STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey and complaint investigation was conducted on 6/21/21 through 6/25/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ETOE11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and a complaint investigation survey was conducted from 6/21/21 through 6/25/21. Event ID# ETOE11. Eight of the 10 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		7/23/21

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

Electronically Signed | 07/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to maintain the dignity of dependent residents through the use of the term "feeder" to describe residents who needed assistance with eating (Resident #14) and failed to keep the collection bag of an indwelling catheter covered (Resident #80) for 2 of 26 residents reviewed for dignity. The findings included: 1. Resident #14 was admitted to the facility 11/15/18 with diagnoses that included Alzheimer's disease and hyperlipidemia. Resident #14's most recent Minimum Data Set (MDS) assessment revealed she was assessed as having unclear speech and severe cognitive impairment. She was coded as dependent for eating requiring the assistance of one person.	F 550	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #80 catheter bag was changed by the Licensed Nurse to one that was equipped with a privacy bag on 6/22/21 to correct the deficient practice of lack of privacy. Nurse Aide #6 and Nurse #8 was immediately educated by the facility DON regarding referring to the residents as “feeders” on 6/21/21. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 During a dining observation on 6/21/21 at 1:27 PM Nurse Aide (NA) #6 was overhead telling Nurse #8 to hand her the "feeder" trays while standing on the 200 hall outside a resident's room. Nurse #8 then repeated the term when handing the trays to NA #6. An interview was conducted with Nurse #8 on 6/21/21 at 1:51 PM. He stated he corrected NA #6 for using that term and he repeated it to her hoping she would notice her error. Nurse #8 stated he was aware that the term "feeder" was not a term that should be used to describe residents who needed assistance with eating. An interview was conducted with NA #5 on 6/21/21 at 2:05 PM who stated she used the term in error. She stated Nurse #8 had taken her aside and explained the term was inappropriate to use when discussing residents who needed assistance with eating. Resident #14 was not able to be interviewed. An interview was conducted on 6/21/21 at 10:00 AM with Resident #58 who was Resident #14's roommate. She stated she had heard the term "feeder" utilized about her roommate frequently. She stated she felt it was an inappropriate term. Resident #58 stated she was disturbed at the thought that this term could be used to describe her (Resident #58) if she needed assistance with eating. An interview was conducted with the Director of Nursing on 6/25/21 at 10:30 AM who indicated staff need to respect the dignity of residents who require assistance with eating and not use derogatory terms to describe them.	F 550	including all those who receive catheter care. All residents with indwelling catheters were audited on 6/22/2021 by the Director of Nursing to ensure that no bag was without the proper cover to prevent any breaches of the resident's dignity and any issues were corrected at that time. All residents that require assistance with eating are at risk for being referred to as feeders. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 100% of staff is to receive in-service education regarding resident's rights/dignity and what is not appropriate language with talking to or referring to residents. this education will be provided by the facility Administrator or designee. 100% of nursing staff is to receive in-service education by the facility DON or member of administrative nursing team, regarding the monitoring of residents with catheters and to ensure they always remain covered. All education is to be completed by 7/23/21. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Facility will initiate inspections to be conducted routinely to ensure that catheter bags remain covered as well as staff adhering to the rules of utilizing appropriate terminology when referring to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 2. Resident #80 was admitted to the facility on 12/31/20. His diagnosis included stoke with right sided hemiplegia and neurogenic bladder. A review of the significant change Minimum Data Set dated 5/17/21 revealed Resident #80 was severely cognitively impaired. He was totally dependent on staff for toileting, personal hygiene, and bathing. His urinary continence was not rated due to indwelling catheter. A review of Resident #80's care plan updated on 5/17/21 revealed he had a urinary catheter. One of the interventions was to provide catheter care every shift. The physician order dated 5/25/21 read Foley catheter 16 F(French)/ 10 ML (milliliter) bulb related to obstructive uropathy. A review of a Urology Consult note dated 6/4/21 revealed Resident #80 had a catheter for neurogenic bladder. The recommendation was for return in 4 weeks for foley change. On 6/22/21 at 4:40 PM the urinary catheter bag was observed from the hallway to be uncovered and urine was visible. The amount of urine caused the bag to sag. Nursing Assistant #2 was standing in the hallway outside of resident #80's room during the observation. NA #2 stated all the facility catheter bags had covers so she did not know why his catheter bag did not have a privacy cover on it. She commented the bag needed to be emptied. On 6/22/21 at 5:15 PM Nurse #7 stated the urinary catheter bag should have a privacy bag on it.	F 550	residents. these inspections will take to form of administrative rounds to be completed by the facility Administrator or designee to ensure continued compliance. rounds will be made daily *5 days, weekly *4 weeks, then monthly *3 months or until sufficient compliance has been achieved. Results of the resident audits will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (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) Include dates when corrective action will be completed: 7/23/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 On 6/22/21 at 5:20 PM the Director of Nursing stated Resident #80 went to a urology appointment today, so the urinary catheter bag was not one used by the facility. She stated the urinary catheter bag should always be covered.	F 550		
F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 5 by: Based on observations, resident and staff interviews, and record review the facility failed to provide an opportunity for the residents on the isolation hall (200 hall) to smoke for 3 of 4 residents (Resident #70, Resident #48, Resident #52) reviewed for smoking. Findings included: 1.Resident #70 was admitted to the facility on 12/3/2020 with diagnoses that included cerebral infarction. An annual Minimum Data Set (MDS) dated 12/10/2020 revealed Resident #70 was cognitively intact with no functional limitations. The MDS was marked yes for current tobacco use. A care plan initiated on 2/20/2021 and last reviewed on 4/29/2021 focused on safety and smoking. The interventions included encourage to wear a smoking apron, keep all smoking material at the nurse's station, and encourage the resident to smoke in the designated areas. The latest Safe Smoking Evaluation dated 5/4/2021 revealed Resident #70 required 1 to 1 supervision while smoking due to the resident had smoked a cigarette in his room on 4/18/2021. During an interview with Resident #70 on 6/21/2021 at 1:00 pm he stated that he was not informed when the 200 hall residents were put on isolation that he would not be able to smoke. He stated he was told that he had to stay on the unit and in his room during the isolation period which started on 6/17/2021. Resident #70 stated that he wanted to smoke so bad that he did not know what to do. He said if had a cigarette, he would	F 561	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility policy for quarantine and smoking has been reviewed by the Senior Corporate Nurse and the Facility Administrator to include provisions for residents who wish to smoke while on quarantine/isolation. The facility Administrator and Social Services Director will meet with Resident #70, #48, and #52, by 7/23/21 and review the revised policy. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident who smokes could have been affected by this alleged deficient practice. The facility Administrator and/or Social Services Director will meet with all current residents who smoke by 7/23/2021, they were provided a copy of Resident Rights which included a copy of the revised policy related to quarantine and smoking. Any new resident will receive a copy of their Resident Rights and a copy of the revised policy, at the time of admissions. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The revised policy related to quarantine	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 6 go in the bathroom and smoke it. He said no alternative to smoking was offered to him. An interview with Nurse #8 on 6/21/2021 at 3:00 pm revealed the 200 hall residents were on isolation and the residents could not leave the unit or their rooms to go smoke. He stated Resident #48 was not offered the opportunity to go outside to smoke because he was on the isolation hall. Nurse #8 stated he did not think about the residents needing to go outside to smoke and gave no directions for the nurse aides to escort the resident outside to smoke. An interview with the Administrator on 6/22/2021 at 11:30 am revealed the residents on the 200 hall were on isolation and could not go out to smoke. He stated he did not have a plan for the residents to go out to smoke. He then stated he did not know what precautions were needed to be in place before the residents could be escorted outside to smoke. The Administrator said he would contact the corporate office for assistance. The second interview with the Administrator on 6/25/2021 at 12:00 pm revealed the facility should have tried to make some arrangements so the residents on the isolation hall could go outside to smoke. 2.Resident #48 was readmitted to the facility on 4/8/2021 with the diagnoses that included congestive heart failure. . The annual Minimum Data Set (MDS) dated 11/9/2020 revealed Resident #48 was cognitively intact and had no functional limitations of the extremities. The MDS was marked yes for current tobacco use.	F 561	and smoking includes provisions for allowing current residents to smoke in a safe environment while on quarantine/isolation. This will include the proper use of Personal Protective Equipment (PPE) for both the resident and staff. If the resident does make the choice to not smoke, the facility will offer an alternative nicotine supplement, as director by the resident attending physician. Facility Administrator will complete training will all facility nursing staff, including licensed, unlicensed and contract nursing), dietary, housekeeping, laundry, and administrative, on resident rights, including the revised policy related to quarantine and smoking. This training will be completed by 7/23/2021. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility Interdisciplinary (IDT) Team will complete interviews with current residents, who smoke to ensure they feel that their Resident Rights, related to choices have been honored timely. They will complete random resident interviews for 10% of residents identified as smokers per week x 4 weeks, then monthly for 3 months. The facility Administrator will complete a summary of these interview results and present at the facility monthly QAPI Meeting, to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 7 The latest Safe Smoking Evaluation dated 5/11/2021 revealed Resident #48 required 1 on 1 supervision for smoking because the resident smoked a cigarette in front of the facility. The care plan that was last reviewed on 4/29/2021 did not have a plan or interventions for smoking. During an interview with Resident #48 on 6/22/2021 at 11:35 am he stated the staff had not taken him out to smoke since they closed the 200 hall down on 6/17/2021. He stated he was not told that he could not go out to smoke and was not offered a nicotine patch. He stated if a patch was offered, he would have taken the patch because it was better than nothing. Resident #48 said that he really wanted to go out to smoke a cigarette and it was not right that he could not do so. An interview with Nurse #8 on 6/21/2021 at 3:00 pm revealed the 200 hall residents were on isolation and the residents could not leave the unit or their rooms to go smoke. He stated Resident #48 was not offered the opportunity to go outside to smoke because he was on the isolation hall. Nurse #8 stated he did not think about the residents needing to go outside to smoke and gave no directions for the nurse aides to escort the resident outside to smoke. An interview with the Administrator on 6/22/2021 at 11:30 am revealed the residents on the 200 hall were on isolation and could not go out to smoke. He stated he did not have a plan for the residents to go out to smoke. He then stated he did not know what precautions needed to be in	F 561	5) Include dates when corrective action will be completed DATE 7/23/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 8	F 561		

