STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345522	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FLETCHER	86 OLD AIRPORT ROAD FLETCHER, NC 28732

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to follow a physician's order for obtaining a diagnostic test related to a diabetic ulcer for 1 of 6 sampled residents (Resident #1).

The findings included:

Resident #1 was admitted to the faclity 04/14/14. Her diagnoses included dementia, vitamin D deficiency, Diabetes, hypertension, and osteomyelitis.

A Wound Care Initial Assessment, from an outside wound clinic dated 08/25/15 noted Resident #1 had her left great toe amputated 05/17/15 which had reopened. The wound assessment noted an "apparently new" wound to the joint of the left second toe. Both wounds were debrided at the 08/25/15 visit.

Resident #1 continued to go to the wound clinic as ordered. The Wound Care Report dated 09/22/15 noted the left second toe was much worse and the infected bone was removed and the area debrided and a dressing applied.

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- Corrective action taken for the alleged deficient practice for Res # 1 was to contact the PA that ordered the CT scan. This was done on 2-25-16 by the ADON. The PA monitored the blood sugar readings of this resident and on 3-10-16, an order was written to discontinue the order for a CT scan by the PA due to the fact that the wound involved in this tag was healed as of 2-24-16. 3-24-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sue Robinson — TITLE: Administrator — (X6) DATE: 3-16-16

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 309	Continued From page 1	F 309		

Resident #1 continued to go to the wound clinic as ordered. The Wound Care Report dated 10/20/15 indicated the wound was better and partial thickness was debrided and a dressing applied. The notes stated the dressing was to be removed the following week and no further care was likely to be needed. Diagnostic impression included osteomyelitis of left second toe.

The Wound Assessment Report completed by the Assistant Director of Nursing (ADON) indicated the left second toe was healed on 11/06/15.

A physician's order dated 12/16/15 included Keflex (an antibiotic) 500 milligrams (mg) twice a day for an infection to the left second toe and orders to clean the ulcer with wound cleanser or saline and apply santyl/collagenase and cover with a dry dressing every day and as needed. She was also to go to the wound clinic.

The Wound Assessment Report dated 12/17/15 completed by Nurse #1 noted the left second toe was open, pale yellow with small purulent drainage measuring 1.10 centimeter (cm) by 2.60 cm by 0.10 cm.

Resident #1 was seen by the wound clinic on 12/29/15 and new orders were received for dressing changes every 2 to 3 days with return to the clinic as needed. The resident did not return to the wound clinic.

Review of the physician telephone orders dated 01/14/16 included orders for a computed tomography (CT) scan to the left second toe to rule out osteomyelitis. This was signed by the Physician Assistant (PA) and noted by Nurse #1 at 4:00 PM.

- All transportation related orders were Reviewed by the ADON and Medical Records Clerk and checked against the appointment book/log to ensure that all required transportation needs had been met. Any identified issues were noted by the DON and/or ADON and the MD contacted. This audit includes all current residents and the audit date begins 1-1-16. This review will be completed on 3-15-16. 3-24-16

- Systematic changes to ensure that all Residents receive timely outside-facility transportation to appointments include:

  1) Inservicing of all professional nurses on the procedure for taking orders

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F 309	Continued From page 2 There was no evidence of a CT scan located in the medical record. The PA who signed the order for the CT scan on 01/14/16 was interviewed on 02/25/16 at 10:02 AM. She stated that Resident #1's blood sugars were out of control which was a previous indication of a deep infection. She stated she examined Resident #1 and noted her toe was swollen and red which indicated there may be an infection. She stated this was a change since her previous examination of the toe. Interview with Nurse #1 via telephone on 02/25/16 at 10:11 AM revealed when an appointment needs to be scheduled the information is passed on to the transporter. Nurse #1 stated a copy of the order is given to the transporter, the white copy of the order form is given to Medical records, the green copy of the order form is given to the Director of Nursing or the ADON and the pink copy of the order form goes to pharmacy. She stated that the transporter was not in the facility at the time this order was received and she recalled leaving a copy of the order on the transporter's desk. Nurse #1 stated the PA wanted to rule out osteomyelitis. Interview with the transporter on 02/24/16 at 4:18 PM via telephone revealed she called to make the appointment and was told the physician had to co-sign for the CT scan. The phone call was disconnected in the midst of the interview and the transporter could not be reached via phone at this time. Interview with the Medical Records staff on	F 309	that require out of facility transport needs and the communication process for this this will be conducted by the ADON 2) Implement the use of a TRANSPORT ORDER box that will be where orders requiring transportation are to be placed, There are two boxes and they are located at each nurses station. There is 24 hour a day accessibility. M-F the transport aide retrieves orders from this box & make the appointments and set up and transportation needs. The transport aide posts notices of appointments at the respective nurses stations advising of time and destination. as of 3-10-16. 3-24-16	

