revealed she was unable to verbalize why there was a bandage on her foot. Interview with Resident #3's responsible party on 10/15/15 at 12:30 pm revealed: -She had accompanied resident to primary care physician's office for appointment. -The primary care physician had written new orders for the resident's foot. -She had seen the resident's foot and said it had improved. Observation of Resident #3 on 10/15/15 at 12:30 pm revealed: -There was no bandage on the right foot. -There was a dark, circular area approximately 3 inches in diameter on the top of the resident's right foot. -The skin was intact. Review of physician's order dated 10/15/15 (no time) revealed: -Apply eucerin cream to the affected area on the residents right foot twice a day. -Follow up with primary care physician in 2 weeks. _____ Review of the facility's Plan of Protection dated 10/15/15 revealed: - No unlicensed staff will attend to the una boot treatment effective immediately. - All treatments shall be evaluated by the	D 163		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 163	Continued From page 13 Resident Care Coordinator (RCC) to determine the level of care required. - The skill sets of each staff member shall be evaluated for each treatment needed. - The RCC will see outside agency for treatment care if unable to be performed by facility staff. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2015.	D 163		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview and record review, the facility failed to contact the primary care physician for 2 of 5 sampled residents related to bruises and weight loss (#5) and labs not being done (#4). The Findings are: Review of Resident #5's current FL-2 dated 5/28/15 revealed the resident's diagnosis included dementia, osteopenia, osteoarthritis, glaucoma, and hemorrhoids. Review of the Resident Register revealed Resident #5 was admitted to the facility on 6/01/15.	D 273	RCD will be re-educated on the process for Med-Techs as it relates to MD orders, labs and incidents. An audit tool has been created for RCD to do a 24-hour follow-up on MD orders, lab results and incidents. RCD will do 24-hour follow-up, identify any errors, determine employee responsible for the error and re-educate or counsel that employee. Copies of the audit will be given to administrator daily. Med Tech staff will be in-serviced on incident reporting and what to do following an incident with a resident. Med Techs will have a clear understanding that they should immediately notify the RCD and the attending physician of any abnormalities with the resident's skin.	11/13/15 11/13/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 273	Continued From page 14 a. Observation on 10/13/15 at 3:30 p.m. revealed: -Resident #5 had two very large (three to four inch) dark red, bluish bruises on her right mid-calf and left inner leg areas. -Resident #5 could not state how the bruises occurred. Interview with the Medication Aide (MA) on 10/14/15 at 9:00 a.m. revealed: -She was not aware of the bruises on the resident's legs. -The resident always laid across the bed with the half rails down. Interview with a Nurse Aide (NA) on 10/14/15 at 12:40 p.m. revealed: -Resident #5 received baths twice per week on Tuesdays and Thursdays. -The NA had seen bruises for the past two days on Resident #5's legs but does not know what happened. -The NA worked with Resident #5 at least three times per week and the resident did not have bruises two days ago when she last worked with the resident. Interview with the second shift MA on 10/14/15 at 3:43 p.m. revealed Resident #5's bruises have been there a while. Interview with the Resident Care Coordinator (RCC) on 10/14/15 revealed: -The MA performed weekly skin checks and document the checks. -The RCC was not aware of Resident #5's bruises. -The RCC could not find documentation and was not sure if Resident #5's physician had been informed of the bruises.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 273	Continued From page 15 Review of Resident #5's "Weekly Skin Check" form revealed no skin issues, to include the code for bruises, was noted for the months of September 2015 through October 15th 2015 for Resident #5. b. Interview with a Nurse's Aide (NA) on 10/14/15 at 12:40 p.m. revealed: -Resident #5 had been losing weight in the past but has been gaining for the past couple of months. -The resident does not eat much at all. -The meals were brought to Resident #5's room. Interview with a Nurse's Aide (NA) on 10/14/15 at 12:40 p.m. revealed: -The NA reported the weight scale was brought to Resident #5's room because of behaviors/refusals. -The NA informed the MA and Resident Care Coordinator (RCC) of the resident's bruises eating less at mealtimes on two occasions a couple of months ago but was unsure of the dates. Observation of Resident #5 on 10/14/15 at 12:45 p.m. revealed: -Resident #5 was in her room lying crossways, in the middle of the bed, not eating the food on tray (less than 10% had been eaten). -Resident #5 was encouraged to eat by MA but began to yell and engaged in behaviors of yelling " leave me alone and I want to die. " Interview with the first shift MA on 10/14/15 at 1:15 p.m. revealed Resident #5 had eaten 10% or less of lunch meal on 10/14/15. Interview with the second shift MA on 10/14/15 at	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 