place before the residents could be escorted outside to smoke. The Administrator stated he would contact the corporate office for assistance.

The second interview with the Administrator on 6/25/2021 at 12:00 pm revealed the facility should have tried to make some arrangements so the residents on the isolation hall could go outside to smoke.

3.Resident #52 was admitted to the facility on 1/22/2018 with diagnoses that included inclusive body mitosis (an inflammatory muscle disease).

The annual MDS dated 1/22/2021 revealed Resident #52 was cognitively intact and had a functional limitation on one side of the upper extremity. The MDS was marked yes for current tobacco use.

A care plan dated 1/22/2021 and last reviewed on 4/29/2021 revealed a plan for safety and smoking. The interventions were to encourage resident to smoke only during smoking hours posted, encourage resident to maintain all smoking materials at nursing station, and encourage resident to smoke in designated areas.

The latest Safe Smoking Evaluation dated 4/15/2021 revealed Resident #52 was safe to smoke unsupervised.

During an interview with Resident #52 on 6/22/2021 at 11:40 am he stated he had not smoked in over 7 days. He stated he did not know that he would not be allowed to smoke when the unit was placed on isolation on 6/17/2021. Resident #52 stated he wanted to go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 9 smoke a cigarette but could not leave his room. . An interview with Nurse #8 on 6/21/2021 at 3:00 pm revealed the 200 hall residents were on isolation and the residents could not leave the unit or their rooms to go smoke. He stated Resident #48 was not offered the opportunity to go outside to smoke because he was on the isolation hall. Nurse #8 stated he did not think about the residents needing to go outside to smoke and gave no directions for the nurse aides to escort the resident outside to smoke. An interview with the Administrator on 6/22/2021 at 11:30 am revealed the residents on the 200 hall were on isolation and could not go out to smoke. He stated he did not have a plan for the residents to go out to smoke. He then stated he did not know what precautions needed to be in place before the residents could be escorted outside to smoke. The Administrator stated he would contact the corporate office for assistance. On 6/25/2021 at 10:00 am during an interview with the Infection Control (IC) Nurse she stated the facility received a phone call from the local hospital on 6/17/2021 concerning a resident that resided on the 200 hall. She stated the resident tested positive for Covid 19. The IC Nurse stated all the residents on the 200 hall were placed on isolation on 6/17/2021. The second interview with the Administrator on 6/25/2021 at 12:00 pm revealed the facility should have tried to make some arrangements so the residents on the isolation hall could go outside to smoke.	F 561		
F 565 SS=D	Resident/Family Group and Response	F 565		7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 10 CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interviews	F 565	1) Address how corrective action will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 11 and record review the facility failed to address in writing and resolve a grievance reported in two consecutive Resident Council meetings for 1 of 2 resident council members (Resident #58). The findings included: A review of resident council minutes from 5/7/21 revealed Resident #58 and Resident #44 expressed a concern about staff turning down the thermostat in their rooms to 66 degrees at night. The minutes further revealed Resident #44 would ask staff to not turn down his thermostat and they would comply. The minutes were not signed by facility staff. A review of resident council minutes from 6/11/21 revealed Resident#58 stated the thermostat in her room was still being changed at night. The minutes indicated staff were consulted and staff believed it was due to the temperature dropping at night and causing the temperature change in her room. Resident #44 had no complaints about his thermostat during this meeting. The minutes were not signed by facility staff. During an interview with Resident #58 on 6/23/21 at 2:35 PM she stated she did not feel that her concern about staff members changing her thermostat was addressed. She stated she was advised the Staff Development Coordinator was going to put a note on the thermostat to not change the setting which had not happened. Resident #58 further stated she was advised the Administrator was going to meet with her and that had not occurred. An interview was conducted with the Administrator on 6/24/21 at 9:15 AM and he	F 565	accomplished for those residents found to have been affected by the deficient practice: The grievance for resident #58 was processed through the facility grievance process by the facility Administrator and completed by 7/19/21 with written follow-up provided to complainant. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents that participate in the resident council have the potential to be affected by this proposed deficient practice. therefore, the resident's council minutes for the past 6 months will be reviewed by the facility Administrator to ensure that any concerns that were brought up were appropriately addressed and written follow up provided to complainant. Any identified that have not will be recorded and addressed through the facility's resident grievance process. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Administrator will provide in-service education to the facility Activities staff on the process of recording and reporting resident grievances that come up during resident council meetings by 7/23/21. the education will detail the revised process of all concerns discussed during morning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 12 stated he did not have a resident council grievance filed about resident thermostats being changed. During an interview with the Activities Director on 6/24/21 at 4:34 PM she stated she was unable to locate a resident council grievance form completed regarding staff changing the settings on resident thermostats. She stated she was responsible for completing resident council grievance forms based on the Resident Council minutes. An interview with the Administrator on 6/25/21 at 10:05 was conducted. He stated he had understood Resident #58's grievance had been resolved. The Administrator indicated a grievance form should have been completed for Resident #58's grievance.	F 565	meetings, being addressed on the appropriate form and delivered to the Administrator or closest available member of management the date of the meeting in order to be addressed. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Facility Administrator will review resident council minutes to ensure any grievances mentioned are addressed. These reviews will be recorded on a Grievance monitoring tool and will take place monthly for 3 months or until sufficient compliance has been achieved. Results of the resident audits will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (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) Include dates when corrective action will be completed: 7/23/21	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 13	F 585		

furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 14 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on family interviews, staff interviews, and record review the facility failed to resolve grievances for 1 of 5 residents reviewed for grievances (Resident #18). The findings included: Resident #18 was admitted to the facility on 4/12/04. The Minimum Data Set (MDS) assessment dated 4/4/21, a quarterly assessment, revealed Resident #18 was assessed as severely cognitively impaired with no speech. A care conference note written by Nurse #9 on 4/2/21 revealed Resident #18's family member expressed a concern about his glasses during the care conference. During a review of grievances filed during January 2020-June 2020 there was no grievance filed on Resident #18's behalf regarding his glasses. During an interview with Nurse #9 on 6/24/21 at 10:15 AM Nurse #9 stated she did not complete a grievance about the concern expressed by Resident #18's responsible party during the care conference on 4/2/21. She reported that she thought she spoke with nursing about the	F 585	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The grievance for resident #18 was recorded by the facility Administrator and to be completed with written follow-up provided to complainant by 7/19/21. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All other residents who have representatives that attend care plan meeting have potential to be affected by the proposed deficient practice. Nurse #9 was provided in-service education by the facility Administrator regarding the grievance reporting policy and the proper method to do so, by 7/23/2021. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility Administrator or designee will provide education to all staff members that details the grievance reporting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 16 concern. Nurse #9 stated she could not remember and was unsure if it was on first or second shift. She reported she may have spoken with the social worker about the glasses. Nurse #9 stated she did not follow up with Resident #18's family member about the concern. An interview was conducted with the facility Social Worker on 6/24/21 at 11:13 AM who stated she did not recall any concerns voiced about Resident #18's glasses and did not speak with his family member about the concern. During an interview with Nurse #10 on 6/24/21 at 12:48 PM she stated Resident #18's glasses were broken during a room change. She stated the glasses were found broken in a box of Resident #18's personal items. Nurse #10 indicated an appointment was made for him to be fitted for new glasses, but his responsible party did not attend. She stated that appointment will be rescheduled. Nurse #10 stated she was unaware of a concern expressed regarding Resident #18's glasses and no one mentioned a grievance to her. An interview was conducted with Resident #18's responsible party on 6/25/21 at 8:50 AM about the concern expressed during the care conference. The family member stated she did not hear anything about her concern and planned to bring it up during the next scheduled care conference. She stated Resident #18 has indicated during window visits that he needs his glasses. During an interview with the Administrator on 6/25/21 at 10:10 AM he indicated that a grievance form should be completed when a concern is	F 585	process and the proper method that is needed to report a concern/ grievance that is voiced by a resident or their family members. The education will also describe each person's role in the grievance resolution process. This education will be completed by 7/23/2021. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility administrator will audit concern reporting during care plan meetings by contacting 10% of the attendees of the meetings held. these audits will be conducted weekly *4 weeks, then monthly *3 months or until sufficient compliance has been achieved. Results of the resident dignity audits will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (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) Include dates when corrective action will be completed: 7/23/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 17 expressed. He further indicated grievances should be investigated and the outcomes should be communicated to the responsible party.	F 585		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to prevent misappropriation of property when an employee stole a resident's cell phone and used the cell phone to download unauthorized applications for 1 of 1 sampled residents (Resident #262) reviewed for misappropriation of property. Findings include: Resident #262 was admitted to the facility on 1/29/21 and discharged to the hospital on 2/5/21 where she died. Resident #262 had diagnoses that included chronic obstructive pulmonary disease and hypertension. A review of the facility's Initial Allegation Report dated 2/8/21 revealed Resident #262's cell phone was missing. A review of the facility's Investigation Report	F 602	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #262 is no longer in the facility, but the property in question was secured and returned to the residents' family on 2/8/21. NA #4 was also terminated from employment. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: IDT Team completed interviews with current alert residents to ensure they had no unresolved issued with missing items. Resident representatives were contacted for any resident unable to communicate to ensure there were no unresolved issues with missing items. Any issues identified	7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 18 dated 2/8/21 revealed the resident's family had contacted the cell carrier for the phone and had it located. The family notified the police department and proceeded to the address were the cell phone was located. The cell phone was retrieved from Nurse Aide (NA) #4. The facility found reasonable suspicion of a crime and the allegation was substantiated. NA #4 was terminated. A review of a police report dated 2/8/21 indicated NA #4 stated she had seen Resident #262 use the phone while a resident of the facility and planned to return the phone to a family member. An interview was conducted with Resident #262's family member on 6/21/21 at1:20 PM who reported NA #4 was arrested and the cell phone was returned. Attempts to contact NA #4 during the survey were not successful. An interview was conducted with the Director of Nursing (DON) on 6/25/21 at 10:30 AM who stated NA #4 reported she planned to return the cell phone when she returned to work. The DON stated NA #4 had deleted Resident #262's information off the phone and had downloaded several phone applications. The DON stated NA #4's employment had been terminated. She stated staff received training at orientation and annually about misappropriation of resident property. The DON indicated this was not acceptable behavior for staff.	F 602	were noted and processed through the facility grievance process by the facility Administrator and/or Social Worker. all interviews are to be completed with concerns processed by 7/23/21. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff will continue to be screened upon hire for criminal history and reviewed/approved by the facility administrator prior to hire. All staff are provided with education by facility SDC or designee on resident's rights and misappropriation prohibition upon hire and at least annually. the facility administrator or designee will provide in-service education to all staff regarding resident's rights and misappropriation of resident property. This education is to be completed by 7/23/2021 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Facility will initiate inspections to be conducted routinely to ensure that staff are aware of resident's rights as it pertains to misappropriation of property. These inspections will take to form of administrative rounds to be completed by the facility Administrator or designee to ensure continued compliance. rounds will be made daily *5 days, weekly *4 weeks, then monthly *3 months or until sufficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 19	F 602	compliance has been achieved. Results of the audits will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (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) Include dates when corrective action will be completed 7/23/21	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment for the areas of physician contraindications to gradual dose reduction of antipsychotic medications (Resident #62), behaviors (Resident #39), and catheter use (Resident #80) for 3 of 26 assessments reviewed. Findings included: 1. Resident #62 was admitted to the facility on 8/25/13 with diagnoses that included hypertension and diabetes mellitus. Record review revealed the physician documented a gradual dose reduction of an antipsychotic medication was contraindicated on 2/5/21.	F 641	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The assessments for resident #62, resident #39 and resident #80 were amended and corrected by the Minimum Data Set (MDS) Coordinator by 7/23/21. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of MDS assessments for the most recent assessment will be completed by the Lead MDS Coordinator by 7/23/2021 validating accuracy of physician contraindications to gradual	7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 20 A quarterly Minimum Data Set (MDS) assessment dated 5/2/21 revealed Resident #62 was coded for using an antipsychotic medication on a routine basis. The assessment did not indicate there was was documentation by the physician that a gradual dose reduction of an antipsychotic medication was contraindicated. During an interview with Nurse #9 on 6/23/21 at 4:07 PM she stated she did not code Resident #62's antipsychotic medication as being contraindicated for a gradual dose reduction documented by the physician because she didn't see the documentation in the chart. During an interview with the Administrator on 6/25/21 at 10:10 AM he indicated Resident #62's assessment should have been coded accurately. 2. Resident #39 was admitted to the facility on 3/18/21 with diagnoses that included heart failure. An admission Minimum Data Set (MDS) assessment dated 3/26/21 revealed Resident #39 was coded as having no behaviors during the 7-day lookback period. A nursing progress note dated 3/19/21 revealed Resident #39 refused medications, refused laboratory testing, and was verbally abusive. During an interview with Nurse #9 on 6/23/21 at 4:07 PM she stated the behavior section of the assessment was coded by the social worker. An interview was conducted with the social worker on 6/23/21 at 4:30 who stated she should have coded Resident #39's behaviors on his assessment. She indicated she must have	F 641	dose reductions (GDR) of antipsychotic medications, presence of behaviors, and catheter use. Any assessments found to be incorrect will be corrected and resubmitted at this time. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: By 7/23/2021, education will be provided to the MDS staff and the facility social worker by the facility Executive Director pertaining to accuracy of assessments. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility Executive Director will audit a sample of 10% of the completed MDS assessments weekly x4 weeks then a sample of assessment monthly x2 months to ensure coding accuracy in contraindication of GDRs, behaviors, and catheter use. These audits will be recorded and kept by the ED for review. Facility Executive Director will report all findings to the Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. 