PRINTED: 11/07/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345523	B. WING			10/05/2017
	ROVIDER OR SUPPLIER	ISEUR		STREET ADDRESS, CITY, STATE, ZIP C 7166 JORDON ROAD RAMSEUR, NC 27316	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 166 SS=D	(j)(2) The resident hamust make prompt of grievances the reside with this paragraph.  (j)(3) The facility must of file a grievance or resident.  (j)(4) The facility must of ensure the prompt regarding the reside paragraph. Upon real a copy of the grievance policy must of the grievance policy must of the grievance policy must of the grievance and the grievance of the grievance o	as the right to and the facility efforts by the facility to resolve lent may have, in accordance st make information on how recomplaint available to the st establish a grievance policy of resolution of all grievances ents' rights contained in this quest, the provider must give nee policy to the resident. The	F 10	66		10/25/17
ABORATORY I	I DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	)E	TITLE		(X6) DATE

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

10/23/2017

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.

**Electronically Signed** 

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			' '	TE SURVEY MPLETED	
		345523	B. WING _			0/05/2017
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F 166	by the facility; maintainformation associate example, the identity grievances submitted written grievance decoordinating with stanecessary in light of (iii) As necessary, tal prevent further potentight while the allege investigated;  (iv) Consistent with § reporting all alleged abuse, including injurand/or misappropriation anyone furnishing seprovider, to the admit as required by State  (v) Ensuring that all vinclude the date the summary statement of the steps taken to invisummary of the pertite regarding the resider as to whether the gric confirmed, any corretaken by the facility and the date the writted (vi) Taking appropriation accordance with State of the residents' right or if an outside entity	any necessary investigations ining the confidentiality of all ed with grievances, for of the resident for those dianonymously, issuing cisions to the resident; and the and federal agencies as specific allegations; wing immediate action to tial violations of any resident diviolation is being  483.12(c)(1), immediately violations involving neglect, ries of unknown source, ion of resident property, by rvices on behalf of the nistrator of the provider; and	F1	66		

F 166  Continued From page 2  Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and  (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/RAMSEUR     C(X4) ID   PREFIX TAG   PREFIX TAG   CONTINUED FROM PROPERTIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    F 166   Continued From page 2   Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			345523	B. WING	······	1	0/05/2017	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 166  Continued From page 2  Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and  (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			SEUR	7166 JORDON ROAD		•		
Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and  (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETION	
This REGUIREMENT is not met as evidenced by:  Based on record review, family interview, and staff interview, the facility failed to investigate and resolve grievances for 1 of 1 residents reviewed for grievances (Resident #108). The findings included:  The facility's grievance policy, with a revision date of March 2017, was reviewed. The policy read, in part, "Grievances and/or complaints may be submitted orally or in writing by the resident or the person filing the grievance or complaint on behalf of the resident. They may also be verbalized to any staff member, who will be responsible for documenting the grievance/concern on the appropriate form."  Resident #108 was admitted to the facility on 12/8/16 with diagnoses that included muscle weakness, difficulty walking, unsteadiness on feet, and abnormalities of gait and mobility.  The Admission Minimum Data Set (MDS) assessment dated 12/16/16 indicated Resident #108's cognition was severely impaired. He was assessed as requiring the extensive assistance of two or more staff for bed mobility, transfers, dressing, toileting, and personal hygiene.  Resident #108 was not steady on his feet and	F 166	Organization, or local confirms a violation frights within its area.  (vii) Maintaining evid result of all grievance 3 years from the issudecision.  This REQUIREMENT by:  Based on record restaff interview, the faresolve grievances for grievances (Residincluded:  The facility's grievance for grievances (Residincluded:  The facility's grievance an submitted orally or in person filing the grief of the resident. They any staff member, wild documenting the grief appropriate form."  Resident #108 was a 12/8/16 with diagnos weakness, difficulty of feet, and abnormality feet, and abnormality assessment dated 12 #108's cognition was assessed as requiring two or more staff for dressing, toileting, and	Il law enforcement agency for any of these residents' of responsibility; and ence demonstrating the es for a period of no less than rance of the grievance.  T is not met as evidenced riew, family interview, and cility failed to investigate and or 1 of 1 residents reviewed dent #108). The findings  The policy read, in dor complaints may be a writing by the resident or the vance or complaint on behalf or may also be verbalized to the will be responsible for evance/concern on the evaluation of the walking, unsteadiness on the evaluation of the walking, unsteadiness on the evaluation of the walking and mobility.  The policy read, in dor complaint on behalf or may also be verbalized to the walking of the exponsible for evance/concern on the evaluation of the walking, unsteadiness on the evaluation of the walking, unsteadiness on the evaluation of the exponsibility, transfers, and personal hygiene.	F 16	This plan of correction cons written allegation of complia Preparation and submission this plan of correction does an admission or agreement provider of the truth of the fathe correctness of the conclusion forth on the statement of deliplan of correction is prepare submitted solely because of under state and federal law, demonstrate the good faith at the provider to improve the of each resident.  IMMEDIATE ACTION TAKES On 10/12/2017, Executive Dinterviewed resident #108 party to determine if the allegation on the compliance remain to be Resident #108 responsible party that there have been not furtable alleged verbal grievance was in the facility grievance form	nce. I of this plan of not constitute by the acts alleged or usions set ficiencies. The ad and requirement and to attempts by quality of life  Noticector is responsible ged an issue. Coarty stated ther issues. As documented and		

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				7166 JORDON ROAD	
UNIVERSA	AL HEALTH CARE/RA	AMSEUR		RAMSEUR, NC 27316	
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F 166	Continued From page	age 3	F 16	66 On 10/12/2017, 10/13/2017	7 10/16/2017
	urinary incontinend triggered for this a	sessment (CAA) related to be indicated Resident #108 had rea due to incontinence and the st/provision for toileting.		2017, and 10/20 the Admis Coordinator, Director Socia the Executive Director inter of all interview able resider any concerns related to car	sions Il services and viewed 100% its to determine
	indicated Resident decision making a and long term mer requiring the exter staff with bed mob and one staff for to Resident #108 was	S assessment dated 9/8/17 t #108 had severely impaired and problems with short term mory. He was assessed as asive assistance of two or more tility, transfers, and dressing bileting and personal hygiene. Is not steady on his feet and tabilize with staff assistance.		at the facility. Any resident able to be interviewed due deficit a responsible party of family member was interviewed fitting and the deficit audit were documented. Grievance audit tool maintagrievances identified and regrievance policy	who was not to cognitive or interested ewed. Findings ted in a ained in the en other
	problem area of th Infections (UTIs) s bowel and bladder provision for elimin area was initiated on 9/12/17.  A family interview #108's Responsibl 11:13 AM. She increported two concetoileting/incontiner stated these concernonth or two. She Nursing Assistance taken Resident #1 him there unattend concern was an N.	or Resident #108 included the erisk for Urinary Tract econdary to incontinence of with the need for staff nation care and hygiene. This on 12/19/16 and last reviewed was conducted with Resident e Party (RP) on 10/2/17 at dicated she had verbally erns to Nurse #5 related to at care for Resident #108. She erns were reported in the past e indicated one concern was a e (NA), name unknown, had 08 to the bathroom and had left ded. She reported the second A, name also unknown, had		SYSTEMIC CHANGES Effective 10/25/2017 all griby resident, or resident repbe documented per facility  Executive Director, Director (DON), Assistant Director (ADON), Staff Developmer (SDC), Director of Social S Nurse Supervisor will compeducation for all active staftime, part time and as need on the facility grievance poeducation will be completed 10/25/2017. Any Staff memeducated by 10/25/2017 will allowed to work until educated ucation will also be addedirentation process for all mand will provided effective	resentative will policy  r of Nursing of Nursing of Coordinator ervices and olete 100% of, to include full led employees, licy. This of by other not ll not be ted. This d on new hires ew employees
	she had completed Resident #108's R	d incontinence care for him. P stated she had not written a concern form related to either		MONITORING PROCESS Effective 10/25/2017, Exec	

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				7166 JORDON ROAD		
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F 166	Continued From pag	ge 4	F 1	66		
	incident. She additi NA no longer worke  A review of the facilithrough 10/2/17 reveiled by or on behalf  A phone interview won 10/4/17 at 2:45 Ffamiliar with Resider required assistance care. She confirmed verbally reported two several months relacare. She stated Refer an NA, name urthe bathroom unatter asked all of the NAstime the concern wards.	onally stated she believed the d at the facility.  ty grievance log from 4/1/17 ealed no grievances were		Director of Nursing, Assista Nursing, Staff Development Admissions Coordinator, Not Supervisor and/or Director Services will interview 5 results (Monday  Friday) to deter satisfaction with care. Any if will be documented in the fagrievance form and addressing grievance policy.  Findings from this monitoring be documented on a daily resident interview tool Executive Direction of dainterview report daily (M-F) weekly x 2 weeks, then momonths.  Effective 10/25/2017, Executive 10/25/	t Coordinator, ursing of Social sidents daily mine their issues voiced acility sed per facility  ag process will resident rector will aily resident X2 weeks, nthly x 3	
	NA, name unknown Resident #108's clos incontinent care for immediately went to had not located a di had asked all of the time the concern wa unable to corroborar revealed she had no for either of these co #108's RP.  An interview was co Nursing (DON) on 1 stated she expected			and/or Director of Nursing was findings of this monitoring programmed facility Quality Assurance and Performance Improvement any additional monitoring or of this plan monthly x 6 months plan monthly x 6 months pattern of compliance is The QAPI committee can make to ensure the facility remains substantial compliance.  Effective 10/25/17, the cent Director and the Director of services will be ultimately remained implementation of the correction for alleged nonce ensure the facility remains a compliance.	crocess to the end Committee for r modification enths, or until semaintained. In a modify this plan enter executive is health esponsible to enis plan of compliance to	

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F 176 SS=D	(c)(7) The right to sel the interdisciplinary to §483.21(b)(2)(ii), has practice is clinically a This REQUIREMENT by: Based on record rev and resident interview a resident for safe self-administicate plan the determines ponsible for the stadministration of med of 1sampled resident self-administer. Find  Resident #43 was ad 7/6/17 with multiple of Obstructive Pulmona admission Minimum I dated 7/13/17 indicat cognition was intact.  Resident #43 had a conformal for Symbicort (used to microgram (mcg) inhallows)	f-administer medications if eam, as defined by determined that this ppropriate.  is not met as evidenced liew, observation and staff v, the facility failed to assess ration of medication and to nation who will be orage and documentation of dication for 1 (Resident #43) observed who ings included:  mitted to the facility on iagnoses including Chronic ry Disease (COPD). The Data Set (MDS) assessment ed that Resident #43's  loctor's order dated 7/6/17 to treat COPD) 80 - 4.5 aler - inhale 2 puffs into	F 176	IMMEDIATE ACTION TAKEN On 10/4/2017 Licensed nurse #1 completed self-medication administrat review in electronic medical records for resident #43. Resident #43 Symbicort inhalers, Proair inhaler and nose spray remained at the bedside for resident to self- administer. On 10/4/2017 Director nursing discussed with resident #43 all her rights to self-administer medication Resident state she prefers for the rest her medication to be administered by facility staff. On 10/05/17 MDS nurse #4 developed a care plan that addresses the facility will handle storage and documentation of medication that residuelled the self-administer.  IDENTIFICATION OF OTHERS: All residents with medication or treatmed.	r  / or of cout n. of thow dent
	On 10/4/17 at 8:30 A during the medication observed to prepare resident's medication questioned, Nurse #2	M, Nurse #2 was observed n pass. Nurse #2 was		orders have the potential to be affected Audit was completed on 100% of active residents on 10/5/2017 and 10/6/2017 licensed nurse #1 to determine if any other resident is currently self-administering their medication. Or other resident was identified as a result the audit. Resident self-medication administration assessment was	e by