273	Continued From page 16 3:43 p.m. revealed the MA was not aware of any weight loss or changes. Review of the Resident Weight form for July 2015 revealed the resident's weight was documented as 84.7 pounds. Review of the Resident Weight form for August 2015 revealed the resident's weight was documented as 76.3 pounds. Review of the Resident Weight form for September 2015 revealed the resident's weight was documented as 74 pounds. Review of the Resident Weight form for October 2015 revealed the resident's weight was documented as 74.2 pounds. Review of Resident #5's Resident Weight forms Revealed: -The resident had lost 8.4 pounds in one month from July 2015 to August 2015. -The resident had lost an additional 2.3 pounds from August 2015 to September 2015. The facility did not notify the resident's primary care physician of Resident #5's weight loss. Telephone interview with Resident #5's primary care physician on 10/15/15 at 9:02 a.m. revealed: -He had been Resident #5's primary care physician since June 2015. The resident had a diagnosis of dementia. -He was not aware that Resident #5 had lost weight and had bruises. He would have wanted to have known about the changes in the resident's status. -Resident #5's bruises could be related to the resident bumping into things and the decreased	D 273	Audit completed for all current residents to identify any significant weight loss/gain. Med Tech notified the physician of any current resident with a significant weight loss/gain and will notify the RP of any new instructions. Nursing staff will weigh new admissions upon admission, once weekly for a month and then monthly by the 5th of the month. Records of resident's weight will be maintained in the resident's medical record. RCD will do monthly weight audits checking for excessive weight loss/gain and will report any such changes to the resident's physician immediately. RCD and/or Med Tech will notify residents RP of any new orders given from the physician.	11/13/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 273	Continued From page 17 appetite could be a sign of increased dementia. Telephone interview with Resident #5's family member on 10/15/15 at 10:10 a.m. revealed: -The family member was not the resident's Responsible Party. -The resident had severe dementia and was declining. -The resident was not "moving around as much." -The resident preferred to stay in bed and be left alone. -When the resident was first admitted to the facility, the resident gained weight and then lost weight. -Resident #5 had never been a "big person." -Currently, the resident did not have any bruises on the skin. -The family member did not have a problem with the care of the resident at the facility. Resident #5's Responsible Party could not be reached by the end of the survey. 2. Review of Resident #4's current FL-2 dated 8/23/15 revealed: -The resident's diagnoses included cerebral vascular accident (CVA), high blood pressure and hyperlipidemia. -The resident was semi-ambulatory and used a walker. -There was nothing documented in the resident's orientation status. -There was an order for Coumadin 5 milligrams (mg) give 1 tablet by mouth at bedtime (Coumadin is a blood thinner used to help prevent or treat blood clots). Review of Resident #4's face sheet revealed: -The resident was admitted to the facility on	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 273	Continued From page 18 5/17/94, which was when the facility was a nursing home. -The resident was re-admitted to the facility on 6/30/04. Review of Resident #4's Care Plan dated 10/7/15 revealed: -The resident had a diagnosis of dementia. -The resident had an order for Coumadin 5 mg 1 tablet daily. Review of a fax cover sheet dated 6/26/15 from the facility to the resident's primary care physician revealed: -The lab company was unable to read the PT (Prothrombin time) ordered for Resident #5. "Would you like the lab to be re-ordered?" -The resident's primary care physician responded if resident was still on Warfarin, yes. Review of a physician's order dated 7/3/15 revealed an order to check PT/INR. (PT/INR are labs used to determine a person's blood clotting time. According to the National Institute of Health, the normal INR therapeutic ranges for individuals on Coumadin are from 2.0-3.0.) Review of a PT/INR lab results collected on 7/10/15 and report was dated 7/11/15 revealed: - The PT/INR results were 46.4/5.09. -There was a note in the comments section of the lab report which documented the lab company called the Administrator on 7/10/15 and reported the critical INR results of 5.09. - Resident #4's primary care physician signed the results and documented to hold warfarin and re-check PT/INR on Monday (7/20/15). -The date of 7/15/15 printed across the top of the faxed results.