5) Include dates when corrective action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 21 overlooked the note documenting the behaviors. During an interview with the Administrator on 6/25/21 at 10:10 AM he indicated Resident #39's assessment should have been coded accurately for behaviors. 3. Resident #80 was admitted to the facility on 12/31/20. His diagnosis included stoke with right sided hemiplegia and neurogenic bladder. A review of the significant change Minimum Data Set (MDS) dated 5/17/21 revealed Resident #80 was severely cognitively impaired. The MDS indicated no catheter. In the following section his urinary continence was not rated due to indwelling catheter. A review of Resident #80's care plan updated on 5/17/21 revealed he had a urinary catheter. One of the interventions was to provide catheter care every shift. On 6/25/21 at 11:45 AM Nurse # 5 stated item HO100 on the significant change MDS dated 5/17/21 was not coded correctly. On 6/25/21 at 11:30 AM the Director of Nursing stated coding as no catheter was an error.	F 641	will be completed 7/23/21	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F 655		7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 22 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a summary of the	F 655	1) Address how corrective action will be accomplished for those residents found to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 23 baseline care plan to residents or their representatives for 2 of 2 residents reviewed for baseline care plans (Resident #262 and Resident #56). The findings include: 1. Resident #262 was admitted to the facility on 1/29/21. Resident #262 had diagnoses that included chronic obstructive pulmonary disease and hypertension. A review of the record revealed no documentation of a written summary of the baseline care plan was given to the resident or responsible party. The baseline care plan could not be located. An interview was conducted with Nurse #5 on 6/25/21 at 9:00 AM who stated she did not know where Resident #262's care plan was located. She stated she completed a baseline care plan but did not provide a written summary to Resident #262 or her responsible party. An interview was conducted with the Administrator on 6/25/21 at 10:10 AM who indicated a written summary of the baseline care plan should be provided to the resident based upon federal guidelines. 2. Resident #56 was admitted to the facility on 4/21/21 with diagnoses that included hypertension and diabetes mellitus. Resident # 56's baseline care plan was completed 4/21/21. There was no documentation of a written summary of the baseline care plan	F 655	have been affected by the deficient practice: Resident #262 is no longer in the facility. Discharged on 2/5/2021. Resident #56 comprehensive care plan was initiated by the Minimum Data Set (MDS) Nurse on 4/21/21. A care conference was held with the resident and responsible party on 7/23/21 and the care plan reviewed, and a written summary of the care plan was provided. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All newly admitted residents have the potential to be affected therefore an audit will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager on new admissions admitted within the past 21 days to ensure a baseline care plan was initiated, and a written summary shared with the resident and responsible party (as applicable). This audit will be completed by 7/23/21. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 7/23/21, all Licensed Nurses and Interdisciplinary Team (IDT) which includes the Director of Nursing, Assistant Director of Nursing, Minimum	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 24 was given to the resident or responsible party. An admission Minimum Data Set (MDS) assessment dated 5/24/21 revealed Resident #56 was assessed as severely cognitively impaired. An interview was conducted with Nurse #9 on 6/23/21 at 4:07 PM. She stated she will provide a copy of the baseline care plan to the resident or resident's responsible party if they request it. Nurse #9 stated no copy or written summary of the baseline care plan was given to Resident #56 or her responsible party. An interview was conducted with the Administrator on 6/25/21 at 10:10 AM who indicated a written summary of the baseline care plan should be provided to the resident based upon federal guidelines.	F 655	Data Set (MDS) Nurse, Social Worker, Activity Director and Dietary Manager will be educated by the facility Administrator regarding the baseline care plan process upon admission which should include the following: o Upon resident admission, the baseline care plan will be initiated by the admitting Licensed Nurse. The facility interdisciplinary team (IDT) which includes the Director of Nursing, Assistant Director of Nursing, Minimum Data Set (MDS) Nurse, Social Worker, Activity Director and Dietary Manager will review the baseline care plan for accuracy during daily clinical meeting the following business day. After baseline care plan is reviewed/finalized, the baseline care plan will be reviewed with the resident/RP and a written summary of the baseline care plan will be given. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 7/26/21 daily Monday – Friday, the IDT will review new admissions to ensure the baseline care plan is initiated/completed. Weekly for a minimum of (3) months, the DON will complete baseline care plan audits to ensure new admission baseline care plans have been discussed/provided to new admissions. Results of the audit will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (3)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 25	F 655	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) Include dates when corrective action will be completed: 7/23/21	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 26 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to develop a comprehensive care plan to address smoking for 1 of 3 residents (Resident #83) and establish a discharge goal for 1 of 2 residents (Resident # 39) reviewed for care plans. The findings included: 1. Resident #83 was admitted to the facility on 2/19/2021 with diagnoses that included congestive heart failure. The admission Minimum Data Set (MDS) dated 2/26/2021 revealed Resident #83 was moderately cognitively impaired and had no functional impairments of the extremities. The MDS was marked no for tobacco use. An interview with Resident #83 on 6/23/2021 at 10:28 AM revealed he did not smoke when he was first admitted to the facility. He stated that he decided to smoke a cigarette on 5/2/2021. A Safe Smoking Evaluation dated 5/3/2021	F 656	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #83 comprehensive care plan was reviewed by the Minimum Data Set (MDS) Nurse and revised to include a smoking care plan on 6/24/21. Resident #39 comprehensive care plan was reviewed by the Social Worker and revised to include a care plan to include discharge planning goals and interventions on 7/23/21. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who smoke have the potential to be affected therefore a care plan audit will be conducted by the MDS Nurse to ensure any resident who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 27 revealed Resident #83 room required 1 to 1 supervision while smoking. A care plan last reviewed on 5/27/2021 did not have a plan or interventions for smoking. During an interview with MDS Nurse #1 at 6/23/2021 at 1:10 pm she stated Resident #83 did not have a care plan to address smoking. She said a care plan should have been developed during the last care plan reviewed on 5/27/2021. On 6/25/2021 at 11:30 am during an interview with the Director of Nursing, she stated the MDS Nurses were responsible for the development of care plans. She said a smoking care plan should have been added to Resident #83 ' s care plan. The Administrator stated on 6/25/2021 at 11:45 am the care plan should have been updated to include a smoking care plan. 2. Resident #39 was admitted to the facility on 3/18/21 with diagnoses that included heart failure. A quarterly Minimum Data Set (MDS) assessment dated 4/11/21 revealed Resident #39 was cognitively intact. The care plan dated 3/26/21 and last reviewed 6/23/21 revealed no interventions or goals related to discharge planning. A social work progress note dated 3/29/21 indicated Resident #39 planned to return to the community after discharge. A social work progress note dated 4/9/21 revealed Resident #39 requested assistance with placement in the community.	F 656	smoke has a smoking care plan implemented. This audit will be completed by 7/23/21. All residents who desire discharge back to the community have the potential to be affected therefore a care plan audit will be conducted by the Social Worker to ensure those residents have discharge planning goals and interventions. This audit will be completed by 7/23/21. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 7/23/21, the MDS Nurse and Social Worker will be educated by the Director of Nursing on ensuring care planning of residents who smoke and care planning of discharge goals and interventions for residents. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 7/26/21 weekly for (3) months the Director of Nursing will review (5) completed comprehensive care plans to ensure those residents who desire discharge back to the community have discharge goals and interventions reflected in the care plan. Also, this review will ensure any resident that smoke has a smoking care plan implemented. Results of this comprehensive care plan audit will be reviewed in monthly Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 28 During an interview with Nurse #9 on 6/23/2021 at 4:07 PM she stated the social worker is responsible for placing discharge goals on the care plan. An interview was conducted with the social worker on 6/23/21 at 4:30 PM. She stated she did not include a discharge goal on Resident #39 ' s care plan because it was not required. The social worker stated a Care Area Assessment did not trigger on the Minimum Data Set assessment completed 3/26/21 so a discharge goal was not required for his care plan. During an interview with the Administrator on 6/25/21 at 10:10 AM he indicated care plans should be completed to accurately reflect the services received by residents.	F 656	and Performance (QAPI) meeting for (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) Include dates when corrective action will be completed: 7/23/21	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 29 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident interviews and record review the facility failed to schedule a care plan meeting for a newly admitted resident (Resident #57) and failed to invite the resident to care plan meetings (Resident #39, Resident #62, and Resident #34) for 4 of 4 residents reviewed for care plan meetings. The findings included: 1. Resident #57 was admitted to the facility on 4/21/21 with diagnoses that included hypertension and diabetes mellitus. An admission Minimum Data Set (MDS) assessment dated 5/24/21 revealed Resident #57 was assessed as severely cognitively impaired. A review of Resident #57's medical record revealed no documentation regarding care plan meetings. During an interview with Nurse #5 and Nurse #9 on 6/23/21 at 4:07 PM revealed that Resident #57 has not had a care plan meeting because she had not been in the facility for 90 days. Nurse #5	F 657	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: By 7/23/21, Resident (#57, #39, #62 and #34) and their Responsible Party (RP) will be contacted by the facility Social Worker or designee to schedule a care conference to review the resident care plan with the facility Interdisciplinary (IDT) Team. