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 12/09/2020

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
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 12/03/20. Additional record review and interviews occurred through 12/09/20; therefore, the exit date was changed to 12/09/20. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# ENU111.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 12/03/20. The survey team returned to the facility on 12/09/20 for additional record review and interviews; therefore, the exit date was changed to 12/09/20. The facility was found out of compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. One allegation was investigated and unsubstantiated. Event ID# ENU111.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by:	F 557		1/4/21

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

Electronically Signed | 12/31/2020

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F 557	Continued From page 1 Based on record review and staff interviews, the facility failed to ensure staff treated residents in a dignified manner when a staff member was overheard making a derogatory comment directed to a resident (Resident #1) while providing care for 1 of 3 residents reviewed for abuse. Findings included: Resident #1 was admitted to the facility on 09/07/16 with multiple diagnoses that included Alzheimer's disease and vascular dementia with behavioral disturbance. Review of the quarterly Minimum Data Set (MDS) dated 10/02/20 indicated Resident #1 had severe impairment in cognition, could rarely make self-understood and was sometimes able to understand others. Further review of the MDS revealed Resident #1 required extensive to total staff assistance with activities of daily living and displayed no behaviors during the 7-day MDS assessment period. An interview was conducted with NA #1 on 12/03/20 at 2:27 PM. NA #1 reported that on 11/26/20, she had helped NA #3 get Resident #1 up out of bed for a shower and a little while later, noticed NA #3 standing at the door of the shower room, thought she might need help and went to assist. NA #1 stated when she got to the shower room, NA #2 was already there and assisting Resident #1. She stated as NA #2 pulled Resident #1 forward in the chair, she overheard NA #2 call Resident #1 a "fat cow" and told her "to lean up fat ass." An interview was conducted with NA #2 on	F 557	Universal Healthcare of Fletcher acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on December 2-9, 2020. Universal Healthcare of Fletcher response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, Universal Healthcare of Fletcher reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. F 557 1. The facility failed to ensure staff treated residents in a dignified manner when a staff member was overheard making derogatory comment directed to Resident #1 while providing care for 1 of 3 residents reviewed for abuse. 2. All current residents have the potential	

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F 557	Continued From page 2 12/03/20 at 12:38 PM. NA #2 denied the accusations reported by NA #1. An interview was conducted with NA #3 on 12/03/20 at 1:45 PM. NA #3 confirmed she was assigned to provide resident showers on 11/26/20 and NA #2 came into the shower room to assist her with transferring Resident #1 from the shower chair to her Geri-chair. NA #3 stated while she was busy cleaning the area, she heard NA #2 call Resident #1 a "fat cow and this is why your husband doesn't want to have sex (paraphrase) with you." An interview was conducted with the Administrator on 12/03/20 at 4:10 PM. The Administrator confirmed NA #3 reported to her today that NA #3 had overheard NA #2 make the statement on 11/26/20 to Resident #1, "fat cow, this is why your husband doesn't want to have sex (paraphrase) with you."	F 557	to be affected by the alleged practice. On 12/31/2020 an audit was completed by the Administrator, Social Worker, and MDS Coordinator on all Alert and Oriented residents to ensure that they felt they are being treated with respect and dignity. Family/RP was contacted for all cognitively impaired residents to ensure they felt they were being treated with dignity and respect. Any issues will be correctly addressed immediately, up to and including a 24-hour report. 3. All staff will be educated regarding resident rights to be treated with dignity and respect. This education will be completed by the Administrator and Director of Nursing by 12/31/2020. Social Worker will interview 10 alert and oriented residents to ensure they are being treated with respect and dignity. This audit will be conducted weekly x 12 weeks. Director of Nursing or Assistant Director of Nursing will observe 10 staff interactions with residents during care and in common areas to ensure they are being treated with dignity and respect. This audit will be conducted weekly x 12 weeks. Administrator will review the results of the weekly audits to ensure any issues identified are corrected. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator	

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F 557	Continued From page 3	F 557	monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator, Social Worker, and Director of Nursing 6. Date of Compliance: 1/4/2021	
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and	F 886		1/4/21

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F 886	Continued From page 4 (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, an interview with the Local Health Department Nurse, the facility failed to 1) conduct required	F 886	Universal Healthcare of Fletcher acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of	

