STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345522	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 3/16/2012
NAME OF PROVIDER OR SUPPLIER: UNIVERSAL HEALTH CARE/FLETCHER	STREET ADDRESS, CITY, STATE, ZIP CODE: 86 OLD AIRPORT ROAD FLETCHER, NC		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record reviews the facility failed to develop a comprehensive plan of care for two (2) of twelve (12) sampled residents. (Residents #17 and #115)

The findings are:

1. Resident #17 was readmitted to the facility on 07/29/11 with diagnoses that included; muscle weakness, psychosis, depressive disorder, osteoporosis and altered mental status. Review of Resident #17's physician orders revealed a 07/29/11 order for the administration of Risperdal (an antipsychotic medication) twice a day. Further review of the resident's physician's orders and Medication Administration Records (MARs) revealed the continued use antipsychotic medications from 07/29/11 to 03/15/12.

Review of Resident #17's Minimum Data Set (MDS) assessments of 07/29/11 revealed she was assessed as receiving antipsychotic medications.

Review of Resident #17's Care Area Assessment (CAA) Summary of 07/29/11 revealed the resident required the use of antipsychotic medications based on the her diagnoses and behaviors. The information on the resident's "Psychotropic Drug Use" CAA specified that staff would develop a care plan to monitor the side effects and effectiveness of the resident's medications.

Review of Resident #17's care plans since her readmission to the facility on 07/29/11, revealed staff did not develop a care plan to address the resident's use of antipsychotic medications.

On 03/16/12 at 10:40 AM an interview was conducted with the facility's Minimum Data Set (MDS) Coordinator. The MDS Coordinator confirmed that a plan of care was not developed to address Resident #17's use of psychotropic medications since her readmission to the facility on 07/29/11. The MDS Coordinator stated that the resident's behaviors and use of antipsychotic medications were being closely

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monitored by staff, but a care plan to address the use of antipsychotic medications was not developed.

2. Resident #115 was admitted to the facility on 11/14/11 with diagnoses which included; difficulty walking, muscle weakness and altered mental status. The resident's Minimum Data Set (MDS) assessments completed on 12/13/11 and 03/08/12 specified the resident received antidepressant medications.

Review of Resident #115's physician orders and Medication Administration Records (MAR) revealed the continued use of antidepressant medications since his admission to the facility on 11/14/11.

Review of Resident #115's Care Area Assessment (CAA) Summary of 12/13/11 specified the resident received antidepressant medication and the area of Psychotropic Drug Use was "triggered" for further review. The CAA further specified that a care plan would be developed to monitor side effects and effectiveness of the resident's medications.

Review of Resident #115's care plans since admission to the facility on 11/14/11 revealed staff had not developed a care plan to address the resident's use of antidepressant medications.

On 03/16/12 at 10:40 AM an Interview was conducted with the facility's MDS Coordinator. The MDS Coordinator stated that Resident #115 had remained on antidepressant medication since admission to the facility on 11/14/11, but staff did not develop a care plan that addressed the use of antidepressant medications as specified on the resident's 12/13/11 CAA. The MDS Coordinator stated the resident's behaviors and use of antidepressant medications were being closely monitored by staff, but a care plan was not developed.

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F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to conduct a significant change assessment to address the decline in condition for one (1) of three (3) sampled residents. (Resident #17) The findings are: Resident #17 was readmitted to the facility on 07/29/11 with diagnoses that included; muscle weakness, psychosis, depressive disorder, osteoporosis and altered mental status. Review of Resident #17's Quarterly Minimum Data Set (MDS) assessment of 10/22/11 revealed she required only set up help with locomotion on and off the unit, only required set up help with eating, did not reject care and had no	F 274	Resident #17 has a significant change assment with an ARD of 3-29-12. All residents have the potential to be affected by the same alleged deficient practice if not assessed correctly; therefore, all current active resident MDSs for the last 3 months were reviewed to determine if a significant change assessment was needed. The MDS nurse was inserviced on 3-29-12 with regard to significant change in status assessments by the Regional MDS Nurse. Measures to ensure the alleged deficient practice does not recur include: TheMDS nurse and other administrative nurses	4-13-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joe Robinson — TITLE: Administrator — (X6) DATE: 4-5-12