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 273	Continued From page 19 Review of the July 2015 Medication Administration Record revealed documentation that the facility did not administer the Coumadin on 7/16/15 through 7/19/15, but resumed administration on 7/20/15. Review of lab results in Resident #4's record revealed there were no PT/INR lab results in the resident ' s record for 7/20/15. Review of the consultant pharmacist's medication regimen review created between 9/1/15 and 9/2 15 revealed, "During this chart review, I cannot locate the INR lab results ordered on lab result dated 7/11/15 and the order to restart Coumadin after holding Coumadin on 7/10/15." Review of a physician's order dated 8/6/15 revealed an order to recheck PT/INR on one week. Review of lab results in Resident #4's record revealed: -There were no lab results in the resident's record for 7/20/15. -There were no lab results in the resident's record for 8/13/15. -There were no other lab results in the resident's record between 7/11/15 to 9/9/15. Telephone interview with a representative from the lab company on 10/15/15 at 6:11 p.m. revealed: -Resident #5 had PT/INR labs done on 9/9/15 and the results were 42.2/4.49, which was high. -Resident #5 had PT/INR labs done on 7/10/15 and the results were 46.4/5.09, which was high. -The labs on 7/10/15 and 9/9/15 were the only PT/INR labs on file for Resident #5. -The facility will contact the lab company when a	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 273	Continued From page 20 resident needs to have labs drawn. Interview with Resident #4 on 10/15/15 at 11:12 a.m. revealed: -"I have been living at the facility for the past 20 something years." -The resident took Coumadin daily. The resident had not had a problem with the Coumadin. Interview with a Medication Aide (MA) on 10/16/15 at 9:25 a.m. revealed: -Resident #4 was on Coumadin, because the resident had a history of a CVA. -She had not noticed any bruising on Resident #4. -The lab company came in on this morning and drew labs for Resident #4. -When the facility received the results of the labs, the MA faxed the results to the resident's primary care physician. -If the physician replies with an order, the order is transcribed on the MAR -If the physician does not reply, then they assume there are not any new orders. -She had not noticed a decline in the resident. Telephone interview with Resident #4's primary care physician on 10/16/15 at 9:30 a.m. revealed: -Resident #4 had been his patient for the past 10 years. -He does not keep the orders for the Coumadin on file. -The facility faxes him the lab, he writes the order and faxes the order back to the facility. -The PT/INR labs should be checked monthly. -He does not always receive the PT/INRs from the facility. -He does not write a new order unless he gets the results of the lab. -He was not aware the PT/INR was never	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 273	Continued From page 21	D 273		

checked as ordered on 7/15/15 and 8/6/15. He would have wanted to have known the labs were never drawn.
-The normal INR range for someone on Coumadin is from 2.0-3.0. Resident #4's average is 5.0.

Interview with the RCC on 10/16/15 at 10:06 a.m. revealed:
-Resident #4 was currently on Coumadin.
-The last PT/INR lab was done on this morning (10/16/15).
-She faxed the request to Resident #4's primary care physician for clarification after she received the pharmacy review recommendations.
-There was no system for checking orders.
-She had developed a check off sheet (between 10/13-10/16/15).
-When the facility received the labs results from the lab company, the results are faxed to the resident's primary care physician. Then the primary care physician faxed back an order.

Interview with the Administrator on 10/16/15 at 10:41 a.m. revealed:
-The RCC informed her of the concern with Resident #4's Coumadin and PT/INR lab on 10/15/15.
-If a resident had an order for PT/INR, the lab should be taken as ordered by the resident's physician.
-When the facility received the labs results from the lab company, the results are faxed to the resident's primary care physician. Then the primary care physician fax back an order if needed.
-Staff should contact the primary care physician if no order is received.
-In the beginning of the month, orders should be checked on the MAR to make sure staff are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 273	Continued From page 22 following the physician's orders. -She will revise a system for making sure Coumadin labs are done and to make sure staff is administering Coumadin as ordered by the physician. Telephone interview with Resident #4's Responsible Party on 10/16/15 at 11:36 a.m. revealed the resident takes Coumadin daily and there had not been any problems with the resident receiving Coumadin. The prior RCC could not be reached by the end of the survey. The facility submitted a Plan of Protection dated 10/16/15 which revealed: -Immediately, all of the resident's charts will be reviewed by the Administrator and the Resident Care Coordinator (RCC) to make sure the physicians ' orders are being followed. -The resident's primary care physician will be contacted, if an order is not being followed. -The RCC will review orders Monday through Friday. -The Administrator will review orders daily to make sure the resident's primary care physician had been contacted. -The Administrator will review the 24 hour reports to determine if the resident had a change in condition. -The resident's physician will be contacted immediately if the resident had a change in condition. -The Medication Aides (MAs) will be inserviced on proper documentation on the MARs and 24 hour reports. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 273	Continued From page 23 15, 2015.