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected therefore, a facility audit of care conferences will be completed by the Social Worker to ensure a care conference with the resident and/RP was conducted to review the completed initial baseline/comprehensive care plan or quarterly care plan review with the facility IDT. This audit will be completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 30 stated care plan meetings were not held until the resident had been in the facility for 90 days. During an interview on 6/25/21 at 10:10 AM the Administrator indicated federal regulations should be followed regarding scheduling care plan meetings. 2. Resident #39 was admitted to the facility on 3/18/21 with diagnoses that included heart failure. A quarterly Minimum Data Set (MDS) assessment dated 4/11/21 revealed Resident #39 was cognitively intact. A nursing note dated 4/22/21 revealed a care plan meeting was held for Resident #39 on 4/22/21. Resident #39 was unavailable for interview. During an interview with Nurse #9 on 6/23/2021 at 4:07 PM she stated she had sent an invitation for the care plan meeting to Resident #39's representative. She revealed she did not invite Resident #39 to the care planning meeting. Nurse #9 said she normally would leave it up to the Representative to request the resident to attend the care plan meeting. During an interview on 6/26/2021 at 10:10 am the Administrator indicated Resident #39 should have been invited his care plan meeting. 3. Resident #62 was admitted to the facility on 8/25/13 with diagnoses that included hypertension and diabetes mellitus. A quarterly Minimum Data Set (MDS) assessment dated 5/2/21 revealed Resident #62	F 657	7/23/21. Any identified need for care conference with a resident and/RP will be scheduled by 7/23/21. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: By 7/23/21, the facility Social Worker, Admission Director, Minimum Data Set (MDS) Nurse and Director of Nursing will be educated by the facility Administrator on the need for inviting and scheduling care conferences with both the resident and/RP to review the completed initial baseline/comprehensive care plan or quarterly care plan review. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 7/26/21, weekly for (3) months the facility Administrator or Director of Nursing will complete an audit of care plan conferences utilizing the MDS calendar to ensure the facility IDT team conducted a care conference with the resident and/RP to review the completed initial baseline/comprehensive care plan or quarterly care plan review. Results of this audit will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 31 was assessed as moderately cognitively impaired. A nursing note dated 5/12/21 revealed a care plan meeting was held for Resident #62 on 5/12/21. An interview was conducted with Resident #62 on 6/24/21 at 2:15 PM. He indicated he could not recall being invited to a care plan meeting. During an interview with Nurse #9 on 6/23/21 at 4:07 PM she stated she had sent an invitation for the care plan meeting to Resident #62's representative. She revealed she did not invite Resident #62 to the care planning meeting. Nurse #9 said she normally would leave it up to the Representative to request the resident to attend the care plan meeting. During an interview on 6/25/2021 at 10:10 am the Administrator indicated Resident #62 should have been invited his care plan meeting. 4. Resident #34 was readmitted to the facility on 1/16/2021 with diagnoses that included peripheral vascular disease and hypertension. A quarterly Minimum Data Set (MDS) dated 4/8/2021 revealed Resident #34 was cognitively intact. A Nursing note dated 5/21/2021 revealed a care plan meeting was held on 5/21/2021. An interview with Resident #34 on 6/22/2021 at 1:22 pm revealed she was not invited to participate in the care planning meeting . During an interview with Nurse #9 on 6/23/2021 at 10:15 am she stated she had sent an invitation for the care plan meeting to Resident #34's	F 657	5) Include dates when corrective action will be completed: 7/26/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 32 Representative. She revealed she did not invite Resident #34 to the care planning meeting. MDS Nurse #1 said she normally would leave it up to the Representative to request the resident to attend the care plan meeting. On 6/25/2021 at 11:30 am during an interview with the Director of Nursing (DON) she stated MDS Nurse #1 should have invited Resident #34 to her care plan meeting. The Administrator stated on 6/26/2021 at 11:45 am Resident #34 should have been invited to the care plan meeting.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff the facility failed to provide nail care for 2 of 3 (Resident #80 & #28) residents who were dependent on staff for activities of daily living (ADLs). The findings included: 1. Resident #80 was admitted to the facility on 12/31/20. His diagnoses included stoke with right sided hemiplegia and diabetes. A review of the significant change Minimum Data Set dated 5/17/21 revealed Resident #80 was severely cognitively impaired. He was totally	F 677	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 6/24/21, Residents #80 and #28 had nail care performed by their respective assigned Nurse Aide (NA). 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected therefore, the facility Director of	7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 33 dependent on staff for toileting, personal hygiene, and bathing. He had limited range of motion on one side. A review of Resident #80's care plan updated on 5/17/21 revealed he required assistance with dressing, grooming, toileting, and bathing related to a right above the knee amputation. An observation on 6/22/21 at 3:00 PM revealed the fingernails on Resident #80's left hand had black debris under the nails. Resident #80's right hand was under the bedspread and could not be observed. On 6/24/21 at 1:35 PM Nurse Aide #2 stated she gave Resident #80 a bath that morning. She observed Resident #80's fingernails and stated they were dirty. She said she forgot to clean Resident #80's fingernails and she would get a nail stick to clean them. On 6/24/21 Nurse #6 who was assigned to Resident #80 stated she was not aware of Resident #80s nails needed care. On 6/24/21 at 2:35 PM the Director of Nursing stated residents' nails should be cleaned as part of the bath. She was unaware Resident #80's nails had not been cleaned since 6/22/21. 2. Resident #28 was admitted to the facility on 11/24/20 and readmitted on 6/11/21 with diagnoses which included Diabetes Mellitus and cerebral infarction. The most recent Minimum Data Set dated 5/25/21 indicated Resident #28 was severely cognitively impaired and she was coded as totally dependent on staff for activities of daily living	F 677	Nursing, Assistant Director of Nursing and Unit Manager conducted a facility tour on 7/23/21 to identify any resident in need of nail care. Any resident identified as needing nail care had nail care completed by the Licensed Nurse or Nurse Aide. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: By 7/23/21, the facility Director of Nursing or Assistant Director of Nursing will educate all nursing staff on ensuring nail care is completed. This will include ensuring resident nails are trimmed and clean when needed. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 7/26/21, the facility Director of Nursing, Assistant Director of Nursing or Unit Manager will audit nail care for (10) residents weekly for (3) months to ensure nails are trimmed and clean. Results of this audit will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (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) Include dates when corrective action will be completed: 7/23/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 34 (ADL). Observation of Resident #28 on 6/24/21 at 1:00 PM revealed her finger nails to be between ¼ - ½ inch long. Resident noted to maintain left hand in closed fist position and left palm noted to have small red indentation on the skin of the thumb palm area from 1st and 2nd finger nail pressure. An observation and interview on 6/24/21 at 1:00 PM with Nurse #1 confirmed that Resident #28's nails were too long and should have been cut. She stated it was the nurses' responsibility to cut the diabetic resident's nails and she did not know why they had not been cut. An observation and interview on 6/24/21 at 1:30 PM with the Director of Nursing (DON) revealed she agreed the nails were too long and should have been cut and she did not know why they had not been cut. An interview on 6/25/21 at 7:29 AM with the Administrator revealed he expected nail care to be provided as needed and he did not know why it wasn't done.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of	F 688		7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 35 motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review the facility failed assess and provide an intervention for a hand contracture for 1 of 1 resident reviewed for range of motion (Resident #74). Findings included: Resident #74 was admitted to the facility on 5/19/2020 with diagnoses that included cerebral vascular accident (stroke). The Admission Minimum Data Set (MDS) dated 5/26/2020 revealed Resident #74 was cognitively intact and was able to make her needs known. The MDS indicated Resident #74 had functional limitations on one side of the upper and lower extremities. The Care Area Assessment (CAA) revealed activity of daily living (ADL) and rehabilitation potential was checked to be addressed on the care plan. The contracture was not documented on the CAA. A care plan initiated on 5/29/2020 and last reviewed on 5/18/2021 for ADLs revealed no interventions to address Resident #74's left hand contracture.	F 688	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: A physician order was obtained, and a therapy referral was initiated by the Director of Nursing on 6/23/21 for Resident #74 to evaluate left hand contracture and provide interventions as appropriate. Therapy evaluation was completed by the Occupational Therapist on 6/23/2021 in which a resting hand splint was recommended and put into place as of 7/1/21. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with contractures have the potential to be affected therefore, the Therapy Director, Director of Nursing, Assistant Director of Nursing and Unit Manager will conduct a facility tour by 7/23/2021 to identify any residents with contractures without contracture management evaluation and initiation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 36 A physician note dated 1/21/2021 revealed Resident #74 requested to start seeing Occupational Therapy (OT) again to work with her on exercising her left hand which was contracted. The physician progress note dated 2/19/2021 revealed Resident #74 would like to see OT to see if there was a brace that she could place on her left hand due to contracture. The note indicated the order for OT was placed. There was no physician order found in Resident #74's record for an OT evaluation or consultation. There was no therapy documentation in the record. No information was found concerning the degree of the contracture Resident #74 had upon admission to the facility. An interview and observation on 6/22/2021 at 9:22 am revealed Resident #74 was resting in bed with her left hand outside of the sheet. The fingers on the left hand were observed to be bent towards the palm of her hand. No redness was observed in the palm of her hand and her fingernails were not touching the palm of her hand. She denied having any pain in her hand. There was no rolled wash cloth or splint device in her left hand. She stated she was unable to open her left hand and was asked why she was not getting services for her left hand. She stated therapy had not worked with her left hand since she was admitted to the facility. Resident #74 stated her left-hand contracture had gotten worse because no one at the facility had worked with her left hand. Resident #74 revealed she had asked the physician for Occupational Therapy twice and had not received the services.	