STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345522	A. BUILDING _____ B. WING _____	C 06/23/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted 06/22/20 through 06/23/20. There were two allegations investigated and one was substantiated. Event ID#NLQD11.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews a nurse failed to stay in the presence of a resident to ensure medications provided were administered for 1 of 4 residents (Resident #1) observed for medication administration. Findings included: Resident #1 was admitted to the facility 06/17/16 with diagnoses including heart failure and hypertension (high blood pressure). Review of Resident #1's Physician orders revealed an order dated 08/30/17 for peridex 0.12% rinse (a medication to help with red and swollen gums) twice daily and Resident #1 may keep the medication at the bedside. Resident #1 also had a Physician's order dated 05/11/20 for Metamucil sugar-free one teaspoon in a full glass of water by mouth twice a day as needed for constipation and may keep at bedside.	F 658	This Plan of Correction constitutes a written allegation of compliance and a desk review is requested. Preparation and submission of this Plan of Correction is not to be construed as an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiency. This Plan of Correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith of the provider. Immediate The facility Licensed Nurse on duty returned to the room to ensured that Resident #1 took her medication. The Licensed Nurse was educated by the Director of Nursing (DON) on not leaving	7/20/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/09/2020

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F 658	Continued From page 1 Review of the quarterly Minimum Data Set (MDS) dated 04/21/20 revealed Resident #1 was cognitively intact and received diuretics 7 out of 7 days in the look back period. Review of Resident #1's care plan for self-administration of medication last updated 04/21/20 revealed she had been assessed and was capable of self-administration. Interventions included assessing Resident #1's ability to self-administer medications as needed and observing her self-administration frequently. An observation of medication administration on 06/22/20 at 7:55 AM by Nurse #1 revealed she entered Resident #1's room with one medication cup containing 2 calcium carbonate tablets and one medication cup containing 2 eye multivitamin capsules, 2 senna tablets (a medication for constipation), 1 furosemide (a diuretic) 80 milligrams (mg) tablet, and 1 potassium 20 milliequivalents (mEq) tablet, and 1 bottle of calcitonin nasal spray (a medication for osteoporosis). Nurse #1 placed the 2 medication cups and bottle of nasal spray on Resident #1's meal tray and exited the room. An interview with Resident #1 on 06/22/20 at 8:01 AM revealed she had resided in the facility for 4 years and the nurses always left her medication in her room and she took the medications when she was ready. Resident #1 stated it was too much for the nurses to come in and give her medications as ordered so they left them for her to take. Resident #1 stated the medications were just vitamins. An interview with Nurse #1 on 06/22/20 at 8:03 AM revealed she left medication in Resident #1's	F 658	medication at the bedside on 6/22/20. Identification of Others The DON and ADON completed a facility tour to ensure that medications were not left at the bedside for current facility residents on 6/22/20. Systematic Changes Facility Licensed Nurses were inserviced by the ADON/SDC on The Five Rights of Medication Administration, and following physician□s orders, specifically not leaving medications at the bedside beginning 6/23/20 and completed on 7/11/20. The DON or ADON will complete random Medication Pass Observations three times a week for eight weeks, then two times a week for four weeks. Additional training will be provided as needed. Newly hired Licensed Nurses will receive training on The Five Rights of Medication Administration, and following physician□s orders, specifically not leaving medications at the bedside during their orientation period. Facility Ambassadors, during their Ambassador Rounds, will monitor that medications are not being left at the bedside for the next twelve weeks beginning on 7/9/20. Monitoring Process Findings of the Medication Pass Observations and Ambassador Monitoring	

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F 658	Continued From page 2 room and did not observe Resident #1 take the medication. Nurse #1 stated she always left Resident #1's medication in her room and she took them when she was ready. Nurse #1 acknowledged nurses were supposed to watch residents take the medication at the time of administration. An interview with the Director of Nursing (DON) on 06/22/20 at 8:10 AM revealed Resident #1 had been assessed to self-administer medications and was a candidate for self-administration for the medications that were ordered to be kept at her bedside. The DON stated nurses were expected to watch residents take their medication at the time it was administered unless ordered otherwise from the Physician. An interview with the Nurse Practitioner (NP) on 06/22/20 at 1:27 PM revealed she expected nurses to stay with residents and watch them take the medication at the time of administration unless the resident had orders for the resident to self-administer medication. An interview with the Administrator on 06/22/20 at 3:35 PM revealed he expected nurses to stay with residents while they took their medications unless there was an order stating they could administer their own medication.	F 658	Rounds will be reported to the Facility Quality Assurance and Performance Improvement Committee Meeting by the DON monthly for the next three months. If necessary, the Quality Assurance and Performance Improvement Committee will modify this plan to ensure the facility remains in compliance.	