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a matching therapeutic diet menu for 4 of 8 sampled residents (#1,#3,#6,#7) with diet orders for a no added salt (NAS)/ no concentrated sweets (NCS) diets and NCS diets. The findings are: 1. Review of Resident #3's FL-2 dated 3/31/15 revealed: -The resident's diagnoses included hypertension, hyperlipidemia, schizoaffective disorder, hypothyroidism, chronic kidney disease, dementia, anemia and renal disease. -Resident #3 was admitted on 4/3/15. -The diet ordered was a pureed NCS diet. Review of facility diet list (no date) revealed Resident #3 was listed to receive a NCS diet. Review of residents weekly cycle 1 menu for 10/14/15 revealed there was no menu for the NCS diet. Observation of the breakfast meal on 10/14/15	D 296	The facility has identified 6 diets the facility will offer (Regular, Low Concentrated Sweets, Regular, No Added Salt, Mechanical Soft, and Puree Dysphagia Diet). RCD to contact all resident's physician's to have diet order form completed and sent back to facility. Administrator to conduct a 100% audit to ensure that resident's diet order forms are on the resident's medical record. RCD is responsible for ensuring that resident's diet order form is completed upon admission and communicated to dietary department.	11/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 296	Continued From page 24 from 8:20 am to 8:45 am revealed the following: -Resident #3 at 8:20 am was served a 6 oz cup of orange juice, 8 oz cup of coffee, 8 oz cup of milk, ½ cup of scrambled eggs, ½ cup of oatmeal, ½ cup pureed sausage and a sugar substitute. At 8:45 am, the resident had consumed all food and beverages. Telephone interview with Residents #3's primary care physician on 10/15/15 at 4:36 pm revealed the office did not keep a copy of the resident's diet orders. 2. Review of Resident #6's current FL-2 dated 3/16/15 revealed: -The resident's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, hypertension, senile dementia, cardiomyopathy and cholelithiasis. -The resident was admitted on 3/17/98. -The diet ordered was NAS and NCS diets, with low fat and low cholesterol with fruit for dessert. Review of facility diet list (no date) revealed Resident #6 was listed to receive a NAS and NCS diet. Review of residents weekly cycle 1 menu for 10/14/15 revealed there was no menu for the NCS diet. Observation of the breakfast meal on 10/14/15 from 8:20 am to 8:45 am revealed the following: -Resident #6 at 8:25 am was served a 6 oz cup of orange juice, 8 oz cup of coffee, 8 oz cup of milk, ½ cup of scrambled eggs, ½ cup of oatmeal, 1 slice of toast, 1 slice of bacon, a salt substitute packet, a sugar substitute packet and packet of grape jelly. At 8:35 am, the resident had eaten ½	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 296	Continued From page 25 of the oatmeal, ½ of the eggs, all of bacon, toast, jelly and beverages. Review of a subsequent physician's order for Resident #6 dated 10/14/15 revealed: -There was an order to discontinue the NCS diet. -The resident's diet was changed to a NAS diet. Refer to telephone interview with primary physician on 10/14/15 at 4:15 pm. Refer to interview with the Dietary Manager on 10/14/15 at 8:45 am and 3:00 pm. Refer to interviews with the Cook on 10/14/15 at 8:50 am and 12:00 pm. Refer to interview with the Resident Care Coordinator on 10/14/15 at 10:45 am. Refer to the interviews with the administrator on 10/ 14/15 at 11:50 am and 3:10 pm. 3. Review of Resident #7's FL-2 dated 4/7/15 revealed: -The resident's diagnoses included diabetes mellitus type 2, obesity, atrioventricular septal defect, hypertensive cardiovascular disease, anemia, schizophrenia, mild parkinson's and chronic psychosis with anxiety. -The resident was admitted on 12/8/00. -The diet ordered was low fat and reduced concentrated sweets (RCS). Review of residents weekly cycle 1 menu for 10/14/15 revealed there was no menu for the NCS diet. Observation of the lunch meal on 10/14/15 from	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 296	Continued From page 26 12:30 pm to 1:15 pm revealed the following: -Resident #7 at 12:45 pm was served an 8 oz cup of unsweet tea, 8 oz cup of water, 4 oz slice of meatloaf, ½ cup of cabbage, ½ cup of cheesy noodles, 1 dinner roll, ½ cup of low sugar peach cobbler, a salt and sugar substitute. At 12:55 pm resident had eaten all of the meatloaf and cobbler and drank all tea and water. The resident did not eat noodles or cabbage. The resident stated, "I had enough to eat". Review of a subsequent physician's order for Resdient #7 dated 10/14/15 revealed: -There was an order to discontinue the NAS diet. -The resident's diet was changed to a NCS diet. Refer to telephone interview with primary physician on 10/14/15 at 4:15 pm. Refer to interview with the Dietary Manager on 10/14/15 at 8:45 am and 3:00 pm. Refer to interviews with the Cook on 10/14/15 at 8:50 am and 12:00 pm. Refer to interview with the Resident Care Coordinator on 10/14/15 at 10:45 am. Refer to the interviews with the administrator on 10/ 14/15 at 11:50 am and 3:10 pm. Telephone interview with Residents #6 and #7's primary care physician on 10/14/15 at 4:15 pm revealed: -He was aware the residents did not receive the diets as he had ordered. -He was informed today (10/14/15) that facility could not provide the diet he had previously	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 296	Continued From page 27 ordered. -He did not feel