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F 886	Continued From page 5 COVID-19 testing on 46 of 68 residents upon the identification of a positive result for Nurse Aide #1 received on 09/24/20; 2) the facility failed to conduct testing on 46 of 68 residents every 3 to 7 days after a newly identified COVID-19 case received on 09/24/20. These failures occurred during a COVID-19 Pandemic. From 09/25/20 to 12/03/20 a total of 1 resident and 1 staff have tested positive for COVID-19. The findings included: A review of the facility's policy and procedure titled, "Testing Requirements," effective date 8/28/20 read in part: The purpose of this policy is to respond to the Centers for Medicaid and Medicare and state Long Term Care facility testing requirements. Under the section titled, "Definitions," an outbreak was defined as a new COVID-19 infection in any healthcare personnel or any nursing home-onset COVID-19 infection in a resident. Under the section titled, "Testing When There is an Outbreak," read in part: upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents should be tested. All staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for period of at least 14 days since the most recent positive result. A review of the facility's weekly routine testing of staff revealed Nurse Aide (NA) #1 received a COVID-19 positive result on 9/24/20. The facility continued to test negative staff weekly and there had been no newly identified COVID-19 case	F 886	Correction to the extent the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on December 2-9, 2020. Universal Healthcare of Fletcher response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, Universal Healthcare of Fletcher reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. F 886 1. The facility failed to 1) conduct COVID-19 testing on 46 of 68 residents upon the identification of a positive result for nurse aide #1 received on 9/24/2020; 2) the facility failed to conduct testing on 46 of 68 residents every 3 to 7 days after a newly identified COVID-19 case received on 9/24/2020. 2. An audit was conducted by the	

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F 886	Continued From page 6 from 9/25/20 through 11/24/20. The next positive result was received on 11/29/20 which identified a second Nurse Aide. The facility continued weekly testing of negative staff which revealed no newly identified COVID-19 positive case from 11/30/20 through 12/3/20. A review of the COVID-19 testing of residents revealed 22 out of 68 residents were tested from 09/24/20 through 09/25/20. All results were received by 09/26/20 and revealed 22 residents were negative. The next facility-wide testing of all negative residents occurred on 11/18/20 which identified 1 resident as being positive for COVID-19. Facility-wide weekly testing of negative residents continued and there has been no newly identified case of COVID-19 from 11/19/20 through 12/3/20. The next scheduled facility-wide testing of negative residents was scheduled for 12/8/20. During an interview on 12/2/20 at 10:40 AM the Director of Nursing (DON) explained when NA #1was identified as being COVID-19 positive the facility performed contact tracing going back 2 weeks. It was determined NA #1 had contact with 21 residents. Those 21 residents were all placed on enhanced droplet contact precautions and remained asymptomatic. One resident who had not had contact with NA #1 was also tested due to having symptoms. All 22 test results received were negative. After it was determined the 22 residents were negative the facility only continued weekly testing of all negative staff. The DON explained facility-wide testing of residents was conducted on 11/18/20 after 1 resident received a positive result. The resident was sent out for a	F 886	Administrator for the last 30 days of testing to ensure the facility performed testing per the facility□s policy and procedure regarding Testing Requirements. Audit completed on 12/30/2020. No issues were identified. 3. Administrator and Director of Nursing received education regarding the facility□s policy and procedure regarding Testing Requirement which includes initiating outbreak testing for staff and residents every 3 to 7 days if a new COVID-19 case is identified on 12/2/2020. This education was provided by Regional Director of Operations and Senior Corporate Clinical Consultant. Administrator will audit facility'□s routine testing roster to ensure that all residents and staff are tested per facility policy and procedure regarding Testing Requirements. This audit will continue weekly x 12 weeks. Regional Director of Operations and Senior Corporate Clinical Consultant will review weekly audits to ensure testing conducted as required per facility policy. Any issues will be corrected immediately. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 886	Continued From page 7 schedule procedure and tested for COVID-19 after returning from an overnight stay in the hospital. It was the facility's policy to test any resident who had an overnight hospital stay. After the positive result was received the DON indicated she was informed by the Administrator facility-wide testing of all negative residents was being initiated and was a corporate decision to test all residents on 11/18/20. The DON defined an outbreak as being 2 positive cases and explained she was in contact with the facility's assigned Local Health Department Nurse and the facility's corporate Nurse Consultant for guidance related to COVID-19. The DON indicated she had not been able to keep up to date with all the policies due to the frequency of changes being made and could not recall how she determined the definition of an outbreak as being 2 newly identified cases of COVID-19. After review of the facility's COVID-19 Pandemic Plan under the section titled, "Testing Requirements," updated on 8/28/20 the DON verified an outbreak was considered 1 positive staff or resident and the guidance was to test all staff and residents weekly until no newly identified cases for a time period of at least 14 days. The DON was unable to give a reason on why the facility did not test all residents after a positive result was received for NA #1 on 9/24/20 and reiterated the facility had done contact trace testing for COVID-19. During an interview on 12/2/20 at 1:30 PM the Regional Director of Operations and the facility's Nurse Consultant confirmed 21 residents were tested for COVID-19 after NA #1 received a positive result which was based on contact tracing. The Nurse Consultant revealed the facility did not test all residents when NA #1 was	F 886	5. Person Responsible: Administrator 6. Completion Date: 1/4/21	