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				7166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAM	SEUR		RAMSEUR, NC 27316		
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F 176	Continued From pag	e 6	F 17	6		
	was observed. A use observed inside a pla on top of the over the On 10/4/17 at 8:33 A interviewed. She sta	M, Resident #43's bedside and Symbicort inhaler was astic container that was kept as bed table.  M, Resident #43 was atted that she had been ambicort to herself. She had		completed on 10/06/2017 by lice nurse #1. Resident will continue self-administer her medication. C 10/5/17 MDS nurse #1 developed plan that addresses the storage adocumentation.  Audit was completed on 100% of residents by licensed nurse #1 or	to on d a care and f active	
		times a day. She added that symbicort after she ate		10/6/17 and 10/9/17 by the Direct Nursing, Staff Development Cook Nursing Supervisor and licensed to identify if every resident had a	rdinator, nurse #2	
	that there was no ass to safely self-adminis was no care plan to or responsible for the st the administration of	ere reviewed and revealed sessment of resident's ability ster medication and there determine who will be torage and documentation of		Self-Administration assessment completed within the past quarte results indicated that no resident assessment completed within the quarter. Self-Administrations assessments were completed on residents on 10/5, 10/6 and 10/7 "Self-Administrator of Medication Determination" tool.	had an e past all using the	
	were not aware that self-administering me stated that the Direct Staff Development C responsible for assesself-administration of On 104/17 at 9:54 Al interviewed. They sta	edication. MDS Nurse #1 for of Nursing (DON) or the coordinator (SDC) was ssing residents for safe medication.  Which the DON and SDC were sated that they were not aware assess residents for safe		SYSTEMIC CHANGES Effective 10/10/2017, the "Self-Administrator of Medication Determination" tool will be compl all residents upon admission, readmission, quarterly and with s changes by the facility licensed in This review will be documented is individual resident electronic medications.	eted for significant nurses. n	
	She stated that as lo order to keep the me	M Nurse #2 was interviewed. ng as there was a doctor's dication at bedside, the dminister the medication.		Effective 10/25/2017 the new "Ac Checklist" tool will be implemented form will enhance the process of accuracy of each resident assess a daily basis. Admitting nurse on	ed. This checking sment on	

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	ROVIDER OR SUPPLIER	SEUR		71	REET ADDRESS, CITY, STATE, ZIP CODE 166 JORDON ROAD AMSEUR, NC 27316		
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F 176			F.	176			
	Administration Recor administered as sche On 10/4/17 at 3:00 P interviewed. She sta	M, the DON was ted that a doctor's order to at bedside would indicate			be responsible to complete the admiss checklist upon admission/re-admission a resident in the facility. (Readmission this purpose indicates any resident whereturn to the facility after 72 hours of discharge).	of for	
	medication. The DO called the corporate of	N further stated that she office and a "Self - dication Determination" form			Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and/o Nurse Supervisor will complete 100% education for all licensed nurses, to		
		M, a Self-Administration of ation form was completed for			include full time, part time and as need staff, on the new revised admission checklist and the requirements to complete Self-Administrator of Medications Determination" tool. This education will be completed by 10/25/2017. Any licensed nurse not educated by 10/25/2017 will not be allowed to work until educated. This education will also be added on new hi orientation process for all new License nurses effective 10/25/2017.	res	
					MONITORING PROCESS Effective 10/25/2017, Director of Nursin Assistant Director of Nursing, and/or S Development Coordinator, will monitor completion of self-medication administration determination (assessment) daily (M-F) by reviewing new admission records from prior day. The audit will ensure each resident admitted has a completed assessment Any issues identified during this monitoring process will be addressed	taff the	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 176 F 278 SS=D	483.20(g)-(j) ASSESS ACCURACY/COORE	SMENT PINATION/CERTIFIED	F 17	promptly. Findings from this audit will documented on a new admission checklist and filed in a daily clinical meeting binder after proper follow ups done. Director of Nursing will review to completion of new admission checklist daily (M-F) x 2 weeks, weekly x 2 more weeks, then monthly x 3 months, or upsite the pattern of compliance is maintained. Effective 10/25/2017, Director of Nurse will report findings of this monitoring process to the facility Quality Assurant and Performance Improvement. Committee for any additional monitori or modification of this plan monthly x 3 months, or until the pattern of compliatis maintained. The QAPI committee commodify this plan to ensure the facility remains in substantial compliance.  Effective 10/25/17, the center Executing Director and the Director of health services will be ultimately responsible ensure implementation of this plan of correction for alleged noncompliance ensure the facility remains in substant compliance.	s are he t he ntil ed. ing ce ng 3 nnce an	
	must accurately reflection (h) Coordination					

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F 278	the assessment is considered to the assessment must significate that portion of the assessment must significate that portion of the assessment for the assessment assessment penalty of not more that assessment; or	e must sign and certify that impleted.  ho completes a portion of the in and certify the accuracy of sessment.  eation and Medicaid, an individual wingly-  I and false statement in a is subject to a civil money	F 27	8		
	\$5,000 for each asset  (2) Clinical disagreer material and false state This REQUIREMENT by: Based on record revinterview, the facility Data Set (MDS) asset area of behaviors for #110) of 5 residents medications and in the (Resident #31) of 3 m. The findings included 1. Resident #13 was	nent does not constitute a atement.  Γ is not met as evidenced liew, observation, and staff failed to code the Minimum ressment accurately in the 3 (Residents #13, #35, reviewed for unnecessary ne area of vision for 1 residents reviewed for vision.		F278 IMMEDIATE ACTION TAKEN  The MDS assessment for resident #1 ARD 9/7/17, #35, ARD 7/22/17 and # ARD 9/14/17 were modified on 10/4/2 to reflect documented behaviors on to look back period per RAI guidelines. modification was done by the social worker. The corrected MDS was also transmitted and accepted on 10/19/1	1110, 2017 ne That	

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F 278	Continued From page	e 10	F 278		
		ssive disorder, anxiety lisorder, mood disorder, and		10/20/17.	
	The quarterly Minimu assessment dated 9/had severely impaired inattention, disorganism with short term and lote, the Behavior Section had no behaviors durback period (9/1/17 the was completed by the A review of the Medic (MAR) during the seven 9/7/17 quarterly MDS Resident #13 revealed four days (9/1, 9/2, 9/2) behaviors on two day An interview was completed by reviewing nursing observations of the rehad not reviewed the section of the MDS. quarterly MDS for Rehad no behaviors durperiod (9/1/17 throug the SW. The MAR for indicated he had physically imperiod of the MDS and the section of the MDS and the secti	7/17 indicated Resident #13 d decision making, zed thinking, and problems on, the seven day MDS look arough 9/7/17). Section E e Social Worker (SW).  Eation Administration Record en day look back of the (9/1/17 through 9/7/17) for d grabbing behaviors on 3, and 9/4) and kicking es (9/3 and 9/4).  ducted with the SW on She stated she was leting Section E, the the MDS assessments. She thed this section of the MDS notes and completing esident. She revealed she MARs to code the behavior Section E of the 9/7/17 sident #13 that indicated he ing the seven day look back th 9/7/17) was reviewed with		The MDS assessment for resident #3 ARD 05/24/2017 Section V Care are Assessment (CAA) was modified on 10/06/2017 for a triggered vision CAA reflect the correct visual devise used this resident. Modified CAAs indicate resident #31 wears glasses as indicated on section B1200. That modification done by MDS nurse #1. The correct MDS was also transmitted and accept on 10/16/17.  MDS nurse #1, MDS nurse #2, and the facility Social Worker met with the MIC consultant from the contracted facility management and consulting compart 10/12/17 to review this alleged noncompliance and to identify the roccause. The root cause analysis concuthat, the MDS nurse #1 and MDS nurse were unable to remove the prepopulated information in section MDS 3.0, even when such information does not reflect resident's assessme Likewise it was identified that Social worker did not code the behaviors documented in Electronic Medication Administration due to unawareness of how to pull such records. It is evident the resident behaviors and vision device assessed as the plan of care rethe use of such is in place. This determination was made on 10/12/17	A to by od ated was ed oted by on ot luded rse / of on ont.
	-	17 MDS for Resident #13		IDENTIFICATION OF OTHERS:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING		10/05/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				7166 JORDON ROAD	
UNIVERSA	AL HEALTH CARE/RAMS	SEUR	RAMSEUR, NC 27316		
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F 278	Continued From page	e 11	F 278	8	
	because she had not documented on the MA follow up interview on 10/4/17 at 2:55 PM the correction/modific of Resident #13's 9/7  An interview was con Nursing on 10/4/17 at expectation was for the accurately.  2. Resident #35 was 9/29/14 with multiple Alzheimer's, anxiety of disorder, and delusion.  The quarterly Minimulassessment dated 7/2 #35's cognition was stassessed with physical processing and the Market Physical Phys	was conducted with the SW M. She stated she had made cation to the behavior section //17 MDS.  ducted with the Director of the 3:00 PM. She reported her the MDS to be coded  admitted to facility on diagnoses that included disorder, major depressive the mal disorder.  In Data Set (MDS) 22/17 indicated Resident severely impaired. She was		100% audit for all active residents' recent MDS assessment was com on 10/19/2017 by the Social Work MDS Coordinator #1 and MDS Coordinator #2 to determine if any resident with documented behavior look back period was coded approper RAI guidelines in section E of 3.0. The results of the audit indicatother residents with documented behaviors identified to be coded inaccurately per RAI guidelines in E of MDS 3.0.  The identified inaccurate MDS assessments were modified on 10 to reflect documented behaviors or look back period per RAI guideline modification was done by the sociation was done by the sociation was done to the sociation of the sociation of the sociation was done to the sociation of the sociation of the sociation was done as were transmitted and accepted on 10/20/17.	pleted er and  other ors in the opriately MDS ated 16  section  0/4/2017 in the es. That al sments
	•	n day MDS review period		100% audit for all active residents recent comprehensive assessmen	
	(MAR) during the sev 7/22/17 quarterly MD for Resident #35 reve - Physical behavior grabbing behaviors (7/18), pus and kicking behaviors - Other behaviors disruptive sounds (7/	ors on five of seven days: 7/16, 7/18, 7/19, 7/21), hitting hing behaviors (7/18, 7/19),		completed on 10/06/2017 and 10/by the MDS Coordinator #1 and M Coordinator #2 to determine if any resident who trigger as using visual appliances on section B1200 of M had a correct visual CAA complete accurately per RAI guidelines. The of the audit indicated 15 other resimple who triggers as using visual applial section B1200 identified to have C completed inaccurately per RAI guint section V of MDS 3.0.	11/2017 IDS r other al DS 3.0 ed e results dents ances in EAAs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
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F 278 Continued From page	ge 12	F 278		
10/3/17 at 3:05 PM. responsible for com Behavior Section, o indicated she comp by reviewing nursing observations of the had not reviewed th section of the MDS. quarterly MDS for R had physical behavione to three days diperiod (7/16/17 throwith the SW. The I indicated she had p behaviors on 5 of 7 back period was reverseled this 7/22/1 coded inaccurately other behaviors docur. A follow up interview on 10/4/17 at 2:55 F the correction/modified of Resident #35's 7/2 An interview was conversely.  3. Resident #110 was 10/5/16 with multiple dementia with behaviors with the section of the section of the section of the section of the section was for accurately.	Inducted with the SW on She stated she was pleting Section E, the f the MDS assessments. She leted this section of the MDS gnotes and completing resident. She revealed she e MARs to code the behavior Section E of the 7/22/17 lesident #35 that indicated she ors and other behaviors on uring the seven day look back ugh 7/22/17) was reviewed MAR for Resident #35 that hysical behaviors and other days during the MDS look riewed with the SW. The SW 7 MDS for Resident #35 was for physical behaviors and ause she had not reviewed mented on the MAR.  In was conducted with the SW PM. She stated she had made rication to the behavior section 122/17 MDS.  Inducted with the Director of at 3:00 PM. She reported her the MDS to be coded  as admitted to the facility on the diagnoses including viors. The annual Minimum ressment dated 9/14/17 was		15 identified inaccurate vision CAAs Section V Care area Assessment (C were modified on 10/11/2017 to reflet correct visual devise used by this re Modified CAAs indicated the approping visual device coded in section B120 MDS. The modifications were done MDS nurse #1, and MDS nurse #2.  SYSTEMIC CHANGES Effective 10/25/2017, social worker review behaviors documented in electronic Medication Administration Records (eMAR) through "behavior report located in the facility used lice Electronic Health records software to ensure all documented behaviors from eMAR on a look back period are codaccurately per RAI guidelines.  On 10/12/17, 10/14/17 and 10/16/17 consultant conducted re-education caccurate coding of MDS using Resident Assessment Instruments (RAI) guident This education covers coding requirements and supportive documentation for each item coded MDS, specifically related to section accurate completion of Care Area Assessment when triggered.  Effective 10/25/2017, Education on Accurate coding of MDS will be adding the whires orientation education for Monurses, Director of Social Services,	ect the sident. riate 0 of by will types" ensed of om ded dent elines. in E and the ed to