any harm was caused to the residents by receiving the incorrect diet. -If facility could not provide diet as ordered, he would have liked to have been notified sooner. Interview with Dietary Manager on 10/14/15 at 8:45 am revealed: -The diets served to the residents are listed on the menu. -She helped update the diet list. -She was not sure when the diet list was last updated. -If the diet was a combination of a NCS and a NAS diet, staff would make the NCS diet a priority and substitute sugar with a sugar substitute. Interview with the Cook on 10/14/15 at 8:50 am revealed a NCS and NAS combination diet would be given the regular meal with a sugar and salt substitute. Interview with Resident Care Coordinator (RCC) on 10/14/15 at 10:45 am revealed: -She was not aware the menu and the diet order must match. -She was unsure how the meals were prepared. -She was unsure who made the diet list. -She was not sure when the diet list was last updated. -She was going to contact the resident's physician's to obtain clarification of diet orders. Interview with the Administrator on 10/14/15 at 11:50 am revealed: -The information on the diet list was generated by a physician's order. -She was updating the diet list today (10/14/15). -She was unsure of when the diet list was last updated.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 296	Continued From page 28 -A NCS diet would have priority over the NAS diet if there was a combination diet ordered. -The Dietary Manager was responsible for training staff that worked in the kitchen. Interview with Cook on 10/14/15 at 12:00 pm revealed: -If the diet was a NCS and NAS combination diet, staff would "pay more attention to NCS diet". -They used the low concentrated sweets diet (LCS) in place of the NCS diet. -A combination of NCS and NAS diets had always followed the LCS diet on menu guide report. -The Dietary Manager trained staff on how to prepare diets. Interview with the Dietary Manager on 10/14/15 at 3:00 pm revealed: -The peach cobbler served at lunch on 10/14/15 was low sugar. -Staff were following the LCS diet if the physician's order was for NCS. -They had been using the LCS diet for the NCS diet as long as she could remember. -She was unaware the physician's order had to match one of the diets listed on menu guide report. -She thought the LCS diet could be substituted for the NCS diet. Interview with Administrator on 10/14/15 at 3:10 pm revealed: -The facility would implement a new diet order sheet that would be sent to all physicians to clarify diet orders. -She was unaware that the new diet order sheet contained a diet that was not on the menu guide report. -She would change NCS diet on physician's order sheet to LCS diet to match the menu guide	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 296	Continued From page 29 report.	D 296		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure documentation of the administration of medications (Prilosec and Coumadin) for 2 of 5 sampled residents (#5, #4). The Findings are: 1. Review of Resident #5's current FL-2 dated 5/28/15 revealed: -The resident's diagnosis included dementia, osteopenia, osteoarthritis, glaucoma, and hemorrhoids. -There was an order for Prilosec one tab by mouth daily for 30 days (Prilosec is used to treat acid reflux). Review of the Resident's Register revealed Resident #5 was admitted to the facility on 6/01/15. Review of Resident #5 physician's orders	D 366	Med Techs will be in-serviced by the RCD and Administrator on proper documentation on the MAR and TAR. Med Techs are to initial the MAR/TAR indicating that the medication was given. Med Techs are to document and notify resident's physician of medication refusals and adverse effects from medications. RCD will conduct weekly audits to ensure Med Techs are correctly documenting on the MAR/TAR. If any errors are identified, RCD will identify, re-educate and/or counsel the Med Tech.	11/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 366	Continued From page 30 revealed a current order dated 10/07/15 for Prilosec one 20 mg tab by mouth daily. Review of Resident #5's August 2015 Medication Administration Record (MAR) revealed: -Prilosec 20 mg give one tab by mouth daily was transcribed on the MAR. -Prilosec was documented as administered from 8/01/15 - 8/31/15. Review of Resident #5's September 2015 MAR revealed: -Prilosec 20 mg give one tab by mouth daily was transcribed on the MAR. -Prilosec had not been documented as administered and/or initialed by staff as given on 9/16/15 - 9/24/15, 9/27/15 - 9/28/15, and 10/13/15. (The spaces on MAR were left blank). -Prilosec was noted on MAR as discontinued on 5/28/15 after 30 days. -Prilosec was documented as administered to the resident from 9/01/15 - 9/15/15 and from 9/29/15 - 9/30/15. Review of Resident #5's October 2015 MAR revealed: -Prilosec 20 mg give one tab by mouth daily was transcribed. -Prilosec was documented as administered 10/01/15 - 10/12/15 and 10/14/15 - 10/15/15. -Prilosec was not documented as administered on 10/13/15. Interview with a Medication Aide (MA) on 10/14/15 at 7:53 a.m. revealed: -When medications are given to residents, staff administering the medication are to initial on the MAR that the medication was given and comment on the back of the MAR when not given and why. -The MA was not aware that Resident #5 had	