F 688	interventions (as appropriate). Any resident identified with a contracture without intervention will be referred to therapy for an evaluation. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: By 7/23/21, all Nursing Staff will be educated by the Director of Nursing or Assistant Director of Nursing on communicating to Nursing Management any resident who has a contracture without interventions (splint, hand roll etc..) to ensure implementation of contracture management to include therapy referral for interventions (as indicated). Any resident who has established interventions for contracture management should have those interventions implemented as ordered by the physician. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 7/26/21, weekly for (3) months the facility Director of Nursing, Assistant Director of Nursing and Unit Manager will audit (5) residents weekly for the presence of any contractures. If any contractures are identified and no interventions are evident. The resident will be referred to therapy for contracture management evaluation. A follow-up of any therapy evaluation related to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 37 An interview with Nurse Aide (NA) # 3 on 6/22/2021 at 11:00 revealed she was not informed that Resident #47 was to have anything in her hand. She stated the nurse would normally inform the NAs of changes made in the resident's care. An interview with Nurse #8 on 6/23/2021 at 10:40 am revealed Resident #74 was admitted to the facility from another long-term care facility with the left-hand contracture. Nurse #8 said he did not know if the contracture had gotten worse or not because she did not use her left hand. He stated he did not recall Occupational Therapy working with her. He stated the physician would write the order for therapy and sometimes the therapist would write their own order and have the physician sign the order. He stated when the physician wrote the order it was given to the therapist for an evaluation. During an interview with the Occupational Therapist on 6/25/2021 at 10:00 am he stated he had seen Resident #74's significantly contracted left hand in the hall and requested an evaluation from the Rehabilitation Manager months ago. He stated an evaluation was not done for Resident #74's left hand because the Manager would not let him do an evaluation . The interview with the Rehabilitation (rehab) Manager on 6/25/2021 at 10:40 am revealed she recalled discussing Resident #74's contracted left hand in the daily management meeting and it was decided a splint was not appropriate for the resident. The Rehab Manager said the Nursing staff was to place a washcloth daily in Resident #74's left hand. She could not give a date for the discussion concerning Resident #74's contracture	F 688	contracture management will be discussed in the facility daily clinical meeting to ensure contracture management interventions are communicated with the Interdisciplinary (IDT) team. Results of this audit will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (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) Include dates when corrective action will be completed: 7/23/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 38 in the meeting and no documentation of the discussion was found in the record. An interview with the Director of Nursing (DON) on 6/28/2021 at 11:30 am revealed she did not recall a discussion concerning Resident #74's contracture in their morning management meeting or either she was not in the meeting. She said she did recall Resident #74 being admitted to the facility with something for her left hand and arm. The DON stated she did not know where the appliance was at that time. During an interview with the Administrator on 6/28/2021 at 11:45 am he stated if a plan was made for Resident #74 to get a rag in her hand, nursing should have followed through with the plan.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 39 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to prevent a urinary catheter bag from coming in contact with the floor and failed to secure the catheter tubing for 1 of 1 resident (Resident #80) reviewed for urinary catheter. The findings included: Resident #80 was admitted to the facility on 12/31/20. His diagnosis included stoke with right sided hemiplegia and neurogenic bladder. A review of the significant change Minimum Data Set dated 5/17/21 revealed Resident #80 was severely cognitively impaired. He was totally dependent on staff for toileting, personal hygiene, and bathing. His urinary continence was not rated due to indwelling catheter.	F 690	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The catheter bag for resident #80 was secured with a securement device and repositioned by the Licensed Nurse so that it was no longer in contact with the floor on 6/22/2021. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents that have indwelling catheters are at risk of being affected by this proposed deficient practice. Therefore, the facility Director of Nursing performed an audit of all residents with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 40 A review of Resident #80's care plan updated on 5/10/21 revealed he had a urinary catheter. The interventions included to secure catheter tubing high to prevent pulling, monitor catheter tubing for kinks or twists, and provide catheter care every shift. 1a. An observation of Resident #80's urinary catheter bag on 6/22/21 at 3:00 PM revealed it was attached to the right side of the bed rail near the foot of the bed. The urinary catheter drainage bag was visible from the doorway and was touching the floor. On 6/22/21 at 4:40 PM Nurse Aide #2 stated she was assigned to Resident #80. She stated his urinary catheter bag should not be touching the floor. She said it was contaminated and needed to be replaced. She said she had not noticed it earlier and she would need to tell Resident #80's nurse. On 6/22/21 at 5:15 PM Nurse #7 reported he was Resident #80's nurse. He walked to the doorway of Resident #80's room and stated the urinary catheter bag should not be touching the floor and he would get it changed before the end of his 7:00 AM to 7:00 PM shift. On 5/22/21 at 5:20 PM the Director of Nursing stated Resident #80's urinary catheter bag should not be touching the floor. 1b. On 6/24/21 at 1:33 PM Nurse Aide #2 observed Resident #80 did not have a leg securement device for his urinary catheter. She stated she gave resident #80 a bath that morning and she noticed Resident #80 did not have a leg securement device for his catheter, so she was	F 690	indwelling catheters and confirmed that no other catheter bags were in contact with the floor and all resident catheters were secured with a securement device on 6/23/2021. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility Director of Nursing or designee will provide in-service education to 100% of the nursing staff about catheter management with emphasis upon proper securement of the catheter with a securement device and positioning of the catheter drainage bag. All education is to be completed by 7/23/21. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility will initiate inspections to be conducted routinely to ensure that catheter bags remain out of contact with the floor and catheters are secured with a securement device. These inspections will take the form of administrative rounds to be completed by the facility Administrator or designee to ensure continued compliance. Rounds will be made daily *5 days, weekly *4 weeks, then monthly *3 months or until sufficient compliance has been achieved. Results of the audits will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (3) months. At that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 41 careful when giving the bath. Upon questioning she said she should have informed the nurse that the leg securement device was not present. On 6/24/21 at 1:35 PM Nurse #6 who was assigned to Resident #80 stated he should always have a leg strap. On 6/24/21 at 5:20 PM the Director of Nursing stated residents with urinary catheters should always have a leg strap.	F 690	time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5) Include dates when corrective action will be completed: 7/23/2021	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and Physician interview, the facility failed to administer significant medications as ordered by the physician on 1/30/21 and/or 1/31/21 for 2 of 2 residents (Resident #82 & Resident #262) resulting in the potential for changes in blood sugar levels, pain, and vital signs. Findings included: 1. Resident #82 was admitted to the facility on 4/04/19 with diagnoses which included Diabetes Mellitus and end stage renal disease. A significant change Minimum Data Set assessment dated 1/27/21 indicated Resident #82 had severe cognitive impairment and was diagnosed with Covid-19. Resident #82 was coded to have received Insulin injections 7 days	F 760	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility Medical Director reviewed both residents' charts on 6/24/21 and found no significant impact from the proposed deficient practice. Resident #262 is no longer a resident in the facility. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: There are no other residents at risk to be affected by this proposed deficient practice as there are no other residents present in the facility covid unit.	7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 42 during the look back period. Review of Physician's Orders for January 2021 revealed Resident #82 had multiple scheduled and as needed medications. The scheduled medications for 9:00 PM on 1/30/21 and 1/31/21 included: - Tresiba Flextouch 100 Unit/milliliter (U/ml) 45 units (U) subcutaneous (SQ) at bedtime (Insulin for Diabetes Mellitus). Check fasting blood sugar level at bedtime (scheduled for 8:00 PM). - Potassium 10 milliequivalent (meq) four times per day for hypokalemia (low potassium) Review of Resident #82's Medication Administration Record (MAR) for January 2021 revealed the following: - Tresiba Flextouch 100 U/ml 45 U SQ at bedtime (Insulin for Diabetes Mellitus) - was not signed as administered for 1/30/21 and 1/31/21. Check fasting blood sugar level at bedtime - was not signed as completed for 1/31/21. - Potassium 10 milliequivalent (meq) four times per day for hypokalemia (low potassium) - was not signed as administered Review of the January and February 2021 MARs revealed Resident #82's fasting blood sugar level on 1/30/21 at 8:00 PM was 179 and on 2/01/21 at 8: 00 her blood sugar level was 161. The Covid Unit Time and Attendance Log revealed Nurse #2 had signed in to work on 1/30/21 at 7:07 AM and signed out at 7:30 PM. The log further revealed Nurse #2 had signed into work on 1/31/21 at 7:07 AM and signed out at 6:15 PM. An interview on 6/23/21 at 7:22 PM with Nurse #2	F 760	3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility DON will provide education to all licensed nursing staff on following physician orders related to the administration of medications. This education will be completed by 7/23/21. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility DON or designee will review a random selection of 10% of administration records for medications provided for residents on the facility covid unit. These reviews will be conducted weekly *3 months. Results of the audits will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (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) Include dates when corrective action will be complete: 7/23/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 43	F 760		