	MENT OF DEFICIENCIES  AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	•	
				7166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAM	SEUR		RAMSEUR, NC 27316		
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F 278	Continued From page	e 13	F 2	78		
	and she had not exhi	bited any physical behaviors.		provided annually for MDS nu Director of Social Services, A		
		ring documented on the ation Record (MAR) during		Director, and the Dietary Man	ager (CDM).	
		od was reviewed. The left that Resident #110 had		MONITORING PROCESS		
	exhibited grabbing ar	nd or kicking behavior on		Effective 10/25/2017, prior to	submission,	
		d 5:17 PM, 9/10/17 at 4:16		MDS Nurse #1 and/or MDS i	nurse #2 will	
	PM, 9/11/17 at 8:22 A	AM and 9/14/17 at 6:31 PM.		review section E of MDS asse		
				completed by the social work		
		M, the Social Worker (SW)		that all documented behavior		
		e stated that she was		is coded accurately per RAI		
	T	g the behavior section of the		These reviews will take place		
		the stated that she reviewed		through Friday, prior to subm		
	the nurse's notes for	behaviors but not the MAR.		weeks on all completed comp		
	On 10/4/17 at 2:55 D	M, the SW stated that she		MDS assessments, 50% of a comprehensive MDS assessr		
		/modification on the behavior		for 2 weeks, then 25% of all of	-	
		ssessment for Resident		MDS assessments monthly for	•	
	#110.	occoment for recordent		or until the pattern of complia		
		M, the Director of Nursing		achieved.		
		ed. She stated that she		Effective 10/25/2017, prior to	submission	
		ssessments to be accurate.		MDS Nurse #1 will review Vi		
	· •	was admitted to the facility		area Assessments (CAAs) co		
	6/17/16. Cumulative			MDS nurse #2 (and vice vers	•	
		and glaucoma (eye disease		that an appropriate visual dev		
	that can damage the	optic nerve and vision loss).		a resident if any, as coded in	section	
				B1200 id reflect in Vision CAA	As per RAI	
	An Annual Minimum	Data Set (MDS) dated		guideline. These reviews will	take place	
		sident #31 was moderately		Monday through Friday, prior		
		h limited vision and was not		submission for 2 weeks on a		
		er headlines but could		comprehensive MDS assessr		
		MDS indicated Resident		of all completed comprehensi		
	#31 had corrective le	nses.		assessments weekly for 2 we		
	A O = = A = = A			25% of all completed MDS as		
		ment (CAA) dated 5/31/17		monthly for 3 months or until	tne pattern	
	-	esident #31 triggered for a diagnosis of glaucoma.		of compliance is achieved.		
	i visual lunction due to	a diadhosis of diadcoma.	1	1		1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING			10/	05/2017
	ROVIDER OR SUPPLIER	SEUR		71	TREET ADDRESS, CITY, STATE, ZIP CODE 166 JORDON ROAD AMSEUR, NC 27316	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Eyeglasses were wor appliances had the for glasses, distance glass magnifying glass.  A care plan dated 6/2 9/13/17 stated Reside glaucoma. Approach monitor and report syrelated to her eyes or On 10/03/2017 at 12: observed sitting in hen ursing station. Resiglasses.  On 10/03/2017 at 2:3 conducted with NA # wore glasses. She steyeglasses on when a conducted with MDS obtained her informat observation, during stated the CAA area of was automatically posterior contact lenses and monitors and eyeglasses.  On 10/4/17 at 3:01 Pl conducted with the D she expected the MD she expected the magnitude of the property o	n. The CAA use of visual sees, contact lenses and 8/16 and last reviewed ent #31 had a diagnosis of es included, in part, to mptoms of change of status vision.  01 PM, Resident #31 was r wheelchair near the dent #31 was wearing eye  3 PM, an interview was who stated Resident #31 she provided care for her.  4 AM, an interview was Nurse #1. She stated she ion about vision from taff interviews and reviewing immaries. MDS Nurse #1 for use of visual appliances oulated and contained eases, distance glasses, agnifying glasses and the emoved. She stated she imments that Resident #31	F	2278	Effective 10/25/17, MDS nurse #1, MD nurse #2, and/or Director of Social Services, will bring the results of this at to the monthly QAPI meeting and press the findings. This will continue for a per of 3 months. The QAPI team will make adjustments to this plan as deemed necessary to ensure compliance.  Effective 10/25/17, the center Executiv Director and the Director of health services will be ultimately responsible to ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantic compliance.	udit ent riod e	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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F 278	Alzheimer's disease that can damage the A Quarterly MDS da Resident #31 was m with limited vision an newspaper headline. The MDS indicated corrective lenses.  On 10/4/17 at 9:44 A conducted with Nursion section of the stated Resident #31 the time of the asses would check her not had refused to wear had not been availar reviewed her noted any documentation #31's glasses were assessment.  On 10/4/17 at 3:01 F conducted with the I she expected the M 4. c. Resident #31 of 6/17/16. Cumulative Alzheimer's disease that can damage the	e diagnoses included and glaucoma (eye disease e optic nerve and vision loss).  Ited 8/17/17 indicated inderately impaired in vision and was not able to see is but could identify objects. Resident #31 did not have  AM, an interview was see #1 who had completed the MDS dated 8/17/17. She did not have her glasses at issment. She stated she ided and see if Resident #31 her glasses or if the glasses on the glasses of the time. Nurse #1 as stated she did not have as to why or where Resident at the time of the  PM, an interview was Director of Nursing who stated	F 2'	78		
	newspaper headline	nd was not able to see is but could identify objects. Resident #31 did not have				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 278 F 281 SS=D	completed the vision 9/11/17. She stated, glasses were not on she did not know if the time and did not ask.  On 10/4/17 at 3:01 F conducted with the E she expected the ME	M, an interview was Nurse #2 who stated she section of the MDS dated at the time, Resident #31's her or available. She stated he glasses were lost at that anyone about the glasses.  M, an interview was Director of Nursing who stated DS to be accurate.  VICES PROVIDED MEET	F 27		10/25/17
	as outlined by the comust-  (i) Meet professional This REQUIREMEN' by: Based on record revices Consultant Pharmac facility failed to admit treat Diabetes Mellituphysician for 1 (Resi resident reviewed whinsulin. Findings incomplete Resident #91 was ac 6/7/17 with multiple of Mellitus. The quarter assessment dated 9/10.	ed or arranged by the facility, imprehensive care plan, standards of quality. T is not met as evidenced view, observation and ist and staff interview, the nister Lantus insulin (used to us) as ordered by the dent #91) of 1 sampled no was receiving Lantus		IMMEDIATE ACTION TAKEN  Staff Development Coordinator (SDC) obtained a clarification order from physician on 10/04/2017 for resident # Lantus at bedtime was clarified to Lev at bedtime. SDC transcribed the clarif order appropriately on resident's Medication administration record. Resident responsible party notified by staff development coordinator on 10/4/2017 of the new order.	#91. emir ied

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE	SURVEY PLETED
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	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMS	SEUR		71	TREET ADDRESS, CITY, STATE, ZIP CODE 166 JORDON ROAD AMSEUR, NC 27316	•	
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F 281	days.  Resident #91 had a property for Lantus insulin 12 bedtime for Diabetes  On 10/4/17 at 11:45 where Resident #91 in There was a used Letreat Diabetes Melliture on it but there was not the state of Lantus and the she expected the nurbeyemir instead of Lantus and she experimental to mit but the she expected the nurbeyemir instead of Lantus and she experimental to mit but there was not the she expected the nurbeyemir instead of Lantus and she experimental to mit but there was not the she expected the nurbeyemir instead of Lantus and she experimental to mit but there was not the she expected the nurbeyemir instead of Lantus and she experimental to mit but there was not the she experimental to mit but there was not the she experimental to mit but there was not the she experimental to mit but there was not the she experimental to mit but there was not the she expected the nurbeyemit instead of Lantus as a pharmacy indicated the physical to mit but there was not the she expected the nurbeyemit instead of Lantus as a pharmacy indicated the physical to mit but the she experimental the she experime	chysician order dated 6/7/17 units subcutaneous (SQ) at Mellitus.  AM, the medication cart resided was observed. vemir insulin pen (used to s) with Resident #91's name of Lantus insulin noted.  M, the Consultant viewed. She stated that same as Lantus insulin and se to write an order to give antus.  M, the Director of Nursing red. She expected the nurse verbe Levemir instead of coted the nurses to make inistered matched with the me was giving Levemir ordered because the red tat Levemir and Lantus red. Nurse #3 added that she	F 2	281	IDENTIFICATION OF OTHERS  All residents with medication or treatmorders have the potential to be affected.  On 10/4/2017, Staff Development Coordinator and Assistant director of Nursing audited all residents with insure orders to determine if correct order was entered into the resident's electronic medical record. As a result of the audit two other resident were identified with appropriate order. On 10/4/2017 Staff development coordinator corrected the identified incorrect order; residents' far and physician were notified. It is evide that resident's insulins identified as incorrect were therapeutically substitut as approved by the facility Medical Director; however the facility did not transcribe the substituted order in resident's electronic Medication Administration Records.  100% audit of current medications for current residents was completed by the Facility's pharmacy personnel, Director Nursing, Staff Development Coordinate and Nursing Supervisor on 10/20/2017 identify any other resident with medication treatment orders that was therapeutically substituted but not transcribed to reflect the substitution in resident's medication and/or treatment administration records. This audit was completed on 10/12/17, 10/13/17, 10/16/17, 10/17, 10/17, 10/18/18 and 10/20/1	in s ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	

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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
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F 281	Continued From page	e 18	F 2	therapeutically substituted meditranscribed in medical records  SYSTEMIC CHANGES Effective 10/25/2017, the new 2 chart check will be implemented 24-Hour chart check is the procected in trecent 24 hours to ensure accurproper transcriptions. If any metreatment order is not transcribe ordered, night shift nurse, Direct Nursing, Assistant Director of N Staff Development Coordinator Supervisor will ensure it is transcorrectly on the electronic Medic Administration Record or electro Treatment Administration Record Hour chart check form will be lobinder titled 24 Hour report at eanurse's station.  Effective 10/20/2017, the center administrative team, which incluad ADON, and/or SDC, initiated a previewing all new physician order change of orders daily (Monday Friday) and will address any dis in a promptly. The assigned nuradministrative team member will orders written in the physician of to orders transcribed on the Meadministration Record (MAR). A identified issues will be address promptly and appropriate action implemented by the DON, ADO and/or Registered Nurse superveffective 10/25/2017, week end	24-hour d. The less of the most rate and edication or ed as stor of lursing, or Nursing scribed cation onic rds. 24-leated in a lach or nursing ludes DON, process for ers or or through screpancy rse ll compare order forms dication Any sed les will be len, SDC visor.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG	1, ,	SURVEY PLETED
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F 281	Continued From page	e 19	F2	Registered Nurse supervisor and/o designated licensed nurse will revinew orders or change of orders ev Saturday & Sunday and will addres discrepancy in a timely manner. The assigned nurse administrative tear member will compare orders written physician order forms to orders transcribed on the Medication Administration Record (MAR). Any identified issues will be addressed promptly and appropriate actions wimplemented as appropriate by the Registered Nurse supervisor, and reported to the center's DON timel On 10/12/2017, Regional Clinical conducted an education with the conducted an education with the conducted an education with the conducted an education emphasize how to identify a root cause when sorder is not transcribed appropriate actions to be taken to address any discrepancies in a timely manner.  Director of Nursing (DON), Assistan Director of Nursing (ADON) and/or Development Coordinator (SDC) word complete 100% education for all licentric transcription. This education word completed by 10/25/2017. Any licentric nurse not educated by 10/25/2017 be allowed to work until educated. education will also be added on new and transcription work until educated.	ew, all ery s any e n in in the rill be rirector enter of arough d on an ely and on ely and on it staff ill ensed e and ur chart stration ill be nsed will not This	