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 366	Continued From page 31 blank spaces without initials or comments on the MAR for Prilosec. -No adverse effects or change in status resulted for Resident #5 not being given the Prilosec. Interview with a second MA on 10/15/15 at 2:46 p.m. revealed: -The MA was unaware that the MAR for Resident #5 had blank spaces and no initials or comments. -Blank spaces on the MAR indicate that a resident did not receive the medication or that the staff forgot to initial. -The staff are to document on the MAR medications given or not given with comments for all residents during medication administration. -No adverse effects or issues with acid reflux resulted for Resident #5 not receiving Prilosec on the dates indicated for September 2015 dates and October 2015 date. Interview with Resident Care Coordinator (RCC) on 10/14/15 at 4:16 p.m. revealed: -Staff are to initial and/or put comments on back of MAR. -There were no staff initials or signatures with comments on the back of MAR for Resident #5. -The RCC was not aware that staff were not documenting their initials or commenting on the back of MAR for the resident. -The RCC had worked at the facility for six weeks and was in the process of reviewing records and correcting them. Interview with the Administrator on 10/14/15 at 4:45 p.m. revealed: -The Administrator was unaware of the process of documenting medications on the MAR by staff but staff should be documenting medication administration for all residents. -The Administrator was not informed that	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 366	Continued From page 32 Resident #5 had blank spaces on her MAR and no initials or comments were noted on the back of the MAR for this resident. -The Administrator will review the documentation process of the MAR with the RCC to ensure that the staff initial the MAR and comment on the back of the MAR as needed for all residents. Telephone interview with Resident #5's primary care physician on 10/15/15 at 9:02 a.m. revealed: -He had been Resident #5's primary care physician since June 2015. The resident had a diagnoses of dementia. -He does not know the resident's current order for Prilosec, because he did not have the resident's chart in front of him. -He was not aware the resident had not received Prilosec from 9/16-9/24/15, 9/27-9/28/15 and on 10/13/15 and he would have wanted to have known. Telephone interview with the pharmacy technician from a local pharmacy on 10/15/15 at 9:35 a.m. revealed: -The pharmacy only had one prescription on file for Prilosec 20 mg give one tablet by mouth daily dated 9/24/15 for Resident #5. -The only time the prescription was filled was on 9/24/15 and 100 capsules were dispensed. -There was another local "sister" pharmacy (gave name) who also filled Resident #5's prescriptions. Telephone interview with a Pharmacist from the other local pharmacy on 10/15/15 at 9:50 a.m. revealed Resident #5 was not file as one of their clients. Telephone interview with Resident #5's family member on 10/15/15 at 10:10 a.m. revealed: -The resident had severe dementia and was	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 366	Continued From page 33 declining. -Another family member, who was the resident's Responsible Party, was responsible for the resident's medications. -The resident had used the Prilosec, because the resident had acid reflux. -The family member did not have any concerns with the resident receiving Prilosec. -The family member did not have a problem with the care of the resident at the facility. Resident #5's Responsible Party could not be reached by the end of the survey. 2. Review of Resident #4's current FL-2 dated 8/23/15 revealed: -The resident's diagnoses included cerebral vascular accident (CVA), high blood pressure and hyperlipidemia. -The resident was semi-ambulatory and used a walker. -There was nothing documented in the resident's orientation status. -There was an order for Coumadin 5 milligrams (mg) give 1 tablet by mouth at bedtime (a blood thinner used to help prevent or treat blood clots). Resident #4's face sheet revealed: -The resident was admitted to the facility on 5/17/94, which was when the facility was a nursing home. -The resident was re-admitted to the facility on 6/30/04. Review of Resident #4's Care Plan dated 10/7/15 revealed: -The resident had a diagnosis of dementia. -The resident had an order for Coumadin 5 mg 1 tablet daily.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 366	Continued From page 34 Review of Resident #4's record revealed: -There was a cover sheet dated 6/26/15. The top of the sheet was a fax number dated 6/30/15. The sheet included an order for Coumadin 5 mg. The order was not dated. -There was an order dated 8/6/15 for Coumadin 5 mg at bedtime. -There was an order dated 8/25/15 for Coumadin 5 mg take one tablet at bedtime. -There was a current order on a fax sheet dated 9/3/15 signed, but not dated, by the resident's primary care physician to resume Coumadin 5 mg daily at night. Review of Resident #4's July 2015 Medication Administration Record (MAR) revealed: -Coumadin 5 mg give 1 tablet at bedtime (5:00 p.m.) for CVA was transcribed on the MAR. -The resident was administered Coumadin from 7/1-7/15/15 and from 7/20-7/30/15. -A Medication Aides (MAs) initial was circled on the MAR on 7/11/15, -"Hold until Monday" was hand written on the MAR from the dates 7/16-7/19/15. -No Coumadin was administered to the resident from 7/16-7/19/15. -Nothing was documented on the back of the MAR to indicate if the resident received Coumadin on 7/11/15. Review of Resident #4's August 2015 2015 MAR revealed: -Coumadin 5 mg give 1 tablet in the evening (5:00 p.m.) for CVA was transcribed on the MAR. -The resident was administered Coumadin from 8/1-8/21/15 and from 8/27-8/30/15. -There was no documentation the resident was administered Coumadin from 8/22-8/25/15. -On 8/9/15 and 8/26/15 the MAs initials were circled.