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F 309	Continued From page 3 02/24/16 at 4:16 PM revealed she was just given the telephone order this date in order to have the physician sign the order. A follow up interview with the transporter on 02/25/16 a at 9:35 AM revealed that she made physician ordered appointments and transported the resident to the appointment as needed. She stated she was supposed to receive a copy of the order and the Medical Records Director was also to receive a copy so there was a double check system to ensure the appointment was scheduled. The transporter stated she had not seen the order for the CT scan for Resident #1 until yesterday (02/24/16). Interview with the ADON on 02/25/16 at 10:54 AM revealed the system to ensure physician ordered appointments are made consisted of nurses making a copy of the order and placing the copy either on the transporter's desk or the medical records staff's desk. She stated sometimes the nurses share the information verbally. The ADON stated that the transporter had told her yesterday she had not seen the order for the CT scan. The ADON could give no reason for the breakdown in the system resulting in the appointment not being scheduled.	F 309	3) Implementation of a TRANSPORTATION MONITORING LOG that will include Res Name, Date of the Order, Destination, Confirmation that the order was placed in the Transport Order Box, Date of the Appointment, and that Documentation was received back from the appointment. This log will be kept at each nurses station and will be kept by the professional nurses and the transport aide starting March 10, 2016. • The Transportation Monitoring Log will be reviewed weekly by the DON and/or ADON. The DON and/or ADON will complete a summary of the monitoring efforts and present this at the monthly QAPI meeting for a period of 3 months to ensure continued compliance. The QAPI committee will determine if any changes to this process are necessary for compliance. • Compliance date 3-24-16	3-24-16
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	POC starts on pg 5 of 12	

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F 514	Continued From page 4	F 514		

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to maintain complete and accurate medical records for 1 of 6 sampled residents. Resident #1's medical record did not include all physician orders for wound care, the treatment administration records were not updated to include new physician orders, and wound documentation did not reflect the correct measurements of the wound to show the progression of healing.

The findings included:

Resident #1 was admitted to the faclity 04/14/14. Her diagnoses included dementia, vitamin D deficiency, Diabetes, hypertension, and osteomyelitis.

A. Wound Care Reports from an out of facility wound clinic revealed on 08/19/16 , Resident #1 was seen for a re-opened surgical incision from her left great toe being amputated and an ulceration noted on her left second toe. During this appointment, both areas were debrided. The order included to clean with normal saline, apply aquacel ag , cover with foam and cast padding and kerlix cover with stockinette and not to change this dressing until the next wound clinic appointment. There was a telephone order dated

3-24-16

- Corrective action for Resident #1 was to contact the Wound Care Center and ask that said documentation be resent to the facility via fax. This was accomplished on 2-25-16 by the Medical Records clerk. This documentation was reviewed by the ADON and placed on the chart on 2-25-16.
- An audit of all medical records for current residents was completed by Medical Records Clerk, Transportation Aide, and ADON on 3-15-16. This audit reviewed all orders that necessitated an out of facility transport to another medical agency & checking to ensure that documentation from

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F 514	Continued From page 5 08/21/15 to keep the dressing intact until the appointment on 08/25/15. Review of Wound Care Reports from the wound clinic, Resident #1 was seen at the wound clinic on 09/08/15. The treatment to the left second toe and the amputation site of the great toe remained the same but the frequency changed to 3 times per week. There were no new physician orders in Resident #1's medical record supporting this order until the facility was faxed the copy of the order by the wound clinic dated 02/25/16 at 9:19 AM. The September 2015 Treatment Administration Record (TAR) reflected the orders from the wound clinic. Review of Wound Care Reports from the wound clinic, Resident #1 was seen at the wound clinic on 09/22/15. The great toe was no longer being treated. There were no new physician orders for treatment in the medical record. Orders faxed from the wound clinic to the facility on 02/15/16 at 9:17 AM revealed the treatment remained the same but the frequency was changed to twice a week. The September 2015 Treatment Administration Record (TAR) reflected the orders from the wound clinic. Per the Wound Care Reports, Resident #1 was seen at the wound clinic on 09/29/16. There were no new physician orders for treatment in the medical record. Orders faxed from the wound clinic to the facility on 02/15/16 at 9:16 AM revealed the dressing was changed at the wound clinic, and the dressing was not to be changed until the following weekly wound clinic appointment. The September 2015 TAR reflected the orders from the wound clinic not to change the dressing.	F 514	the visit was received & on the medical record. Any identified missing information was retrieved from the appropriate agency and placed on the medical record by the Medical Records Clerk by 3-15-16. • Systematic changes in this Process include: 1) inservicing of the nurses regarding this tag and the importance of the placing the documentation in the medical record & entering any new orders on the MAR or TAR if applicable 2) Develop an audit tool for the professional nurses in which the nurse documents on the log that document-	3-24-16

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F 514	Continued From page 6	F 514		

Per the Wound Care Reports, Resident #1 was seen at the wound clinic on 10/06/15. There were no new physician orders for treatment in the medical record. Orders faxed from the wound clinic to the facility on 02/15/16 at 9:15 AM revealed the dressing was changed at the wound clinic, and the dressing was not to be changed until the following weekly wound clinic appointment. The October 2015 TAR reflected the orders from the wound clinic not to change the dressing.