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F 281	Continued From page	e 20	F 28	orientation process for all new nurses effective 10/25/2017.  MONITORING PROCESS Effective 10/25/2017, Director Assistant Director of Nursing, Development Coordinator, wil proper transcription of physicic conducting clinical meeting dareview of physician orders wriprior clinical meeting, any admission/discharges occurred last clinical meeting and/or an or accidents occurred from the clinical meeting. The audit and will ensure physician orders a transcribed correctly to the MA Any issues identified during the monitoring process will be addepromptly. Findings from this mode documented on a daily cliniform and filed in clinical meetin Director of Nursing office after follow ups are done. Director will review the completion of direport daily (M-F) for 2weeks, more weeks, then monthly x 3 until the pattern of compliance maintained.  Effective 10/25/2017, Director will report findings of this mon process to the facility Quality A and Performance Improvemer Committee for any additional or modification of this plan momonths, or until the pattern of is maintained. The QAPI commodify this plan to ensure the	r of Nursing, and/or Staff II monitor an orders by aily (M-F), itten from the monitor and from the monitoring weekly x 2 months or exist of Nursing dially clinical weekly x 2 months or exist of Nursing monitoring Assurance monitoring onthly X3 compliance mittee can	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING _		<del></del>	10/	05/2017
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMS	EUR	•	71	TREET ADDRESS, CITY, STATE, ZIP CODE 166 JORDON ROAD AMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	FROM UNNECESSA  483.45(d) Unnecessa Each resident's drug annecessary drugs. drug when used  (1) In excessive dose therapy); or  (2) For excessive dura  (3) Without adequate  (4) Without adequate  (5) In the presence of which indicate the dose discontinued; or  (6) Any combinations	RUG REGIMEN IS FREE RY DRUGS  ry Drugs-General. regimen must be free from An unnecessary drug is any  (including duplicate drug  ation; or		329	remains in substantial compliance.  Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible to ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance.	0	10/25/17
	483.45(e) Psychotrop Based on a comprehe resident, the facility m	ensive assessment of a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		345523	B. WING	·	10	)/05/2017
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	drugs are not given t medication is necess	e 22  ave not used psychotropic hese drugs unless the ary to treat a specific ed and documented in the	F 32	9		
	gradual dose reduction interventions, unless an effort to discontinuthis REQUIREMENT by: Based on record reversality failed to obtain Basic Metabolic Paniphysician for 2 (Residual Residual Res	clinically contraindicated, in		IMMEDIATE ACTION  Resident #43 Basic Metabolic obtained on 10/05/2017 by the Development Coordinator, blo to the Licensed Laboratory, re received and communicated to 10/06/2017 by Licensed nurse	e Staff od was sent sults o MD on	
	10/5/16 with multiple Hypertension and Atr Minimum Data Set (N 9/14/17 indicated that cognitive impairment Resident #110 had a 10/5/16 for Magnesiulevel of Magnesium i (mgs) 1 tablet by mo Resident #110 had a 10/26/16 for Magnes week.  Resident #110's med	diagnoses including rial Fibrillation. The annual MDS) assessment dated to treat low in the body) 400 milligrams with twice a day.  physician's order dated ium level to be drawn in 1  dical records including are reviewed and there was		Resident #110).  Magnesium level was also obt 10/05/2017 by the Staff Devel Coordinator, blood sent to the Laboratory, results received a communicated to MD on 10/06 licensed nurse #2. No Critical findings noted. Results for bot tests are filed in each resident records  IDENTIFICATION OF OTHER  All residents who take medica requires laboratory test monito potential to be affected.	tained on opment Licensed nd 6/17 by I laboratory h laboratory medical	

PRINTED: 11/07/2017 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345523	B. WING _		1	0/05/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		0,00,2011
				7166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RA	MSEUR		RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES CNCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 329	Continued From page 23 On 10/4/17 at 11:36 AM, the Staff Development			100% of resident lab ord for the past three months		
	that she could not	was interviewed. She stated find a Magnesium level report edical records. The SDC also		of Nursing on 10/6/17 an lab orders were then cor resident's chart to identif	mpared to each	
	the laboratory did	had called the laboratory and not have a Magnesium level		corresponding lab result result of this audit, it was	found that no	
	the Magnesium lev			other residents were four ordered labs documente results that weren't comp	d on laboratory oleted as	
	(DON) was intervie	PM, the Director of Nursing weed. The DON stated that he laboratory reports were		indicated. Findings of thi documented on the "lab		
	considered doctor expected the nurse Magnesium level.	s order. She indicated that she to transcribe the order for the The DON indicated that the esium level was missed.		100% of resident ordered results for the last three to identify any if there is ordered laboratory test dany result. This audit was all results for all active respired or of Nursing, Staff	months reviewed any follow up locumented on s completed for esidents by the	
	7/6/17 with multiple Congestive Heart Minimum Data Set 7/13/17 indicated t	as admitted to the facility on e diagnoses including Failure (CHF). The admission (MDS) assessment dated hat Resident #43's cognition had received a diuretic the last 7 days.		Director of Nursing, Staff Coordinator, Nurse Supe Licensed nurse #1. As a audit, it was found that to were found to have miss were received for a TSH and an iron study for res These results were recei and 10/12/17, reported to physician and placed in the charts. Findings of this a	ervisor and/or result of this wo other residents ing labs. Orders for resident 1386 ident 1652. ived on 10/11/17 o the attending the resident	
		a physician's order for Lasix ams by mouth daily for CHF.		documented on the "lab form".		
	reviewed. The replevel of 130. The melliequivalent peindicated that the	d 8/24/17 for Resident #43 was port revealed a low Sodium reference range was 137-146 r liter (meq/L). The report also Sodium level had improved 17 and 127 on 8/4/17.		100% audit for all require laboratory tests necessa of medication usage for was completed by the Lipharmacist, Director of Nassistant Director of necessity.	ry for monitoring current residents censed Nursing and	

Facility ID: 991059

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING _			10/05/2017
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS 7166 JORDON RO RAMSEUR, NC		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD E S-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 329	Review of Resident a including electronic report after 8/24/17.  On 10/4/17 at 11:38 Coordinator (SDC) with the she could not find September 2017 in the records. The SDC at called the laboratory have a BMP report of 2017. She added the missed.  On 10/4/17 at 3:00 F (DON) was interview orders written on the considered doctor's dexpected the nurse to	ohysician's order dated	F3	10/16/17, a other laboramedication ordered or identified waroutine laboramedication obtained. A tests order 10/20/17, 1 Results of a communical promptly. I documente form".  SYSTEMIC Effective 10 process will This process laboratory and results physician in process will to ensure of the first stellicensed nuresident (nu will transcript to both the records and effective 10. The second licensed nuresident of the	and 10/17/17 to identify any ratory test necessary for monitoring that was either obtained. 25 other resident with medication that require a coratory test for monitoring on but was either not ordered all identified needed laborated and will be completed or 10/23/2017 and 10/24/2017. It those laboratory tests will be attending physical findings of this audit is ad on the "Routine lab audit or the attending physical findings of this audit is ad on the "Routine lab audit or the attending physical findings of this audit is at a timely manner. This lab are resported to residents attending the attending physical findings of this audit or the attending physical findings of this audit is an attending physical findings of this audit is reported to residents attending the accompliance.  The will be completed by a compliance.  The will be completed by a compliance on duty). Nurse on dutit is any ordered laboratory the facility electronic medical don the daily laboratory log 0/25/2017.  The destending the completed by a compliance on the daily laboratory log 0/25/2017.	not tts a if or ory n e iiiity. hed, ding ach the ty test

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ( IDENTIFICATION NUMBER: A. BUILDING		' '	(X3) DATE SURVEY COMPLETED		
		345523	B. WING _			10/	05/2017
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMS	SEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES IE MUST BE PRECEDED BY FULL PRE SC IDENTIFYING INFORMATION) TA		х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	e 25	F	329	Night shift nurse will complete a 24 ho chart check and ensure all orders to include laboratory tests were transcrib appropriately. If any laboratory test wa not transcribed as ordered, night shift nurse will ensure it is transcribed.  Laboratory tests will be obtained by the DON, ADON, SDC and/or designated licensed nurse on the date ordered to completed and results will be returned the facility via facsimile.  The third step will involve the nurse on duty on the evening shift, Effective 10/25/2017, the evening shift nurse on duty will be responsible to ensure all ordered laboratory tests are resulted a communicated to MD in a timely manned the step in the step in all shifts are responsible report laboratory results to physician promptly as they receive the laboratory results. Evening shift nurses are the gatekeepers of this process.  New standing orders lab protocol reimplemented in the facility effective 10/20/2017. This laboratory protocol we used to identify type of laboratory terecommended with different therapeut medication classes to ensure adequate monitoring. When a resident is admitted the required laboratory tests necessary medication monitoring per lab protocol be ordered ad entered in facility electromedical records.	ed s e be to  nd er. ailly t at to  /  ill ests c e ed,  / for will	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345523	B. WING	<del></del>		10/05/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/RAMS	SELIR		7166 JORDON ROAD			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 329	Continued From page	e 26	F 32	Effective 10/25/17, At the beginneach month, the Director of Nursing, st development, Nursing manager designated licensed nurse will reroutine laboratory report obtaine Facility electronic health records and ensure completion per orde On 10/20/2017, Regional clinical completed an education to the Director of nursing, Staff Development Code and Licensed nurse #100 the new laboratory process in the facility Director of nursing, staff Develo Coordinator and/or Nurse Manal complete 100% education for all nurses, to include full time, part as needed staff, on the new laborated by 10/25/2017. Any licensed nurseducated by 10/25/2017 will not allowed to work until educated.  The new laboratory process will to new hire orientation process flicensed nurses effectively 10/25 and will also be provided annual MONITORING PROCESS  Effective 10/25/2017; Director or Staff development Coordinator, Manager and/or designated licenurse will review physician orde prior day, for proper transcription follow through. Director of Nursidevelopment Coordinator, Nursid	sing, aff and/or eview the ed from a software r.  Il director Director of ordinator, ew  pment ger will I licensed time and oratory completed rse not be  be added for all 5/2017, llly.  f Nursing, Nursing nsed rs for the n and ng, Staff		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG	' '	(X3) DATE SURVEY COMPLETED	
		345523	B. WING _		10/	05/2017	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMS	SEUR	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC  (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329	Continued From page	; 27	F	supervisor and/or Designated Licens nurse will follow up to ensure any laboratory tests noted were obtained ordered. This monitoring process will done daily (Monday - Friday) for 2 w Weekly x 2 more weeks then monthl months or until the pattern of complicis maintained. The result of this monitoring process will be document "Daily laboratory monitoring tool and be maintained in the facility compliant binder.  Effective 10/25/2017; Medical record Clerk will review laboratory log for the prior day(s) and compare with laboratests obtained on that date, to ensurordered laboratory tests were complianted and followed through appropriately. Any discrepancies not will be reported to the Director of nursund/or the Administrator promptly. Tomonitoring will be done daily (Monda Friday) x 2 weeks, Weekly x 2 more weeks then monthly x 3 months or use the pattern of compliance is maintain.  Effective 10/25/2017, Director of Nurwill report findings of this monitoring process to the facility Quality Assuration and Performance Improvement. Committee for any additional monito or modification of this plan monthly three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to enthe facility remains in substantial compliance.	as be eeks, / x 3 ince ed on will ce etory e all eted, ed sing nis y - ntil ed. sing or		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING _			10/	05/2017
	ROVIDER OR SUPPLIER	BEUR	•	71	TREET ADDRESS, CITY, STATE, ZIP CODE 66 JORDON ROAD AMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	e 28	F:	329	Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible tensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance	0	
F 428 SS=E	483.45(c)(1)(3)-(5) DE REPORT IRREGULA	RUG REGIMEN REVIEW, R, ACT ON	F	128			10/25/17
	c) Drug Regimen Rev	riew					
	reviewed at least once pharmacist.  (3) A psychotropic drubrain activities associ and behavior. These	of each resident must be e a month by a licensed  ug is any drug that affects ated with mental processes drugs include, but are not e following categories:					
	(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.						
	to the attending physi	ctor and director of nursing,					
	``	le, but are not limited to, any riteria set forth in paragraph an unnecessary drug.					
		noted by the pharmacist st be documented on a ort that is sent to the					