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F 886	Continued From page 8	F 886		

identified positive but did continue to test all negative staff weekly. She gave no specific reason why the facility did not complete facility-wide resident testing after identification of a new case of COVID-19 on 9/24/20 and reiterated the residents exposed to NA #1 were tested and all resulted negative. The Nurse Consultant confirmed after the exposure by NA #1 facility-wide resident testing did not occur until 11/18/20. The Nurse Consultant explained facility residents were being monitored for COVID-19 symptoms each shift which included auscultation of lung sounds, temperature and oxygen saturation checks and if identified a Point of Care and Polymerase Chain Reaction (tests used to detect a COVID-19 infection) test would be done. The facility also continued to screen employees prior to their shift and perform testing based on the county positivity rate and test negative staff weekly. The Nurse Consultant defined an outbreak as being 1 newly identified case of COVID-19 which required all negative staff and residents be tested until no new cases were identified for at least 2 weeks.

During an interview on 12/2/20 at 2:50 PM the Administrator revealed she spoke with the facility's corporate leaders approximately 3 times a week to discuss updates related to policies and COVID-19 but did not recall a discussion related to testing requirements of residents. The Administrator revealed initially her definition of an outbreak was the identification of 2 positive results. After review of the facility's current COVID-19 Pandemic Plan under the policy titled, "Testing Requirements," updated 8/28/20 the Administrator confirmed the facility's policy defined an outbreak as being upon the

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identification of a single new case of COVID-19 in any staff or resident and all staff and residents should be tested. The Administrator had no reason of why the facility did not perform facility-wide testing of all residents after the identification of NA #1 being positive on 9/24/20. A second interview conducted on 12/4/20 at 11:22 AM the Administrator confirmed 21 residents were tested after being exposed to NA #1 and 1 resident due to symptoms and only 1 round of testing was done for those residents. The Administrator confirmed no facility-wide testing of residents was conducted until 11/18/20. Since the facility's continuation of weekly testing all negative residents and staff thus far 1 resident received a positive result on 11/18/20 and 1 Nurse Aide resulted positive on 11/29/20. On 12/1/20 71 residents and 88 staff have been tested and all were negative from the results received on 12/3/20. The next scheduled facility-wide testing was scheduled for 12/8/20.

During an interview on 12/4/20 at 1:50 PM the Local Health Department (LHD) Nurse confirmed she was facility's contact nurse and who they reported new cases of COVID-19. The LHD Nurse indicated the facility did inform her when a new case of COVID-19 was identified and had done a good job protecting residents and staff. The LHD Nurse explained for the purpose of her reporting the definition of an outbreak was 2 or more cases of COVID-19 in a facility. The LHD Nurse explained when a facility has a newly identified case of COVID-19 the guidance was to conduct facility-wide testing of all negative staff and residents and continue weekly testing for 28 days from the last collected test date until no new COVID-19 cases were identified. The LHD did not

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F 886	Continued From page 10 recall having a conversation with the DON related to testing requirements during the time of 9/24/20 but indicated the facility was currently conducting weekly testing of all negative staff and residents.	F 886		