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 366	Continued From page 35 -There was no documentation on the MAR to why Coumadin had not been documented as administered from 8/22-8/25/15 and to why staff had circled their initials on 8/9/15 and 8/26/15. Review of Resident #4's September 2015 MAR revealed: -Coumadin 5 mg give 1 tablet at bedtime (5:00 p.m.) for CVA was transcribed on the MAR. -Coumadin 5 mg was administered from September 1-30, 2015 Review of Resident #4's October 2015 MAR revealed: -Coumadin 5 mg give 1 tablet at bedtime (5:00 p.m.) for CVA was transcribed on the MAR. -Coumadin was administered from October 1-15, 2015. -From 10/10-10/11/15, the MAs initials were circled. -There was no documentation on the MAR to why Coumadin had not been documented as being administered from 10/10-10/11/15 and to why staff had circled their initials. Review of the medication label revealed Coumadin 5 mg 1 tablet by mouth daily at night. Interview with a MA on 10/14/15 at 7:53 a.m. revealed: -Staff administering the medications should initial on the MAR the medication was given and comment on the back of the MAR if the medication was not given and why. Interview with a second MA on 10/15/15 at 2:46 p.m. revealed: -Blank spaces on the MAR indicate a resident did not receive the medication or staff forgot to initial. -The staff should document on the MAR if the	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 366	Continued From page 36 medications were given or not given. Interview with the Resident Care Coordinator (RCC) on 10/14/15 at 4:25 p.m. revealed: -She had been the RCC at the facility for 6 weeks. -She was not aware staff had not been initialing on the MARs or commenting on the back of the MARs, if a medication had not been given. -She was in the process of checking the documentation by the MAs on the MARs. Interview with Resident #4 on 10/15/15 at 11:12 a.m. revealed: -"I have been living at the facility for the past 20 something years." -The resident took Coumadin daily. The resident had not had a problem with the Coumadin. Interview with the RCC on 10/16/15 at 10:06 a.m. revealed: -Resident #4 was currently on Coumadin. -There was no system for checking orders. -She did not know why staff circled their initial on 7/11/15, 8/22-8/25/15, 8/9/15, 8/26/15 and 10/10-10/11/15 for Coumadin. Interview with the Administrator on 10/16/15 at 10:41 a.m. revealed: -The RCC informed her of the concern with Resident #4's Coumadin on 10/15/15. -Her expectation is for staff to administer Coumadin as ordered and document the administration on the MAR. -In the beginning of the month, orders should be checked on the MAR to make sure staff are following the physician's orders. -The prior RCC would have been responsible for making sure the Coumadin order was transcribed on the MAR and staff documented the	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D 366	Continued From page 37 administration correctly in the MAR. Telephone interview with Resident #4's Responsible Party on 10/16/15 at 11:36 a.m. revealed the resident takes Coumadin daily and there had not been any problems with the resident receiving Coumadin. The prior RCC could not be reached by the end of the survey.	D 366		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to staff competency validation and referral and follow-up. The findings are: 1. Based on observation, interview and record review, the facility failed to assure non-licensed staff were competency validated to apply a unna boot to a resident's foot and leg for 1 of 5 sampled residents (Resident #3). [Refer to Tag D0163, 10A NCAC 13F .0504(c). (Type B Violation)].	D912	The RN will audit the non-licensed staff for competency validation records of the LHPS task by November 30. Any non-licensed staff that has not been validated will not be allowed to perform the LHPS task until competency is validated by a RN or appropriate licensed professional is completed. All Med Techs have been in-serviced on labs (i.e. how to request them, lab follow-up, and faxing lab results to physician, etc). Med Tech staff has been in-serviced on incident reporting and what to do following an incident with a resident. Med Techs now have a clear understanding that they should immediately notify the RCD and the attending physician of any abnormalities with the resident's skin.	11/30/15 11/13/15 11/13/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064028	A. BUILDING: _____ B. WING _____	10/16/2015

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) COMPLETE DATE