	OF DEFICIENCIES F CORRECTION	I DENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345523	B. WING _	<del></del>		0/05/2017		
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAM	SEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 428	director and director minimum, the resider and the irregularity the continuous of the irregularity has been action has been take be no change in the physician should door the resident's medication for the resident's medication for the different steps the pharmacist identifies an irregular to protect the resident to protect the resident This REQUIREMENT by:  Based on record revent pharmacist and staff Pharmacist failed to Magnesium level, fair regimen review and gradual dose reduction medication for 2 (Residents remedications. Finding 1a. Resident #110 w 10/5/16 with multiple Dementia with behave Fibrillation. The ann assessment dated 9/10/15/16 minimum and the resident of the continuous fibrillation. The ann assessment dated 9/10/15/16 with multiple Dementia with behave Fibrillation. The ann assessment dated 9/10/15/16 with multiple pharmacist manner that the continuous fibrillation. The annuassessment dated 9/10/15/16 with multiple pharmacist manner that the continuous fibrillation. The annuassessment dated 9/10/15/16 with multiple pharmacist failed to the continuous fibrillation. The annuassessment dated 9/10/15/16 with multiple pharmacist failed to the continuous fibrillation. The annuassessment dated 9/10/15/16 with multiple pharmacist failed to the continuous fibrillation. The annuassessment dated 9/10/15/16 with multiple pharmacist failed to the continuous fibrillation.	and the facility's medical of nursing and lists, at a nt's name, the relevant drug, he pharmacist identified.  Sysician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending nument his or her rationale in all record.  See the monthly drug regimen but are not limited to, time int steps in the process and must take when he or she with that requires urgent action int.  To is not met as evidenced riew and Consultant interview, the Consultant address the missing led to have an accurate drug failed to identify a failed on (GDR) for antipsychotic sidents #110 & #35) of 5 eviewed for unnecessary gs included:  as admitted to the facility on diagnose including viors, Hypertension and Atrial and Minimum Data Set (MDS)	F 4:	IMMEDIATE ACTION  1a. Drug Regimen Review d for resident #110 dated 8/5/2 9/10/17 reviewed and clarific Licensed Pharmacist to correntry error, and to reflect the medication resident was take of the review. It is concluded root cause analysis process errors happened at the time licensed pharmacist was traindividual resident Drug Reg from one electronic health reto another using copying and functionality. The clarified do	2017 and ed by the ect the data e correct ing at the time d based on that those when nsferring gimen Review ecord software d pasting			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345523	B. WING _		10/05/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	·
				7166 JORDON ROAD	
UNIVERSA	AL HEALTH CARE/RA	AMSEUR		RAMSEUR, NC 27316	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE COMPLETION THE APPROPRIATE
F 428	Continued From p	age 30	   F4	.28	
S   (   t	Resident #110's p Seroquel (antipsy (antidepressant),	hysician's orders included chotic), Prozac and Remeron Depakote ( used to treat s (anticoagulant), Metoprolol		This clarification was cond 10/12/2017  b. Magnesium level was al	
	(antihypertensive) Magnesium suppl use to treat Atrial	, Magnesium Oxide ( ement), Digoxin and Cardizem( Fibrillation) and Simvastatin		10/05/2017 by the Staff De Coordinator, blood sent to Laboratory, results receive	evelopment the Licensed d and
	(antihyperlipidemi	a). nt #110's drug regimen review		communicated to MD on 1 licensed nurse #2. No Crit findings noted. Results for	ical laboratory
	8/5/17 revealed "c	cted. The DRR notes dated continue Remeron 30 daily are 0.5 every 6 hours PRN (as		tests are filed in each residence records.	lent medical
	needed) anxiety a	nd agitation, Zoloft 100 daily ( dose increased in		Resident #35 failed Grad Reduction for Seroquel in I	
	with behavioral dis	osych eval note 4/27, dementia sturbances, fair, Zyprexa for		is now documented in Lice Pharmacist from July 2017	to current.
	Remeron, no acut	improved with Zoloft and e, continue to monitor. Noted		Director Clinical Services of Vender that provides services	ces to the
	reactions, attempt	) daily, no adverse drug gradual dose reduction (GDR)		facility was notified of this a noncompliance by the facil	ity executive
	Zoloft, Medical Do			Director on 10/12/2017. Ph Director addressed the inv	olved licensed
The DRR notes dated 9/10/17 indicated 20 mgs by mouth daily for depression) d 10/25) and then increased back 3/23. K 0.5 mgs twice a day PRN (as needed) anxiety/depression (changed from sched		daily for depression) decreases acreased back 3/23. Klonopin ay PRN (as needed) n (changed from scheduled		pharmacy who omitted failuresident #35 per pharmacy policy. No further action tal alleged non-compliance.	personnel
	"help me." " On Se	d some incidences of yelling out eroquel 12.5 twice a day added ning. Will request GDR in		IDENTIFICATION OF OTH	IERS
	October."			All residents has a potentia affected.	al to be
	Pharmacist was in that her DRR note indicated that Res Zoloft, Zyprexa, O	1 PM, the Consultant sterviewed. She was informed as dated 8/5/17 and 9/10/17 sident #110 was on Ativan, meprazole and Klonopin. The acist stated that she had to		100% audit of DRR docum active residents was comp Licensed Pharmacist to en completion and accuracy. covered all DRR documen	leted by the sure This audit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345523	B. WING			10/	05/2017	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				71	166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAN	MSEUR		R	AMSEUR, NC 27316			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 428	Continued From pag	ge 31	f F	428				
		on her tablet during the DRR			months. This audit was aimed to identi	fv.		
		e had to cut and paste her			any in-accurate DRR documentation	ıy		
		s computer. She added that			and/or any missing failed GDR			
	_	and paste the wrong			documentation. No other resident			
	_	esident's records, She			identified as having incorrect or missing	7		
		Resident #110 was not on			DRR. This audit was completed on	9		
	_	exa or Omeprazole. She also			10/12/2017. Findings of this audit is			
		t #110 might have been on			located in the facility compliance binde	r.		
		po but she would check the						
	records.				100% of resident lab orders were audit	ed		
					for the past three months by the Direct	or		
					of Nursing on 10/6/17 and 10/9/17. The	ese		
	b. Resident #110 wa	as admitted to the facility on			lab orders were then compared to each	า		
	10/5/16 with multiple	e diagnose including			resident's chart to identify if a			
	Dementia with beha	viors, Hypertension and Atrial			corresponding lab result is present. As	а		
	Fibrillation. The ann	nual Minimum Data Set (MDS)			result of this audit, it was found that no			
		9/14/17 indicated that			other residents were found to have			
	Resident #110 had	severe cognitive impairment.			ordered labs documented on laborator	y		
					results that weren't completed as			
		a physician's order dated			indicated. Findings of this audit is	_		
		ium Oxide (used to treat low			documented on the "lab order audit for	m".		
		in the body) 400 milligrams						
	(mgs) 1 tablet by mo	outh twice a day.			100% of resident ordered laboratory te			
	D				results for the last three months review	ed		
		a physician's order dated			to identify any if there is any follow up			
		sium level to be drawn in 1			ordered laboratory test documented or			
	week.				any result. This audit was completed for			
	Docident #110's me	dical records including			all results for all active residents by the Director of Nursing, Staff Development			
		vere reviewed and there was			Coordinator, Nurse Supervisor and/or			
	no Magnesium leve				Licensed nurse #1. As a result of this			
	no magnesiam leve	Toport Hoteu.			audit, it was found that two other reside	ents		
	Review of Resident	#110's drug regimen reviews			were found to have missing labs. Orde			
		ed. The DRR notes revealed			were received for a TSH for resident 1			
	, ,	Pharmacist had conducted a			and an iron study for resident 1652.			
		1/5/16, 2/3/17, 3/5/17 and			These results were received on 10/11/	17		
		ndicated "Magnesium level in			and 10/12/17, reported to the attending			
		abs (laboratory)." The DRR			physician and placed in the resident	,		
		indicated "Magnesium level in			charts. Findings of this audit will be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345523	B. WING _				10/05/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
				71	166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		R	AMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 428	Continued From page	e 32	F 4	428				
	June 2017 through S	bs NN (nursing)." From eptember 2017, the missing s not addressed on the DRR			documented on the "lab results audit form".  100% audit for all required routine laboratory tests necessary for monitor	ing		
	had addressed on he Magnesium level as of 2016 through April 20 addressed the missir Nursing. She acknow follow up with the Dir Magnesium level after 2. Resident #35 was 9/29/14 with diagnost disorder, major depredelusional disorder.  A physician's order for 11/2/16 indicated a G (GDR) of Seroquel (a Resident #35's previous for Seroquel was 1000)	viewed. She stated that she er notes to follow up for the ordered from November 17. On May 2017, she ing Magnesium level with wledged that she failed to ector of Nursing the missing er May 2017.  admitted to the facility on es that included anxiety essive disorder, and or Resident #35 dated for adual Dose Reduction antipsychotic medication). Our order (prior to 11/2/16) of milligrams (mg) twice daily.			of medication usage for current reside was completed by the Licensed Pharmacist, Director of Nursing and Assistant Director of nursing on 10/13. 10/16/17, and 10/17/17 to identify any other laboratory test necessary for medication monitoring that was either ordered or obtained. 25 other resident identified with medication that require routine laboratory test for monitoring of medication but was either not ordered obtained. All identified needed laborate tests ordered and will be completed of 10/20/17, 10/23/2017 and 10/24/2017 Results of those laboratory tests will be communicated to the attending physic promptly. Findings of this audit is documented on the "Routine lab audit form".	nts /17, not ts a of or ory n . e ian		
	to 75 mg in the morning remaining at 100 mg.  Resident #35's month (DRR) was complete Pharmacist on 11/9/1 with a GDR of Seroque 2016) with physician' morning and 100 mg.  Resident #35's month	hly Drug Regimen Review d by the Consultant 6. Resident #35 was noted uel this month (November s orders for 75 mg in the at bedtime. hly DRR was completed by			SYSTEMIC CHANGES  Effective 10/25/2017, Licensed pharmacist will document monthly DR include any failed GDR in resident's electronic medical records and also w provide a hard copy of all DRR month the facility Executive Director and/or Director of nursing to be filed in reside medical records.	ill nly to ent's		
		nacist on 12/5/16. The DRR uel 75 mg [in the morning]			Effective 10/25/2017, licensed pharma will provide the list of outstanding and			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NITIMBED:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING _			10	)/05/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
				7	166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAMS	EUR		R	AMSEUR, NC 27316		
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F 428	Continued From page	≥ 33	F4	428			
	and 100 mg [at bedtin [2016] will continue to A physician's order da increase in the morning from 75 mg for Re 12/10/16. The evening remained at 100 mg ff #35 was noted to have Seroquel.  There was no monthly for Resident #35's month the Consultant Pharm 4/5/17, 5/3/17, and 6/ listed read, in part, "S morning] and 100 mg November [2016] will was no documentation Pharmacist of Reside Seroquel in December February 2017 through Resident #35's month	me]GDR in November of watch."  ated 12/9/16 indicated an ang dose of Seroquel to 100 esident #35 starting on ang dose of Seroquel for Resident #35. Resident we failed the GDR for  by DRR in the medical record at 12/6/16 through 2/4/17.  The DRR for all dates be a factorial for the interest of the interest for the interest fo		720	past due laboratory tests needed for medication monitoring. This list will be provided to the Executive Director and Director of nursing for proper follow through.  Effective 10/25/2017, a new laboratory process will be implemented in the faci This process will ensure all ordered laboratory tests are transcribed, obtain and results reported to residents attend physician in a timely manner. This lab process will involve three steps approat to ensure compliance.  The first step will be completed by a licensed nurse responsible to care for the resident (nurse on duty). Nurse on duty will transcribe any ordered laboratory to both the facility electronic medical records and on the daily laboratory log effective 10/25/2017.  The second step will be completed by a licensed nurse responsible to care for the resident during night (Night shift nurse) Night shift nurse will complete a 24 hou chart check and ensure all orders to	lity. ed, ding ch the est a the	
	2016]."  The quarterly Minimu assessment dated 7/2 #35's cognition was s	rrent dose in [December m Data Set (MDS) 22/17 indicated Resident severely impaired. She was chotic medication on 7 of 7			include laboratory tests were transcribe appropriately. If any laboratory test was not transcribed as ordered, night shift nurse will ensure it is transcribed.  Laboratory tests will be obtained by the DON, ADON, SDC and/or designated licensed nurse on the date ordered to be completed and results will be returned the facility via facsimile.	e De	
	A review of the currer	nt physician orders for			The third step will involve the nurse on		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345523	B. WING			10/	05/2017
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMS	SEUR	•	STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316			
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F 428	Resident #35 was cophysician's orders incremained on Seroque 12/10/16.  An interview was conpharmacist on 10/4/1 she completed a DRF month. She indicated duplicate her note frow then adjust the note a order dated 11/2/16 then adjust the note and order dated 11/2/16 then adjust the note and consultant Pharmacidated 12/9/16 that incomplete the failed Gradentified th	inducted on 10/4/17. The dicated Resident #35 el 100 mg twice daily since diducted with the Consultant 7 at 10:50 AM. She stated R for residents once per d her normal process was to om the previous month and as needed. The physician's hat indicated a Seroquel 5 was reviewed with the st. The physician's order dicated the Seroquel GDR failed was reviewed with the st. The monthly DRR's from gh June 2017 that had not 6DR of Seroquel for Resident with the Consultant Pharmacist stated explain why she had not 6DR of Seroquel that 10DR of Seroquel that	F	428	duty on the evening shift, Effective 10/25/2017, the evening shift nurse on duty will be responsible to ensure all ordered laboratory tests are resulted at communicated to MD in a timely manne Evening shift nurse will indicate on a dalaboratory log form when the test result are not back during evening shift on the day. Nurse in all shifts are responsible report laboratory results to physician promptly as they receive the laboratory results. Evening shift nurses are the gatekeepers of this process.  New standing orders lab protocol reimplemented in the facility effective 10/20/2017. This laboratory protocol wibe used to identify type of laboratory terecommended with different therapeutic medication classes to ensure adequate monitoring. When a resident is admitted the required laboratory tests necessary medication monitoring per lab protocol be ordered ad entered in facility electromedical records.  Effective 10/25/17, At the beginning of each month, the Director of Nursing, Assistant Director of Nursing, staff development, Nursing manager and/or designated licensed nurse will review the routine laboratory report obtained from Facility electronic health records softwal and ensure completion per order.  On 10/20/2017, Regional clinical direct completed an education to the Director Nursing, Staff Development Coordinate and Licensed nurse #1on the new	er. ailly at to  Il sts c ed, rfor will unic or of	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 428	Continued From pag	e 35	F4	128	laboratory process in the facility.  Director of nursing, staff Development Coordinator and/or Nurse Manager will complete 100% education for all licens nurses, to include full time, part time ar as needed staff, on the new laboratory process. This education will be complete by 10/25/2017. Any licensed nurse not educated by 10/25/2017 will not be allowed to work until educated.  The new laboratory process will be add to new hire orientation process for all licensed nurses effectively 10/25/2017 and will also be provided annually.  MONITORING PROCESS  Effective 10/25/2017, the facility medic record clerk, and/or Executive Director review the facility monthly DRR to ensucompletion. Any identified omission will reported to the licensed pharmacist immediately. This audit will be completed monthly for 3 months or until the patter of compliance is maintained. This monitoring process will be documented "Medical Records audit tool"  Effective 10/25/2017, Pharmacy Clinical Director and/or designated Licensed Pharmacy will review the facility month DRR documentation to ensure completed and accuracy. This audit will focus to ensure documentation are accurate to include but not limited to failed GDR is any. This monitoring process will take place monthly within 10 business days	ed nd tted ded , al will ure l be ed n d on al		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 428	Continued From page	e 36	F4	the Licer or until the maintain Effective Staff dev Manage nurse will prior day follow the developing supervision nurse will laborate ordered, done da Weekly months is maintain monitori. "Daily labe maintain binder.  Effective Clerk will prior day tests obtoordered resulted appropri will be reand/or the monitorii Friday) weeks the patternal control of the patternal control or until the patternal con	nsed pharmacist visit for 3 more he pattern of compliance is ned.  e 10/25/2017; Director of Nursice velopment Coordinator, Nursice and/or designated licensed ill review physician orders for y, for proper transcription and grough. Director of Nursing, Soment Coordinator, Nursing for and/or Designated License ill follow up to ensure any gry tests noted were obtained. This monitoring process will illy (Monday - Friday) for 2 wex 2 more weeks then monthly or until the pattern of compliant ained. The result of this ng process will be documented boratory monitoring tool and of tained in the facility compliance of 10/25/2017; Medical record II review laboratory log for the y(s) and compare with laborate tained on that date, to ensure laboratory tests were completed and followed through itately. Any discrepancies note the Administrator promptly. Thing will be done daily (Monday at 2 weeks, Weekly x 2 more men monthly x 3 months or undern of compliance is maintained at 10/25/2017, Director of Nurse at 10/25/2017, Di	sing, ng the taff ed as be eks, ance ed on will ce story all ted, ed sing is / -		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 428	483.70(i)(1)(5) RES RECORDS-COMPLE LE (i) Medical records. (1) In accordance with standards and practic	TE/ACCURATE/ACCESSIB  In accepted professional es, the facility must ords on each resident that ented; ented; er; and ganized	F 4	will report findings of this monitor process to the facility Quality Ass and Performance Improvement Committee for any additional mor or modification of this plan month three months, or until the pattern compliance is maintained. The Q committee can modify this plan to the facility remains in substantial compliance.  Effective 10/25/17, the center Exp Director and the Director of health services will be ultimately respon ensure implementation of this plat correction for alleged noncompliatensure the facility remains in sub compliance.	urance nitoring ly for of API o ensure ecutive n sible to n of	10/25/17	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
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F 514	(iii) A record of the record o	ion to identify the resident; sident's assessments; ive plan of care and services by preadmission screening evaluations and fucted by the State; e's, and other licensed	F 5		N nentation for red from ronic Health red in resident's ronic Health red in resident's ronic Health red in resident's red from three months of audit represent. rentation for reved from ronic Health	
	indicated there was r 2/24/17 and 5/2/17 in	ws (DRRs) for Resident #13 no DRR between the dates of a the medical record.		medical records on 10/5/201 licensed pharmacist. Execut audited resident 35's medica 10/19/17 to ensure the past MRRs are present. Results of	ive Director al record on three months	