Per the Wound Care Reports, Resident #1 was seen at the wound clinic on 10/13/15. There were telephone orders that reflected to leave the dressing intact and the October 2015 TAR accurately reflected no new physician orders for treatment in the medical record. Orders faxed from the wound clinic to the facility on 02/15/16 at 9:15 AM revealed the dressing was changed at the wound clinic, and the dressing was not to be changed until the following weekly wound clinic appointment. The October 2015 TAR reflected the orders from the wound clinic not to change the dressing.

Per the Wound Care Reports, Resident #1 was seen at the wound clinic on 10/20/15. There were no new physician orders for treatment in the medical record. Orders faxed from the wound clinic to the facility on 02/15/16 at 9:14 AM revealed the left second toe was dressed at the wound clinic and orders were to leave the dressing intact until Tuesday (10/27/15) and do not replace. The October 2015 TAR reflected the orders from the wound clinic not to change the dressing. The TAR blocked off 10/27/15 indicating the date the dressing was to be removed,

3-24-16

tation has been received for the returning resident, and that any new orders have been transcribed onto the TAR, AND if documentation has not been received within 48 hours then the nurse is to call the agency and request that it be sent to the facility,

3) this audit tool will be reviewed weekly by the DON or ADON to ensure that documentation has been received and that any new orders have been placed on the TAR.

4) All orders will be reviewed Daily (M-F) by the DON &/or ADON making note of the orders requiring out of facility appointments

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F 514	Continued From page 7	F 514		

however, no initials were on this TAR indicating the dressing was removed.

Interview with the Assistant Director of Nursing on 02/25/16 at 10:54 AM revealed she could not say why the wound clinic's orders were not in the medical record or could be located in the facility. She stated normally the wound clinic sends back a form, i.e. the ones received via fax. She stated the nurses had to have seen the form in order to fill out the TARs and know what to do for Resident #1.

B. A Mobile Clinic Services form indicated Resident #1 was seen on 12/16/15 with orders for Keflex (an antibiotic) 500 milligrams (mg) twice a day for 10 days for an infection to the left second toe and orders to clean the ulcer with wound cleanser or saline and apply santyl/collagenase and cover with a dry dressing every day and as needed. This form also noted there was an appointment for her to go to a wound clinic appointment scheduled for 12/22/15.

A physician's order dated 12/16/15 included Keflex (an antibiotic) 500 mg twice a day for an infection to the left second toe and orders to clean the ulcer with wound cleanser or saline and apply santyl/collagenase and cover with a dry dressing every day and as needed. The ordered included an appointment with wound care on 12/22/15. This was signed by the Physician Assistant on 12/17/15.

A Wound Assessment Report dated 12/17/15 completed by Nurse #1 noted the left second toe was open, pale yellow with small purulent (containing pus) drainage measuring 1.10 centimeter (cm) by 2.60 cm by 0.10 cm. The

and then checking to make sure 3-24-16 that documentation was received back from the visit and that orders have been entered onto the TAR.

- A summary of our monitoring efforts will Be prepared and presented to the QAPI Committee during the monthly meeting by The DON or ADON. This will be reviewed At the QAPI meeting for a period of 3 months to ensure continued compliance. The QAPI committee will determine if any Changes are necessary for compliance.
- Compliance date 3-24-16

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F 514	Continued From page 8	F 514	F 514 B • Corrective action for Res #1 was to contact the MD however the wound involved was healed so no new orders were received. This was done on 2-25-16 by the ADON. • All orders were checked by the Medical Records Clerk comparing the timeframes noted in the MD orders with the timeframes on the MARs and TARs. Any discrepancies were corrected by the Medical Records Clerk by 3-16-16.	3-24-16

wound bed description included epithelial tissue 10 percent, granulation tissue 0 percent and slough 10 percent. The wound edges were described as distinct with the outline clearly visible and macerated. The notes on this form indicated orders including cleaning the area with normal saline, applying a small amount of Santyl ointment, covering the dressing and changing the dressing 3 times weekly. The notes stated she was followed by the wound clinic.