confirmed she had worked on 1/30/21 and 1/31/21 on the Covid unit. She stated she did not remember if she gave Resident #82 any of her scheduled bedtime medications early or if she gave them at all. She stated she did not remember if there was another nurse to work the Covid unit either of those nights.

An interview on 6/24/21 at 3:38 PM with Nurse #4 revealed she did not remember if she had worked on 1/30/21 or 1/31/21. She confirmed she did not go to the Covid unit at any time in January. She revealed she had not obtained blood sugar levels or given scheduled medications when Resident #82 was on the Covid unit on 1/30/21 or 1/31/21.

The Covid Unit Time and Attendance Log revealed Nurse #3 had signed in to work on 2/01/21 at 7:00 AM and signed out at 6:30 PM.

An interview on 6/24/21 at 1:43 PM with Nurse #3 confirmed she had worked on 2/01/21 on the Covid unit. She stated on the morning of 2/01/21 she had signed Resident #82's scheduled medications from 1/30/21 and 1/31/21 as 'not administered' but she did not know if they had been given or not. She stated she signed them to clear them off her computer medication screen during the medication pass for her shift.

An interview on 6/24/21 at 2:48 PM with the Director of Nursing (DON) confirmed there was a Nursing Assistant (NA) assigned to the Covid unit on 1/30/21 and 1/31/21 from 7:00 PM to 7:00 AM. She also confirmed there was a nurse available on another unit, Nurse #4, if there was an emergency on the Covid unit. She stated if Nurse #4 had gone to the Covid unit she would have had to leave the building and another nurse would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 44	F 760		

have taken her assignment. The DON did not verbalize a plan to administer Resident #82's scheduled Insulin and Potassium while in the Covid unit on 1/30/21 and 1/31/21.

An interview on 6/24/21 at 5:19 PM with the Physician revealed she was unaware that Resident #82 had not received blood sugar checks or scheduled medications for the evenings or nights of 1/30/21 or 1/31/21. She stated she did not believe there was any significant impact to the resident because of the missed medications but also expected her orders to be followed.

An interview on 6/25/21 at 7:26 AM with the Administrator revealed he was unaware that Resident #82 had missed her scheduled medications and could not explain what happened. He also revealed he expected the Physician's orders to be followed.

2. Resident #262 was admitted to the facility on 1/29/21 with diagnoses which included chronic obstructive pulmonary disease (COPD), fibromyalgia (widespread pain), and Covid-19.

The most recent Minimum Data Set dated 2/05/21 indicated Resident #262 was cognitively intact. Resident #262 was coded to have received antidepressants, diuretics (water pills), and opioids for 7 days during the look back period.

Review of Physician's Orders for January 2021 revealed Resident #262 had multiple scheduled and as needed medications. The scheduled medications for 9:00 PM on 1/31/21 included:
- Diclofenac Sodium 1% gel applied to affected area four times per day for pain (arthritis pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 45	F 760		

cream)
- Ipratropium-Albuterol 0.5-3 (2.5) mg/3 milliliters (ml) inhalation four times per day for wheezing and shortness of breath
- Pulmicort 0.5 mg/2 ml inhalation twice a day for COPD
- Oxycodone 20 mg every 12 hours for pain

Review of Resident #262's MAR for January 2021 was not signed as completed on 1/31/21 at 9:00 PM for the following medications:
- Diclofenac Sodium 1% gel applied to affected area four times per day for pain
- Ipratropium-Albuterol 0.5-3 (2.5) mg/3 ml inhalation four times per day for wheezing and shortness of breath
- Pulmicort 0.5 mg/2 ml inhalation twice a day for COPD
- Oxycodone 20 mg every 12 hours for pain

Review of Physician's Orders for January 2021 revealed Resident #262 had orders for:
- Obtain vital signs every shift
- Pain assessment every shift

A review of the January MAR for Resident #262 revealed:
- no pain assessment for 1/31/21 at 10:30 PM
- no vital signs for 1/30/21 and 1/31/21 at 10:30 PM

Review of the MAR revealed:
- On 1/30/21 at 2:30 PM the resident's vital signs were within normal limits
- On 1/31/21 at 2:30 PM the resident had a pain level of 0 (no pain) and her vital signs were within normal limits
- On 2/01/21 at 6:30 AM the resident had a pain level of 0 and her vital signs were within normal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 46	F 760		

limits

The Covid Unit Time and Attendance Log revealed Nurse #2 had signed in to work on 1/30/21 at 7:07 AM and signed out at 7:30 PM. The log further revealed Nurse #2 had signed into work on 1/31/21 at 7:07 AM and signed out at 6:15 PM.