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			SURVEY PLETED
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			7166 JORDON ROAD		
AL HEALTH CARE/R	AMSEUR		RAMSEUR, NC 27316		
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Continued From r	page 39	F 5	14		
Pharmacist on 10 she completed a month. She indicher own electronic pasted her docume electronic medical record for there was no DRI dates of 2/24/17 at the Consultant Proposition of the Pharmacist stated pasted Resident in 2017 DRR from her facility's electronic An interview was Administrator on the expected the CODRR to be located 2. Resident #35 versident in 10 proposition of the proposi	DRR for residents once per ated she completed the DRR on c system and then cut and nentation into the facility's all records system. The facility's r Resident #13 that indicated R for Resident #13 between the and 5/2/17 was reviewed with narmacist. The Consultant d she must have not copied and #13's March 2017 DRR or April her electronic system into the complete medical records system.  conducted with the 10/4/17 at 12:00 PM. He stated Consultant Pharmacist's monthly d in the facility's medical record.		revealed all three months at 3. Staff Development Coord obtained a clarification order physician on 10/04/2017 for Lantus at bedtime was clarificated at bedtime. SDC transcribed order appropriately on reside Medication administration of Resident responsible party staff development coordinat 10/4/2017 of the new order.  IDENTIFICATION OF OTHE 100% audit of DRR document active residents was completed for the coordinated occumented in the last 3 monother resident identified as 1 DRR. This audit was completed 10/12/2017. Findings of this	linator (SDC) or from or resident #91. fied to Levemir d the clarified ent's ecord. notified by the for on  ERS entation for all eted by the he Executive on of medical all DRR onths. No naving missing eted on a audit is	
Drug Regimen Refrom 11/1/16 throm no DRR for Resid 12/6/16 and 2/4/1  An interview was Pharmacist on 10 she completed a month. She indicher own electronipasted her document of the she completed and the she completed a month.	eviews (DRR) for Resident #35 ugh 10/3/17 indicated there was lent #35 between the dates of 7.  conducted with the Consultant l/4/17 at 10:50 AM. She stated DRR for residents once per lated she completed the DRR on c system and then cut and mentation into the facility's		Coordinator and Assistant of Nursing audited all residents orders to determine if correct entered into the resident's emedical record. As a result two other resident were idea appropriate order. On 10/4/2 development coordinator condentified incorrect order; reand physician were notified that resident's insulins identified.	lirector of s with insulin ct order was electronic of the audit, ntified without 2017 Staff orrected the sidents' family . It is evident	
	ROVIDER OR SUPPLIER  SUMMAR (EACH DEFIC REGULATORY)  Continued From p Pharmacist on 10 she completed a month. She indic her own electronic pasted her docum electronic medical medical record fo there was no DRI dates of 2/24/17 a the Consultant Ph Pharmacist stated pasted Resident a 2017 DRR from h facility's electronic  An interview was Administrator on he expected the 0 DRR to be locate  2. Resident #35 v 9/29/14 with diagr disorder, major de delusional disorder A review of the Co Drug Regimen Re from 11/1/16 throm no DRR for Resid 12/6/16 and 2/4/1  An interview was Pharmacist on 10 she completed a month. She indic her own electronic pasted her docum electronic medical	F CORRECTION IDENTIFICATION NUMBER:	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMSEUR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 39  Pharmacist on 10/4/17 at 10:50 AM. She stated she completed a DRR for residents once per month. She indicated she completed the DRR on her own electronic system and then cut and pasted her documentation into the facility's electronic medical records system. The facility's medical record for Resident #13 that indicated there was no DRR for Resident #13 between the dates of 2/24/17 and 5/2/17 was reviewed with the Consultant Pharmacist. The Consultant Pharmacist stated she must have not copied and pasted Resident #13's March 2017 DRR or April 2017 DRR from her electronic system into the facility's electronic medical records system.  An interview was conducted with the Administrator on 10/4/17 at 12:00 PM. He stated he expected the Consultant Pharmacist's monthly DRR to be located in the facility's medical record.  2. Resident #35 was admitted to the facility on 9/29/14 with diagnoses that included anxiety disorder, major depressive disorder, and delusional disorder.  A review of the Consultant Pharmacist's monthly Drug Regimen Reviews (DRR) for Resident #35 from 11/1/16 through 10/3/17 indicated there was no DRR for Resident #35 between the dates of 12/6/16 and 2/4/17.  An interview was conducted with the Consultant Pharmacist on 10/4/17 at 10:50 AM. She stated she completed a DRR for residents once per month. She indicated she completed the DRR on her own electronic system and then cut and pasted her documentation into the facility's electronic medical records system. The facility's electronic medical records system. The facility's electronic medical records system.	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMSEUR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 39  Pharmacist on 10/4/17 at 10:50 AM. She stated she completed the DRR on her dectronic system and then cut and pasted her documentation into the facility's electronic medical records system. The facility's her deats of 2/24/17 and 5/2/17 was reviewed with the Consultant Pharmacist. The Consultant Pharmacist stated she must have not copied and pasted Resident #13's March 2017 DRR or April 2017 DRR from her electronic system into the facility's electronic medical records system.  An interview was conducted with the Administrator on 10/4/17 at 12:00 PM. He stated he expected the Consultant Pharmacist's monthly DRR to be located in the facility's medical record.  2. Resident #35 was admitted to the facility on 9/29/14 with diagnoses that included anxiety disorder, major depressive disorder, and delusional disorder.  A review of the Consultant Pharmacist's monthly Drug Regimen Reviews (DRR) for Resident #35 from 11/1/16 through 10/3/17 indicated there was no DRR for Resident #35 between the dates of 12/6/16 and 2/4/17.  An interview was conducted with the Consultant Pharmacist on 10/4/17 at 10:50 AM. She stated she completed the DRR on interview was conducted with the Consultant Pharmacist's monthly Drug Regimen Reviews (DRR) for Resident #35 from 11/1/16 through 10/3/17 indicated there was no DRR for Resident #35 between the dates of 12/6/16 and 2/4/17.  An interview was conducted with the Consultant Pharmacist's monthly prong Regimen Reviews (DRR) for Resident #35 from 11/1/16 through 10/3/17 indicated there was no DRR for Resident #35 between the dates of 12/6/16 and 2/4/17.  An interview was conducted with the Consultant Pharmacist in included anxiety disorder.  An interview was conducted with the Consultant Pharmacist in included anxiety disorder in the facility on the resident were disorder in the facility complication of the	A BULDING  345523  B. WING  STREET ADDRESS, CITY, STATE, JIP CODE  7166 JORDON ROAD  RAMSEUR, NC 27316  SUMMARY STATEMENT OF DEPICIENCIES  (EACH DEPICIENCY MUST BE PRECEDED BY PULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 39  Pharmacist on 10/4/17 at 10:50 AM. She stated she completed the DRR on her own electronic system and then cut and pasted her documentation into the facility's electronic medical records system. The facility's medical record for Resident #13 that indicated the consultant Pharmacist. The Consultant Pharmacist is tated she must have not copied and pasted Resident #130 facility in the Consultant Pharmacist is monthly DRR to be located in the facility's medical record is passive in the facility's medical record is passive in the facility's electronic medical records system.  An interview was conducted with the Addininistrator on 10/4/17 at 12:00 PM. He stated he expected the Consultant Pharmacist's monthly DRR to be located in the facility's medical record.  2. Resident #35 was admitted to the facility on 10/4/2017 of the new order.  3. Staff Development Coordinator (SDC) obtained a clarification order from physician on 10/4/2017 for resident #31 that indicated the consultant Pharmacist is monthly DRR to be located in the facility's medical records of 2/24/17 and 5/21/17 was reviewed with the Administrator on 10/4/17 at 12:00 PM. He stated he expected the Consultant Pharmacist's monthly DRR to be located in the facility's medical records.  A review of the Consultant Pharmacist's monthly Drug Regimen Reviews (DRR) for Resident #35 between the dates of 12/6/16 and 2/4/17.  An interview was conducted with the Consultant Pharmacist to 10/4/17 at 10/4