The medical record contained no reports from the wound clinic. This report was faxed to the facility on 02/25/16 at 9:06 AM. This report stated Resident #1 was seen by the wound clinic on 12/29/15. The left second toe measured 0.2 by 0.2 by 0.1 (no unit of measurement) and new orders were received for aquacel ag, aquacel nonadherent foam, cast padding, and kerlix stockinette to be changed every 2 to 3 days. The resident was to return to the clinic as needed. There were no additional wound care visits made for Resident #1.

Review of physician orders revealed no orders in the medical record regarding the change to aquacel AG to the left second toe until the wound clinic report was faxed to the facility on 02/25/16 at 9:06 AM.

Review of Resident #1's Treatment Administration Records (TAR) for January 2016 revealed instructions for her left second toe to be cleaned with normal saline, pat dry, and apply a thin layer of Santyl to affected area and cover with a dry dressing and change daily with a start date of 12/17/15. The January 2016 TAR was not changed to reflect the new order from the wound clinic dated 12/29/15 for aquacel treatment

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provided 2 to 3 times a week. The TAR was set up for documentation of dressing changes Mondays, Wednesdays and Fridays. Blanks on the TAR indicating no treatment was provided were noted between Wednesday 01/06/16 through Tuesday 01/12/16 and after Monday 01/25/16 through Sunday 01/31/16.

Review of the Resident #1's TAR for February 2016 revealed instructions for her left second toe to be cleaned with normal saline, pat dry, and apply a thin layer of Santyl to affected area and cover with a dry dressing and change daily with a start date of 12/17/15. The February 2016 TAR was not changed to reflect the new order from the wound clinic dated 12/29/15 for aquacel treatment provided 2 to 3 times a week. The TAR included an initial that was circled, indicating the treatment was not provided but there was no explanation on the back of the TAR.

Nurse #3 was interviewed on 02/24/16 at 10:20 AM. She stated Resident #1's toe treatment was due this date. When reviewing the TAR, she stated the blanks would reflect that the in house wound consultant would have changed the treatment on the Mondays 02/08/16 and 02/15/16. She reviewed the orders noted in the medical record which had no additional orders other than the order dated 12/16/15 for Santyl with daily dressing changes. She then changed the TAR to reflect daily dressing changes of Santyl.

Telephone interview with the in house wound consultant on 02/24/16 at 4:32 PM revealed he had not seen Resident #1 since March 2015.

Observations made with Nurse #3 on 02/24/16 at

3-24-16

Systematic changes in this process include:

1) Inservicing of all professional nurses of the order entry process with a return demonstration. This was done by the ADON by 3-15-16. PRN nurses will receive this inservice before the next time they work.

2) An audit tool will be implemented in which 10 medical records will be reviewed weekly by the medical records clerk for entry accuracy. These records will be selected at random and any orders

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F 514	Continued From page 10 1:28 PM revealed there was no dressing on Resident #1's left second toe and the area was healed. Interview with the ADON 02/24/16 at 1:51 PM stated the orders on the TAR appeared to be a transcription error. She stated the TARS were to be checked "ongoing throughout the month" for accuracy and completeness. ADON stated she was responsible for checking them monthly but that every nurse would also check for accuracy. The Wound Assessment Reports completed by Assistant Director of Nursing (ADON) dated on 12/31/15, 01/07/16, 01/15/16, 01/23/16, 01/29/16, 02/05/16, 02/12/16, 02/19/16 all stated the exact same measurements, descriptions and Santyl orders as the one completed on 12/17/16. All reports stated she was followed by the wound clinic. The wound was noted to be healed on 02/25/16. Interview with the ADON on 02/25/16 at 10:54 AM revealed the Wound assessment Reports were filled out weekly to track a wounds progression. She stated that measurements were obtained by the wound clinic or the in house wound consultant and she just inputted the information. She stated she did not change any of the information related to measurements, descriptions, or orders due to time restraints. She did not say where measurements would have come from in Resident #1's case. She stated that the wound clinic was responsible for tracking a wounds progression. The ADON also stated that the wound clinic always sent orders so that nurses knew what to do for the resident. She could not explain the breakdown in the system for Resident #1.	F 514	requiring clarification or correction will be presented to the DON and/or ADON to be addressed immediately. This audit will compare the current MD orders to the MARs and TARs, 3) Monthly, the MARS & TARS will be reviewed and clarified or corrected by the professional nurses for the following month comparing these to the MD orders. Any inconsistency will be clarified and/or corrected immediately by the nurse.	3-24-16

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 conclusion set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely because it is required by provisions of state and federal law.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345522	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FLETCHER	86 OLD AIRPORT ROAD FLETCHER, NC 28732

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3-24-16

- A summary of the

Monitoring efforts will be Presented to the QAPI Committee monthly by the DON and/or ADON. This will Be reviewed at the QAPI meeting for a period of 3 months to ensure continued compliance. The QAPI committee will determine if any changes are necessary for compliance.

- Compliance date: 3-24-16

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