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 274	Continued From page 1 skin ulcers present. Review of Resident #17's Quarterly MDS assessment of 01/13/12 revealed she had experienced a decline in her condition since her 10/22/11 MDS assessment. The resident's 01/13/12 MDS assessment specified that she required extensive assistance with locomotion on and off the unit, extensive assistance with eating, rejected care every one to three days and had two venous/arterial ulcers present. Observations on 03/15/12 at 2:20 PM revealed Resident #17 was seated in a wheel chair in her room and was requesting staff assistance. Staff was observed to enter the resident's room to provide care. On 03/16/12 at 9:10 AM Nursing Assistant (NA) #1, who regularly provided care for Resident #17, was interviewed. NA #1 stated that Resident #17 had experienced declines in physical condition and now required total assistance with most Activities of Daily Living (ADLs) including locomotion on and off the unit. NA #1 further stated that Resident #17 did refuse restorative ambulation on a daily basis. On 03/16/12 at 10:15 AM the facility's MDS Coordinator was Interviewed. The MDS Coordinator reviewed Resident #17's previous MDS assessments and confirmed that between 10/22/11 and 01/13/12 the resident had declined in the ADL areas of locomotion and eating, behaviors and had newly developed skin ulcers. The MDS Coordinator specified that as of 03/16/12 Resident #17 continued to require extensive to total dependence with ADLs	F 274	will evaluate and compare the current MDS to the previous MDS to determine if a significant change has occurred by evaluating section responses. MDS nurse and other designated administrative nurses will also review daily nursing 24 hour clinical reports at the daily clinical meeting to determine if a significant change is a potential. Weekly audit of MDS response evaluations will be conducted by the MDS nurse and other designated administrative nurses. Ten random audits will be done per week. If a significant change has occurred, the resident will be scheduled for a significant change assessment. Audits will be done weekly X4 weeks, and then monthly for 3 months. Results will be presented at the weekly Survey Compliance committee meeting for one month and then monthly at the QA	4-13-12

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F 274	Continued From page 2 (including locomotion), rejected care on a daily basis and had stasis ulcers on her left outer ankle. The MDS Coordinator confirmed that a significant change MDS assessment for Resident #17 should have been completed due to her declines in condition from 10/22/11 to 01/13/12.	F 274	meeting for 3 months. If sustainability has been achieved, then the POC will be discontinued. If not, appropriate changes will be made and the monitors will be continued.	4-13-12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews facility staff failed to verify placement of a gastrostomy tube (G-tube) prior to administering medications through the gastrostomy tube for one (1) of one (1) residents observing during medication administration. (Resident #35). The findings are: The facility's policy for administering medications via enteral tube, revised November 2011, specified: To safely and accurately administer oral medication through an enteral tube: Verify tube placement: unclamp the tube and use either of the following procedures: 1) insert a small amount of air into the tube with the syringe and listen to stomach with stethoscope for gurgling sounds; or 1) aspirate stomach contents with syringe. Resident # 35 had diagnoses which included cerebrovascular accident with dysphagia.	F 281	Resident #35 is having PEG placement checked prior to all medication administration. There are no other residents in the facility at this time with a a PEG tube so no one else was affected. LN #1 was inserviced on proper placement check of PEG tube prior to administering medications by the ADON on 3-15-12.	

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F 281	Continued From page 3 Review of the March 2012 Physician Orders revealed orders for all medications to be administered crushed via G-tube and to flush with 75 cc (cubic centimeters) water after medication administration. Observation of medication administration on 03/15/12 at 10:20 AM revealed Licensed Nurse (LN) #1 placed the following medications in a med cup: Celexa 20mg (milligrams), Aspirin 81mg, Lisinopril 5mg, Tambocor 50mg and Calcitrate 200mg & crushed the medications. LN #1 then opened an Omeperazole DR (delayed release) 20mg capsule and poured the contents in with the crushed medication. The medications were mixed with approximately 60 cc water. LN #1 proceeded to unclamp the G-tube, flushed with approximately 75 cc water, poured in the crushed medications in water, and then flushed the tube again with more water. LN #1 did not verify placement of the resident's G-tube prior to flushing with water or administering the medication. During an interview on 03/15/12 at 10:36 AM, LN #1 stated she should have checked for placement by aspirating stomach contents or inserting air while listening with a stethoscope for gurgling. During an interview on 03/16/12 the ADON (Assistant Director of Nursing) stated her expectation was for all staff to check for placement of G-tubes before administering medications.	F 281	Measures put into place to prevent this from recurring include: 1) inservicing all professional nurses on how to check for proper PEG tube placement per facility policy to be completed by the ADON by 4-9-12, and 2) a monitor will be conducted 3 times per week by the DON or ADON when feedings or meds are being administered via PEG tube to ensure that the proper method of checking for PEG tube placement is done. The results of the monitor will be presented and reviewed weekly at the Survey Compli-Ance Committee meeting for one month and monthly at the QA meeting for 3 months. This will be presented by the DON and changes will be made as necessary until the Facility is in compliance with this practice.	4-13-12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 4 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	The alleged deficient practice was corrected by providing immediate education to LN #2 regarding the proper use of gloves when administering eye drops. This was done on 3-14-12 by the ADON. All residents with eye drops have the potential to be affected by this practice but only LN #2 was identified to be out of compliance. The following measures were put into place to prevent this alleged incident from recurring: 1) in-servicing regarding this alleged deficient practice and its importance to all professional nurses by the ADON and 2) monitoring of eye drop administration (to be done 2 times weekly of all potentially affected residents) by the DON or ADON. The monitors will be presented by the DON and reviewed weekly by the Survey Compliance Committee for one month and then monthly by the QA committee for 3 months. Necessary changes will be made to affect positive results as appropriate until compliance is achieved.	4-13-12