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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F 514	Continued From page	<del>-</del> 40	F	514			
	Tarriana and Tarriana Panga	r Resident #35 between the	'	017	Director; however the facility did not		
		2/4/17 was reviewed with			transcribe the substituted order in		
		nacist. The Consultant			resident's electronic Medication		
		e must have not copied and			Administration Records.		
		s January 2017 DRR from					
	1 -	into the facility's electronic			100% audit of current medications for	all	
	medical records syste				current residents was completed by th	е	
					Facility's pharmacy personnel, Directo	r of	
	An interview was con	ducted with the			Nursing, Staff Development Coordinat		
		1/17 at 12:00 PM. He stated			and Nursing Supervisor on 10/20/2017		
	· •	sultant Pharmacist's monthly			identify any other resident with medica	ıtion	
	I .	the facility's medical record.			or treatment orders that was		
		s admitted to the facility on			therapeutically substituted but not	_	
	I .	diagnoses included diabetes insulin. A Significant Change			transcribed to reflect the substitution in resident's medication and/or treatment		
	_	ated 9/14/17 indicated			administration records. This audit was		
		gnitively intact. Diagnoses			completed on 10/12/17, 10/13/17,		
	I .	ledications administered			10/16/17, 10/17, 10/18/18 and 10/20/1	7.	
		nt period included 7 days of			No other resident identified with		
	injections and 7 days	•			therapeutically substituted medication	not	
	A ravious of physician	orders dated 8/18/17			transcribed in medical records		
		Lantus insulin 25 units			SYSTEMIC CHANGES		
	subcutaneous twice				OTOTEMIO OTI/MOEG		
		,.			Effective 10/25/2017, Licensed		
	A review of physician	orders for September and			pharmacist will document monthly DRI	R to	
		ed the order remained for			include any failed GDR in resident's		
	Lantus insulin 25 unit	s subcutaneous twice daily.			electronic medical records and also wi	Ш	
					provide a hard copy of all DRR month	ly to	
		M, Nurse #4 was observed			the facility Executive Director and/or		
		ss. She prepared Levemir			Director of nursing to be filed in reside	nt's	
		tered Levemir 25 units			medical records.		
	subcutaneously to Re	esident #78.			F#0-tite 40/05/0047 # 04 !	_	
	An about the after	modication roys als diffe			Effective 10/25/2017, the new 24-hour		
		e medication revealed the			chart check will be implemented. The		
	milliliter vial on 9/13/1	nsed the Levemir 100 units/			24-Hour chart check is the process of		
	milliller vial on 9/13/1	i / IUI RESIDEIIL#/O.			checking all orders received in the more recent 24 hours to ensure accurate an		
	A review of the electr	onic Medication			proper transcriptions. If any medication		
	1 TO STORY OF LITE CIECLE	orno modioanon			propor nanocipacito. Il arry inculcatio	11 01	1

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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UNIVERSA	AL HEALTH CARE/RAM	SEUR		71	66 JORDON ROAD		
				R/	AMSEUR, NC 27316		
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F 514	Continued From pag	e 41	F 5	514			
F 514	Administration Record documentation that F Lantus insulin 25 unit #4.  On 10/3/17 at 4:29 P conducted with Nurse administered the Lev reviewed the Medica (MAR) and physician stated Lantus 25 unit Nurse #4 stated the p substituted the Lantu On 10/4/17 at 3:00 P (DON) was interview to write an order to g Lantus and she expesure medication admidoctor's order.  On 10/4/17 at 3:03 P conducted with the P stated she expected	Resident #78 had received ts subcutaneously by Nurse  M, an interview was e #4 who stated she had remir as ordered. She tion Administration Record orders and indicated both is subcutaneous twice daily. Othermacy must have is with Levemir insulin.  M, the Director of Nursing ed. She expected the nurse ive Levemir instead of ected the nurses to make inistered matched with the	F 5	514	treatment order is not transcribed as ordered, night shift nurse, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Nurs Supervisor will ensure it is transcribed correctly on the electronic Medication Administration Record or electronic Treatment Administration Records. 24-Hour chart check form will be located in binder titled 24 Hour report at each nurse's station.  Effective 10/20/2017, the center nursin administrative team, which includes DOADON, and/or SDC, initiated a process reviewing all new physician orders or change of orders daily (Monday throug Friday) and will address any discrepant in a promptly. The assigned nurse administrative team member will comporders written in the physician order for to orders transcribed on the Medication Administration Record (MAR). Any identified issues will be addressed promptly and appropriate actions will be implemented by the DON, ADON, SDC and/or Registered Nurse supervisor and/or designated licensed nurse will review, new orders or change of orders every Saturday & Sunday and will address at discrepancy in a timely manner. The assigned nurse administrative team member will compare orders written in physician order forms to orders.	esing  - n a  ng ON, s for gh ncy are rms n  ne C  all	
					Registered Nurse supervisor and/or designated licensed nurse will review, new orders or change of orders every Saturday & Sunday and will address at discrepancy in a timely manner. The assigned nurse administrative team	ny	

