STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

(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 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete weekly skin checks by a licensed nurse for a resident at risk for pressure ulcers (Resident #1) resulting in an unstageable pressure ulcer for one of three residents reviewed for pressure ulcers. The findings included: Resident #1 was readmitted to the facility on 11/25/15 with a history of diagnoses including hemiplegia following cerebral infarct affecting left (non-dominant) side, stage 3 chronic kidney disease (CKD), legal blindness, stiffness of left knee, and generalized muscle weakness. Resident #1 was discharged on 4/6/2016. A review of the Minimum Data Set (MDS), dated 2/16/16 indicated resident #1 was assessed as being severely cognitively impaired, needed extensive to total assistance with activities of daily living (ADLs), had unilateral upper and lower extremity range of motion (ROM) impairment and was at risk for pressure ulcers, but there was no pressure ulcer reported on the MDS at the time of the assessment.	F 314	Immediate Action: Resident #1, Is no longer in this facility. He Was discharged from the facility on 4/6/2016. Identification of Others 100% skin audit completed on 4/18/2016 by Director of Nursing, Assistant Director of Nursing, and House supervisor. This audit focus on identification of any skin alteration, and whether or not such alteration is on the care plan. Systemic Changes The facility will institute the following measures to ensure the alleged deficient practice will not occur: Weekly skin assessment schedule revised by the Regional Clinical Director on 5/4/2016. New weekly skin assessments schedule shown resident's assessment due between days of Sunday and Thursday, every week. This will allow monitoring of	5/12/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/04/2016

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F 314	Continued From page 1 Resident #1 ' s care plan for pressure ulcers was updated on 3/6/16 to reflect the new unstageable ulcer to the left heel. The previous care plan was dated 11/22/15 and had not included information regarding a pressure ulcer on the left heel. Interventions for the prevention of pressure ulcers included weekly skin checks. A review of the Weekly Skin Assessment for resident #1 revealed weekly skin assessments were not documented as performed on the weeks of 2/22/16 and 2/29/16. The weekly skin assessment dated 2/15/16 stated that Resident #1 ' s skin was intact. The weekly skin assessment dated 3/8/16 stated that Resident #1 ' s skin was not intact and a new area was noted. A review of the Pressure Ulcer Record, dated 3/15/16, for Resident # 1 revealed an unstageable left heel ulcer was identified on 3/6/16. The pressure ulcer was measured with a length equal to 3.0 centimeters (cm) and a width equal to 6.0 cm and a depth equal to 0.2 com. The pressure ulcer was assessed as having a moderate amount of serous drainage with a wound bed that contained 80 percent granulation tissue and 20 percent eschar. In an interview with the Assistant Director of Nursing (ADON) on 4/15/16 at 2:30 PM, she stated that the floor nurses were responsible for doing the weekly skin assessments and treatments and that she rounded with nurses to do measurements. The ADON stated she was unable to locate documentation showing a weekly skin assessment was performed for resident #1 on the weeks of 2/22/16 and 2/29/16 and stated	F 314	completion of scheduled assessments by members of nursing administration between week days Monday through Friday. 100% in service education will be completed by the Director of Nursing, Assistant Director of nursing or designee to all nursing staff by 5/6/2016, among the topics was the emphasis on completing weekly skin assessments per schedule. Any nursing staff not educated by 5/6/2016 will not be allowed to work until educated. Monitoring Process DON, ADON or Designee will review completion of the prior day weekly skin assessment on daily clinical meeting (M-F) for the next 30 days then weekly for another 30 days. Results of these audits will be presented at Quality Assurance and Improvement (QAPI)monthly by the Director of Nursing or designee until 100% compliance is archived and maintained for three consecutive months.	

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F 314	Continued From page 2	F 314		

she expected the nurses to do a weekly skin check for every resident and to document the assessment on appropriate form in the resident ' s electronic medical record.

An interview was conducted with Nurse #1 on 4/15/16 at 2:40 PM. Nurse #1 stated she would have been the nurse to perform the weekly skin checks Resident #1 on the weeks of 2/22/16 and 2/29/16, but did not know why she failed to document the assessment on the weekly skin assessment form in the electronic medical records. Nurse #1 stated that if the assessments were not in the computer, they would not have been completed in a book or anywhere else other than the resident ' s electronic record.

In an interview with the facility ' s Corporate Consultant Nurse on 4/15/16 at 4:35 PM, he stated that there had been a verbal order for treatment of a left heel pressure ulcer for Resident# 1 on 2/28/16, but the nurse was not sure if she had just forgotten to write the order on a telephone order form or if she had written it and it had been misplaced. The Corporate Consultant Nurse also presented an assessment that had been written on a form with only a short description of suspected deep tissue injury to Resident# 1 ' s left heel. The form did not include any measurements and it had not been signed by the nurse performing the assessment. The Corporate Consultant Nurse was informed that Nurse #1 had stated that there would not have been any other assessment if it was not found in the resident ' s electronic medical record.

On 4/15/16 at 4:50 PM the Director of Nursing (DON) stated that it was her expectation that all weekly skin checks be completed by the assigned

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F 314	Continued From page 3 floor nurse and documented in each resident ' s electronic medical record per facility protocol and all documentation for wound assessments and treatments be kept accurate and up to date.	F 314		