The Controlled Drug Receipt Record for Resident #262's Oxycontin (Oxycodone) revealed a 20 mg tablet was signed out on 1/31/21 at 6:00 PM by Nurse #2.

An interview on 6/23/21 at 7:22 PM with Nurse #2 confirmed she had worked on 1/30/21 and 1/31/21 on the Covid unit. She stated she did not remember if she gave Resident #262 any of her scheduled bedtime medications early or if she gave them at all. She stated she did not remember if she gave Resident #262 her Oxycontin early or not. She stated she did not remember if there was another nurse to work the Covid unit either of those nights.

An interview on 6/24/21 at 3:38 PM with Nurse #4 revealed she did not remember if she had worked on 1/31/21. She confirmed she did not go to the Covid unit at any time in January. She revealed she had not obtained vital signs, pain assessments or given scheduled medications Resident #262 on 1/31/21.

The Covid Unit Time and Attendance Log revealed Nurse #3 had signed in to work on 2/01/21 at 7:00 AM and signed out at 6:30 PM.

An interview on 6/24/21 at 1:43 PM with Nurse #3 confirmed she had worked on 2/01/21 on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 47 Covid unit. She stated she had signed Resident #262's scheduled medications from 1/31/21 as 'not administered' but she did not know if they had been given or not. She stated she signed them to clear them off her computer medication screen during the medication pass for her shift. An interview on 6/24/21 at 2:48 PM with the Director of Nursing (DON) confirmed there was a Nursing Assistant (NA) assigned to the Covid unit on 1/31/21 from 7:00 PM to 7:00 AM. She also confirmed there was a nurse available on another unit, Nurse #4, if there was an emergency on the Covid unit. She stated if Nurse #4 had gone to the Covid unit she would have had to leave the building and another nurse would have taken her assignment. The DON did not verbalize a plan to administer Resident #262's scheduled pain medications or breathing inhalers while in the Covid unit on 1/31/21. An interview on 6/24/21 at 5:19 PM with the Physician revealed she was unaware that Resident #262 had not received vital signs, pain assessments, or scheduled medications for the evenings or nights of 1/31/21. She stated she did not believe there was any significant impact to the resident because of the missed medications but also expected her orders to be followed. An interview on 6/25/21 at 7:26 AM with the Administrator revealed he was unaware that Resident #262 had missed her scheduled medications and could not explain what happened. He also revealed he expected the Physician's orders to be followed.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 48 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove loose unsecured pills, discard expired medications that were available for resident use, and ensure all medications had resident identifier information in 4 of 5 medication carts. Findings included: On 6/24/21at 10:23 AM an inspection was made of the 100 Hall medication cart with the Director	F 761	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility Director of Nursing (DON) along with the administrative nursing staff removed all expired medications and loose pills from the 100-hall cart immediately after being identified on 6/23/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 49 of Nursing (DON) with the following observations: - 7 unidentified dark round pills in individual plastic and foil packaging with no resident identifier or expiration date in the top right drawer - approximately 35 unidentified pills of various sizes, shapes and colors which were found loose in the bottom of several medication cart drawers - 2 expired boxes of Cepacol lozenges (for sore throat) -- one with 12 lozenges with the expiration date of 5/21 -- one with 14 lozenges with the expiration date of 4/21 -2 Wixela inhalers (inhaler for asthma or chronic obstructive pulmonary disease) with no resident identifier or dosage information. On 6/24/21 at 10:30 AM an inspection was made of the 200 Hall medication cart with the DON with the following observations: - 15 unidentified pills of various sizes and colors all of which were found loose in the bottom of several medication cart drawers - 1 open bottle of Loratadine 10 milligram (mg) tables with the expiration date of 12/20 which was available for resident use. On 6/24/21 at 10:40 AM an inspection was made of the 400 Hall medication cart with the DON with the following observation: - 10 unidentified pills of various sizes and colors all of which were found in the bottom of several medication cart drawers On 6/24/21 at 10:45 AM an inspection was made of the 500 Hall medication cart with the DON with the following observations: - 2 unidentified white, oblong pills which were found in the bottom of the right 2nd medication	F 761	2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The administrative nursing team performed a 100% audit of all medication carts on 6/23/2021 for expired medications, loose pills, and unlabeled or unidentifiable medication without resident identifies and expiration date. No further discrepancies were noted as a result of the audit. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility DON or designee will provide education to all licensed nursing staff regarding proper medication storage to including the removal of lose or unidentifiable medications and to ensure mediations are properly labeled with dates and resident identifiers. This education is to be completed by 7/23/21. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: All medication carts will be audited by the assigned nurse and corresponding administrative nurse weekly for a total of 3 months to ensure they remain in compliance with the proper storage of all medications. Results of the audits will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (3) months. At that time, the QAPI committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 50 cart drawer During the above medication cart observations on 6/24/21 from 10:23 AM through 11:08 AM an interview with the DON revealed she expected expired medications to be discarded by the expiration date, all medications to have resident identifier and dosage information, and no loose unidentified pills on the medication carts. She stated all nurses were responsible for checking the medication carts for loose pills, expired medications and unlabeled medications. She stated she did not know why this had not been done. An interview on 6/25/21 at 7:30 AM with the Administrator revealed he expected no loose pills, unlabeled medications, or expired medications to be on the medication carts and he did not know why they were on the medication carts.	F 761	will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5) Include dates when corrective action will be completed: 7/23/21	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the call system failed to activate when pressed for 1 of 8 residents reviewed for call lights (Resident #18).	F 919	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	7/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 51 The findings included: Resident #18 was admitted to the facility on 4/12/04. The Minimum Data Set (MDS) assessment dated 4/4/21, a quarterly assessment, revealed Resident #18 was assessed as severely cognitively impaired with no speech. During an observation on 6/21/21 at 2:05 PM Resident #18's call light was not working. When the call light was activated the call light did not illuminate outside the resident door. NA #2 stated she did not know Resident #18's call light was not working until she activated the call light. An interview was conducted with Nurse #12 who stated the call lights are checked by maintenance monthly. She reported that nursing staff do not check call lights. Nurse #12 further stated if a call light is malfunctioning nursing staff would contact maintenance. During an observation on 6/21/21 at 3:00 PM the maintenance director was observed working on the call light outside Resident #18's room. An observation on 6/21/21 at 4:16 PM the call light outside Resident #18's room was functional. During an interview and observation with Nurse #10 and Nurse #11 on 6/23/21 at 8:34 AM they stated Resident #18 was able to use his call light. Resident #18's call light illuminated outside his door when activated. They stated maintenance staff checked call lights on a regular basis. An interview was conducted with the Maintenance Director on 6/23/21 at 10:20 AM. He stated he	F 919	The call light for resident #18 was examined by the facility Maintenance Director and was determined that the bulb was blown. the bulb was replaced on 6/21/21 and therefore restored the functionality of the call bell system. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The facility maintenance director or designee will perform an audit of all resident rooms to ensure the call bell system is functional. Any found to be none functioning for any reason will be recorded and corrected at that time. The audit and all corrections will be completed by 7/23/21. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility administrator will provide in-service education for the maintenance staff on the importance of performing routine maintenance of the resident call bell system, and the expectation that a log be kept when the system is checked and when corrections are made. This education will be provided by 7/23/21. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Maintenance Director or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 06/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 52 does not have a set schedule to check the call system. The Maintenance Director further stated he checked call lights when he was notified of a problem. An interview was conducted with the Administrator on 6/25/21 at 10:10 AM who stated he believed the call system was being checked by maintenance monthly. He indicated that the call system should be checked by the Maintenance Director monthly. During an interview with the Director of Nursing on 6/25/21 at 10:30 AM she indicated the call lights were checked by maintenance monthly. She stated nursing staff do not check call lights on a routine basis. She further indicated call lights should be tested routinely.	F 919	perform audits of 10% of total resident's room on each hall to ensure the continued functionality of the call bell system. Audits will be conducted daily *5 day, weekly *3 weeks, and monthly *3 month. Results of the audits will be reviewed in monthly Quality Assurance and Performance (QAPI) meeting for (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) Include dates when corrective action will be completed 7/23/21	