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		345523	B. WING _			10/05/2017	
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F 514	Continued From page	÷ 42	F 5	identified issues will be address promptly and appropriate action implemented as appropriate by Registered Nurse supervisor, a reported to the center's DON to On 10/12/2017, Regional Cliniconducted an education with the DON and SDC about the proceeding new physician order changes of orders daily (Monderiday). This education emphase how to identify a root cause whorder is not transcribed appropactions to be taken to address discrepancies in a timely manner Director of Nursing (DON), Assentiated Director of Nursing (ADON) are Development Coordinator (SD complete 100% education for an urses, to include full time, paraseneded staff, on the new 24 check form and medication ad and transcription. This education completed by 10/25/2017. Any nurse not educated by 10/25/2017 be allowed to work until educated education will also be added orientation process for all new nurses effective 10/25/2017, the facility record clerk, and/or Executive review the facility monthly DRI completion. Any identified omi reported to the licensed pharmimmediately. This audit will be	ons will be y the and timely.  ical director the center tess of the ce		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345523	B. WING _			10	)/05/2017	
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F 514	Continued From page	e 43	F	moder of moder of moder of moder of moder of modern of m	conthly for 3 months or until the patter compliance is maintained. This politoring process will be documented edical Records audit tool."  Fective 10/25/2017, Pharmacy Clinic rector and/or designated Licensed for armacy will review the facility month RR documentation to ensure compliance documentation are accurate to the but not limited to failed GDR is y. This monitoring process will take acce monthly within 10 business day at Licensed pharmacist visit for 3 mountil the pattern of compliance is a sintained.  Fective 10/25/2017, Director of Nursing, and/or evelopment Coordinator, will monitor evelopment Coordinator e	ed on ical thly letion o is e /s of onths sing, Staff or ers by -), m the ents ssion Rs. I will oort ler in ing		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 514	Continued From page		F 5		report daily (M-F) for 2weeks, weekly x more weeks, then monthly x 3 months until the pattern of compliance is maintained.  Effective 10/25/2017, Director of Nursir will report findings of this monitoring process to the facility Quality Assuranc and Performance Improvement Committee for any additional monitorin or modification of this plan monthly X3 months, or until the pattern of compliant is maintained. The QAPI committee camodify this plan to ensure the facility remains in substantial compliance.  Effective 10/25/17, the center Executive Director and the Director of health services will be ultimately responsible the ensure implementation of this plan of correction for alleged noncompliance to ensure the facility remains in substantial compliance.	or  ng e g ce n	10/25/17
SS=D	(o) Hospice services.			20			10/23/17
	(1) A long-term care ( the following:	LTC) facility may do either of					
	(i) Arrange for the pro through an agreemen Medicare-certified hos						
	(ii) Not arrange for the services at the facility a	e provision of hospice through an agreement with					
		spice and assist the resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 526	the provision of hos requests a transfer.  (2) If hospice care is through an agreeme (o)(1)(i) of this section facility must meet the control of the transfer.  (i) Ensure that the hoprofessional standar to individuals providing the timeliness of the control of the timeliness of the control of the transfer of the control	acility that will arrange for pice services when a resident so furnished in an LTC facility ent as specified in paragraph on with a hospice, the LTC end following requirements:  cospice services meet reds and principles that apply a services in the facility, and to enservices.  Greement with the hospice authorized representative of the cospice care is furnished to written agreement must set out green authorized representative of the cospice will provide.	F 52	6	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
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F 526	Continued From page	e 46	F 52	6		
	(E) A provision that the notifies the hospice a	ne LTC facility immediately about the following:				
	(1) A significant chan mental, social, or em	ge in the resident's physical, otional status.				
	(2) Clinical complicat alter the plan of care.	ions that suggest a need to				
	(3) A need to transfer for any condition.	r the resident from the facility				
	(4) The resident's dea	ath.				
	responsibility for detection	g that the hospice assumes ermining the appropriate re, including the nge the level of services				
	responsibility to furnis care, meet the reside nursing needs in coo representative, and e	at it is the LTC facility's sh 24-hour room and board ent's personal care and rdination with the hospice ensure that the level of care ttely based on the individual				
	including but not limit direction and manage counseling (including bereavement); social supplies, durable me necessary for the pal associated with the to conditions; and all other	the hospice's responsibilities, ted to, providing medical ement of the patient; nursing; pspiritual, dietary, and work; providing medical dical equipment, and drugs diation of pain and symptoms erminal illness and related ther hospice services that are the of the resident's terminal				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 526	illness and related co  (I) A provision that we personnel are responsof prescribed therapid determined appropriatelineated in the hose facility personnel may where permitted by State LTC facility.  (J) A provision station report all alleged violomistreatment, neglect and physical abuse, is source, and misapproby hospice personnel administrator immediate becomes aware of the CK) A delineation of the hospice and the LTC bereavement services.  (3) Each LTC facility hospice care under a designate a member interdisciplinary team working with hospice coordinate care to the LTC facility staff and interdisciplinary team clinical background, is scope of practice act assess the resident of the service of the control of the con	when the LTC facility asible for the administration es, including those therapies ate by the hospice and pice plan of care, the LTC y administer the therapies state law and as specified by a general that the LTC facility must eations involving the transport of unknown oppriation of patient property leading injuries of unknown oppriation of patient property leading to the hospice ately when the LTC facility enabled when the LTC facility enabled with a large of the facility to provide so to LTC facility staff.  The arranging for the provision of written agreement must of the facility's the who is responsible for representatives to the resident provided by the	F	526			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/RAMSEUR			STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	1		
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The designated interesponsible for the form (i) Collaborating with and coordinating LTC the hospice care play residents receiving the hospice care play and other healthcare provision of care for conditions, and other of care for the patien (iii) Ensuring that the with the hospice meattending physician, participating in the play as needed to coordinate medical care provided (iv) Obtaining the following hospice:  (A) The most recent to each patient.  (B) Hospice election (C) Physician certifithe terminal illness second coordinate the coordinate that the coordina	rdisciplinary team member is collowing:  In hospice representatives C facility staff participation in nning process for those hese services.  With hospice representatives a providers participating in the the terminal illness, related reconditions, to ensure quality and family.  The LTC facility communicates dical director, the patient's and other practitioners rovision of care to the patient that the hospice care with the end by other physicians.  Illowing information from the thospice plan of care specific in form.  The cation and recertification of specific to each patient.  It that information for hospice	F 52	26			
	ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIENT REGULATORY OR REGULATORY OR COntinued From page The designated interesponsible for the feet and coordinating LTG the hospice care plaresidents receiving the hospice care plaresidents receiving the hospice care for conditions, and other healthcare provision of care for conditions, and other of care for the patien (iii) Ensuring that the with the hospice meattending physician, participating in the plass needed to coordinate attending physician, participating in the plass needed to coordinate attending to the plasma seed of the patient.  (B) Hospice election (C) Physician certification the terminal illness seed (D) Names and compersonnel involved in patient.  (E) Instructions on the summary of the patient.	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMSEUR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 48 The designated interdisciplinary team member is responsible for the following:  (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.  (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.  (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.  (iv) Obtaining the following information from the hospice:  (A) The most recent hospice plan of care specific to each patient.  (B) Hospice election form.  (C) Physician certification and recertification of the terminal illness specific to each patient.  (D) Names and contact information for hospice personnel involved in hospice care of each	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMSEUR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 48  The designated interdisciplinary team member is responsible for the following:  (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.  (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.  (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.  (iv) Obtaining the following information from the hospice:  (A) The most recent hospice plan of care specific to each patient.  (B) Hospice election form.  (C) Physician certification and recertification of the terminal illness specific to each patient.  (D) Names and contact information for hospice personnel involved in hospice care of each patient.  (E) Instructions on how to access the hospice's	ROUIDER OR SUPPLIER  AL HEALTH CARE/RAMSEUR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 48  The designated interdisciplinary team member is responsible for the following:  (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.  (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care to the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.  (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient as needed to coordinate the hospice care with the medical care provided by other physicians.  (iv) Obtaining the following information from the hospice:  (A) The most recent hospice plan of care specific to each patient.  (B) Hospice election form.  (C) Physician certification and recertification of the terminal illness specific to each patient.  (D) Names and contact information for hospice personnel involved in hospice care of each patient.  (E) Instructions on how to access the hospice's		

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F 526	Continued From page	e 49	F 5	526			
	(F) Hospice medicati	ion information specific to					
	(G) Hospice physicia any) orders specific to	an and attending physician (if o each patient.					
	orientation in the poli- facility, including patie	LTC facility staff provides cies and procedures of the ent rights, appropriate forms, equirements, to hospice staff C residents.					
	a written agreement in resident's written plan most recent hospice description of the ser facility to attain or ma practicable physical, well-being, as required This REQUIREMENT	vices furnished by the LTC intain the resident's highest mental, and psychosocial					
	and hospice staff interdesignate a member interdisciplinary team provided between the and to have the most including the hospice all the hospice notes services provided by hospice resident for I sampled resident who services. Findings in	to coordinate the care e facility and hospice staff recent plan of care, medication information and pertaining to the care and the hospice staff to the (Resident #72) of 1 o was receiving hospice cluded:			IMMEDIATE ACTION Most recent plan of care, hospice medication information, certification of terminal illness, hospice contact information and visit notes were placed resident #72's Hospice Notebook by th Social Worker on 10/5/2017. IDENTIFICATION OF OTHERS On 10/6/17, 10/9/17, 10/10/17 and 10/11/17 the Social Worker audited 10 of active hospice residents in the facilit ensure the appropriate documentation present in the resident's chart. There were no further issues noted as a resu	e 0% y to is	
	Resident #72 was ad 8/31/16 with multiple	mitted to the facility on diagnoses including			the audit. Findings of this audit is documented and maintained in the faci	lity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 526	Dementia with behave psychosis. The annuassessment dated 8/Resident #72 had set and he was receiving resident at the facility. Resident #72's care previewed. One of the have chosen to receimy diagnosis of cereight sided weakness was "I will remain corthospice care as evid comfort following intermanagement x (times minutes of interventic coordinate my care wfamily and physician, Team to assure I expressible, provide activated to my right sided to my right side on 10/3/17 at 12:05 lf #72 was observed. In he had no signs or sydiscomfort.  Resident #72's medic electronic records we section of the records information including hospice communication log for had visited the reside 4/3/17, 4/7/17, 4/10/18/21/17 and 9/28/17. The most recent hospice.	iors and unspecified al Minimum Data Set (MDS) 22/17 indicated that were cognitive impairment hospice services while a decare plan problems was "I we Hospice care related to provascular accident with (hemiplegia)." The goal infortable throughout enced by report of improved reventions for pain as 3 months (within 45-60 m)." The approaches "to with my Hospice Team, my coordinate with the Hospice erience as little pain as vities of daily living (ADL) ded weakness."  PM and 2:27 PM - Resident de was up in wheelchair and reptoms of pain or  cal records including the are reviewed. The hospice descontained hospice hospice election form and	F 526	compliance binder SYSTEMIC CHANGES Effective 10/20/2017, the facility designated the Director of Social Serv of the center to coordinate the care provided between the facility and Hosy staff. Effective 10/20/2017, facility will utilize "hospice binder, located at the nurses station. Most recent resident's plan of care to include hospice medication information, most recent hospice note pertaining to the care and services provided by the Hospice agency to the resident. Effectively 10/25/2017 a monthly hosp audit tool will be utilized to ensure all appropriate documentation is present the resident's Hospice Notebook. This form will be maintained in each Hospic resident's notebook located in the faci On 10/6/17, the Administrator in-servic the Social worker on the "monthly hos audit" tool. 100% education will be provided by th Director of Nursing, Staff Development coordinator and/or nursing manager to licensed nurses including full time, part-time and as needed staff regardir documentation and communication wi the hospice agencies utilized by the facility. Education of nursing staff will to complete by 10/25/17. Any Licensed nurse who has not received education 10/25/2017 will not be allowed to cont working until educated. MONITORING PROCESS.	pice s s s c c c c c c c c c c c c c c c c	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	•
				7166 JORDON ROAD	
UNIVERSAL HEALTH CARE/RAMSEUR			RAMSEUR, NC 27316		
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F 526	Continued From p	page 51	F 5	226	
	T	I complete hospice visit notes.		Administrator will audit the h	ospice
				notebook weekly for 4 week	s then
	On 10/3/17 at 3:4	5 PM, the Social Worker (SW)		monthly for three months or	until the
	was interviewed.	She stated that she coordinated		pattern of compliance is mai	ntained.
		to hospice residents between		Findings of this audit will be	
	•	he facility staff. The SW further		in monthly Hospice Audit To	
	stated that the hospice agency providing hospice			Effective 10/25/2017; the Ex	
	care and services to Resident #72 stated that a			Director, Director of Nursing	
	hospice plan of care was not needed. She also			worker will report findings of	
	stated that the Hospice Aide visited weekly and			monitoring process to facility	·
	the SW had no scheduled visit, she visited			Assurance Performance imp	
	-	/ revealed that the Hospice staff		Committee monthly for 3 mo	
		their tablet and she didn't know		the pattern of compliance is	
	ii their notes were	e sent to the facility.		The QAPI committee will red additional monitoring needs	-
	On 10/3/17 at 3:5	2 PM, Nurse #6 was		of this requirement as it dee	
		stated that the Hospice Nurse		appropriate	
		visited every 1-2 weeks and she			
		notes on her tablet. She didn't		Effective 10/25/17, the center	er Executive
	know if the hospid	ce notes were sent to the facility		Director and the Director of	health
	or not. Nurse #6	also indicated that she had not		services will be ultimately re	sponsible to
	seen a Hospice A	ide or SW visited Resident #72.		ensure implementation of th	is plan of
				correction for alleged nonco	mpliance to
		5 AM, the SW provided copies		ensure the facility remains in	າ substantial
		t plan of care of Resident #72,		compliance	
		ion and recertification, Hospice			
		ation and hospice visit notes			
		1/17, 9/22/17 and 9/28/17. She			
		had called the office of the			
		nd the office faxed these			
		facility. She reported that she			
		e Hospice Nurse who informed			
		d asked their office as to why			
		not sent to the facility. The SW			
		the hospice agency indicated			
		n of care was not needed for			
		added that she was informed			
		was assigned to visit Resident			
	#1∠ once a week	on Wednesdays and no			

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NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/RAMSEUR			1	STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 526	Hospice Aide, SW or  On 10/4/17 at 3:00 Pl (DON) was interviewed she expected a hospin hospice plan of care anotes filed in the residuded that she didn't with this hospice agen hospice care plan me  On 10/5/17 at 8:50 Al interviewed She stated the signee for Residen once a week and as and designee for Residen once a week and as and cumented her visit also revealed that a President #72 twice and documented her note Hospice Nurse report Chaplain scheduled to request. She stated to (POC) should include each discipline and the POC should records and a copy in Nurse further indicate recertified for hospice the hospice notes car facility. She stated the facility designee was	Chaplain.  M, the Director of Nursing ed. The DON stated that ce resident to have a and to have their hospice dent's medical records. She have a good communication ney and they didn't have a eting.  M, the Hospice Nurse was seed that she was the hospice of the transport of the transport of the transport of the transport of the medication information on the transport of the medication information of the transport of the medication information of the transport of	F 5	26		