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by:
Based on observations, record review and staff interview facility staff failed to wear gloves when administering eye drops to two (2) of two (2) residents observed during medication administration. (Residents # 66 and # 100).

The findings are:

The facility's undated policy on Standard Precautions specified: gloves should be worn whenever exposure to following is planned or anticipated and listed ten (10) items which included mucous membranes.

1. Resident # 66 had diagnoses which included hypertension and tear film insufficiency.

Review of the March 2012 Physician's Orders revealed an order for Systane ultra lubricating eye drops one drop each eye QID (four times a day) for dry eyes.

Observation of medication administration on 03/14/12 at 3:37 PM revealed Licensed Nurse (LN) #2 lifted Resident #66's right upper eyelid with ungloved hands, administered one (1) drop of Systane eye drops and patted Resident's #66's right eye with a tissue to remove liquid from around the eye. LN #2 then lifted Resident # 66's left upper eyelid with ungloved hands, administered one (1) drop Systane eye drops and patted Resident # 66's left eye with a tissue to remove liquid from around the eye. LN #2 then returned to the medication cart, placed the eye drops in the cart and sanitized her hands.

During an interview on 3/14/12 at 4:02 PM LN #2

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F 441	Continued From page 6 stated she didn't need to wear gloves when giving eye drops as long as she sanitized or washed her hands after giving them. During an interview on 3/16/12 with the ADON (Assistant Director of Nursing), the facility's policy on Standard Precautions was reviewed. The ADON confirmed that the facility's policy specified that gloves should be worn any time there was potential for contact with a resident's blood, body fluids or mucous membranes. The ADON stated the eyes are considered mucous membranes and tears are considered body fluids. The ADON stated staff should treat any blood or body fluids as potentially contaminated. 2. Resident # 100 had diagnoses which included macular degeneration. Review of the March 2012 Physician's Orders revealed an order for Systane 15 ml (milliliter) eye drops one drop each eye QID (four times a day) for dry eyes. Observation of medication administration on 03/14/12 at 3:42 PM revealed Licensed Nurse (LN) # 2 lifted Resident # 100's right upper eyelid with ungloved hands, administered one (1) drop of Systane eye drops and patted Resident's #100's right eye with a tissue to remove liquid from around the eye. LN # 2 then lifted Resident # 100's left upper eyelid with ungloved hands, administered one (1) drop Systane eye drops and patted Resident # 100's left eye with a tissue to remove liquid from around the eye. LN #2 then returned to the medication cart, placed the eye drops in the cart and sanitized her hands.	F 441		

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F 441	Continued From page 7 During an interview on 3/14/12 at 4:02 PM LN #2 stated she didn't need to wear gloves when giving eye drops as long as she sanitized or washed her hands after giving them. During an interview on 3/16/12 with the ADON (Assistant Director of Nursing), the facility's policy on Standard Precautions was reviewed. The ADON confirmed that the facility's policy specified that gloves should be worn any time there was potential for contact with a resident's blood, body fluids or mucous membranes. The ADON stated the eyes are considered mucous membranes and tears are considered body fluids. The ADON stated staff should treat any blood or body fluids as potentially contaminated.	F 441		