D912	Continued From page 38 2. Based on observation, interview and record review, the facility failed to contact the primary care physician for 2 of 5 sampled residents related to bruises and weight loss (#5) and labs not being done (#4). [Refer to Tag D273, 10A NCAC 13F .0902(b). (Type A2 Violation)].	D912	Audit has been done on current resident weights (11/13/15) to determine significant weight loss/gain. Nursing staff will be in-serviced on the new procedure for weighing residents, as well as reporting and documenting any changes in appetite immediately. Procedure as follows: Nursing staff will weigh new admissions upon admission, once weekly for a month, and then monthly. Current residents will be weighed monthly by the 5th of the month. Records of the resident's weight will be maintained in the resident's medical record. RCD will do monthly weight audits checking for excessive weight loss/gain and will report any such changes to the resident's physician immediately. Nursing staff will notify resident's RP of any new orders given from the physician.	11/30/15

Addendum to UHC Nashville's POC

December 9, 2015

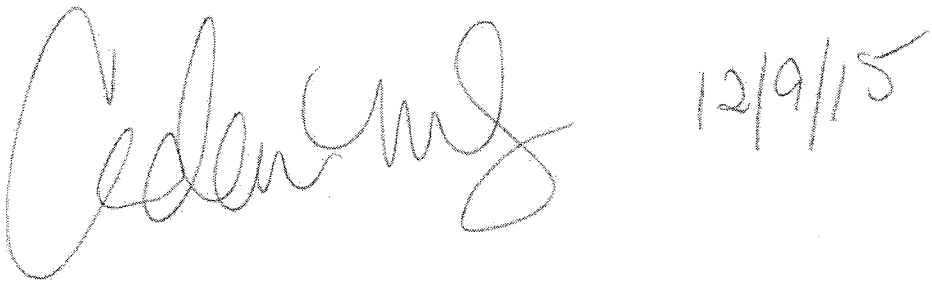
1. LHPS Competencies: What process has been put in place to ensure staff is validated on tasks outside of the 28 established LHPS tasks?
    a. When the staff receives an order for a task that is not one of the approved 28 LHPS tasks, the staff will have the resident's physician fill out the form that gives non-licensed staff permission to perform that task. Once that permission is received the RN will in-service and validate the competency of the staff to perform the task. Until the competencies have been validated for the task, the staff will contact home health to come in and perform the tasks so that the resident does not go untreated. The RCC and Administrator will monitor the staff competency validations
2. Weight Loss/Weight Gain:
    a. Residents are weighed monthly, unless the physician has ordered weekly weights. The RCC monitors weight loss/gain by using the audit tool established. The RCC and Dietary Manager will compare the previous month's weight with the current month's weight to determine if there has been significant weight loss/gain. Significant is described as 5% or more of weight loss/gain in a month. If it is determined that there is significant weight loss/gain the resident's physician will be notified. The nursing staff will implement any new recommendations/orders from the physician and document these changes in the resident's medical record
3. Lab Process: What is the process for lab follow-up?
    a. The process for abnormal labs is as follows:
        i. The med tech receiving the lab results will review the results for values marked abnormal/ high/low and telephone the physician regarding the critical results and follow up with faxing the results
        ii. Mark lab sheet as "faxed" with date and initials
        iii. A copy of the results will be given to the RCC and the original will be placed on the medical record.
        iv. The med tech will document in nurses notes.
        v. When MD responds with follow-up orders, the med tech receiving the orders will process them accordingly.
    b. Process for normal lab results:
        i. Review the lab results for values within normal range and fax results to MD
        ii. Mark lab sheet as "faxed" with date and initials
        iii. Place a copy of results in the RCC box and place originals on the medical record
        iv. Document in nurses notes
        v. When MD responds with follow-up orders, the med tech receiving orders will process accordingly

approved
12/16/15

c. Note: if no response has been received from the resident's physician within 24 hours, staff will refax the lab results and follow up with a telephone call.

4. Vital Signs: What is the process for vital signs and who is responsible for monitoring vital signs?
   a. Vital signs are taken monthly, unless otherwise requested by the resident's physician. Vital signs are reviewed by the RCC and documented on the residents medical record by the med tech
5. Nutrition and Food Service: What is the process for follow-up if a resident's diet has been changed?
   a. When the med tech receives an order for a diet change the med tech will process that order following the Physician's Order procedure:
      i. Transcribe the order on the current month's MAR
      ii. Fax the order to pharmacy
      iii. Place a copy of the order in the RCC box
      iv. Place the original order in the residents medical record
      v. Notify the resident's RP
      vi. Document in the resident's medical record
   b. RCC will be responsible for ensuring that the dietary staff is notified about the change in diet. Dietary Manager will update the diet order list and the RCC will review for accuracy.
6. Medication Administration- Please clarify the process for medication administration as it relates to refusals and adverse reactions
   a. The med techs will follow the general procedures for medication administration. Med techs will monitor residents for adverse reactions to medications. Physician will be notified of all adverse reactions to medications. Physician will be notified of patterns of medication refusals for OTC/Stock medications and notified as soon as possible, per shift, for any refusals of scheduled medications. All adverse reactions and medication refusals will be documented on the residents MAR or TAR.

**Facility has implemented a weekly Standards of Care meeting where resident's wounds, weights, labs and falls are discussed.



12/9/15