PRINTED: 12/03/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345181	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	040101		S	TREET ADDRESS, CITY, STATE, ZIP CODE	111/	13/2024
UNIVERSA	AL HEALTH CARE/GREE	ENVILLE			578 WEST FIFTH STREET REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
	from 11/12/24 throug HZH511. The following	ation survey was conducted h 11/13/24. Event ID# ng intakes were investigated 223868, NC00223920, and					
	4 of the 17 complaint defciency.	allegations resulted in a					
F 684 SS=D	, ,		F	684			
	applies to all treatme facility residents. Bas assessment of a resident residents received accordance with profipractice, the compredicare plan, and the resident res	Indamental principle that int and care provided to sed on the comprehensive dent, the facility must ensure it treatment and care in essional standards of inensive person-centered sidents' choices. To is not met as evidenced liew and interviews with lurse Practitioner (NP), the rethere was effective g shift to shift reporting staff to avoid a lapse sident #1's STAT is obtained to when the implete blood count (CBC) ing in failure to identify ry results. This deficient in the interview in the int			Past noncompliance: no plan of correction required.		
	The findings included	! :					
LABORATORY	 DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE		TITLE		(X6) DATE

Electronically Signed 11/25/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION IG	(XX	3) DATE SURVEY COMPLETED
		245404	B. WING			С
	ROVIDER OR SUPPLIER AL HEALTH CARE/GREE	345181 :NVILLE	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST FIFTH STREET GREENVILLE, NC 27834	<u> </u>	11/13/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	results dated 10/30/2 hemoglobin was 8.4 (and her hematocrit w 35.0-47.0). Resident #1 was adm 10/30/24 with diagnostic disease, anemia, a vicausing inflammation diabetes, parathyroid and hypertension A progress note dated the facility's NP was in Resident #1 having e gave an order to have and notify the provide were available for rev. A telephone interview at 3:30pm with the fashe was in the facility resident visits. The N reviewed Resident #1 10/22/24-10/30/24 stated it was in her m Resident's diagnosis her ongoing anemia at The NP stated that be abnormal lab values of multiple health diagnosis her completed. The the facility contact he when the lab results we stated she did not reconor was there a notation.	of Resident #1's hospital lab 4 revealed on 10/29/24 her formal values 12.0-16.0) as 27.7 (normal values initted to the facility on sees that included heart ral infection of the liver and swelling of the liver, disease, history of a stroke, in the facility and notified pisodes of vomiting. The NP is a STAT CBC lab drawn for as soon as the lab results riew. The was completed on 11/12/24 completing P stated during her visit she it's hospital records for her ay and spoke to the nurse on that day. The NP	F 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SUR COMPLETE	
	345181	B. WING _			C 11/13/2	2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u>'</u> E	11/10/2	.024
			2578 WEST FIFTH STREET			
UNIVERSAL HEALTH CARE/GREEI	NVILLE		GREENVILLE, NC 27834			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	-	(X5) DMPLETION DATE
Coordinator. The Nurs facility on 11/1/24 and Resident #1. The Nurs at approximately 2:43 order. The MDS Coord the Resident's assigned STAT lab order and er Resident #1's medical. A telephone interview at 12:00pm with Nurse was assigned to Resident from 11/1/24. Nurse unable to recall if she 3pm-11pm nurse of the written it on the 24-horstated it was her routin nurse of pending labs #2 stated she informed #1's jaundice had increwith her the day before An interview was com 4:30pm with Nurse #5 assigned to Resident shift on 11/1/24. Nurse recall Nurse #2 notifyill labs for Resident #1. Notice is not pending a 24-hour Resident #1 had pend Lab results dated 11/1 phlebotomist (medical blood) obtained the bleat 6:10pm on 11/1/24.	pleted on 11/12/24 at in Data Set (MDS) Nurse se stated the NP was in the ordered stat labs for se stated she called the lab pm to place the STAT lab dinator stated she notified ed 7am-3pm Nurse of the intered a progress note in record regarding the order. was completed on 11/12/24 et #2. The Nurse stated she dent #1 during the 7am-3pm et #2 revealed she was had notified the oncoming e pending STAT labs or ur Report Sheet. Nurse #3 ine to alert the oncoming during shift report. Nurse do the NP she felt Resident eased since she worked et. pleted on 11/12/24 at incoming the 3pm-11pm et #5 revealed she did not ing her of pending STAT lurse #5 stated she did not in Report Sheet alerting ling labs.	F	584			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		OATE SURVEY COMPLETED
		345181	B. WING			C
	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST FIFTH STREET GREENVILLE, NC 27834	l	11/13/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	and the result of the laboratory at 7:35pm follows: hemoglobin laboratory noted the level. A telephone interview at 1:43pm with Nurswas assigned to Res 11pm-7am shift on 1 did not recall the 3pm Resident #1 had per stated she did not repending labs on the A telephone interview at 3:20pm with the falaboratory's Regional The Representative and the facility contraction that facility months are the facility months without success. The 5 day stay MDS revealed Resident #1's responsive the Resident #1's responsive the Resident sevaluation due to Renormal baseline. The vital signs were as for 106/62, pulse: 70 be respirations were 20 note stated the nurse she opened her eyes nurse. Emergency S	CBC lab was received at the in The CBC results were as 5.5 and hematocrit 17.8. The se values to be at a critical was completed on 11/12/24 at 4. The Nurse stated she sident #1 during the 1/1/24. Nurse #4 stated she in-11pm nurse notifying her adding STAT labs. Nurse #4 call seeing Resident #1 had 24-hour report sheet. Was completed on 11/12/24 addility's contracted all Service Representative. Stated the hospital laboratory, acted laboratory attempted to ultiple times on 11/1/24 and #1's critically low lab values assessment dated 11/3/24 at was cognitively impaired. add 11/3/24 at 4:03pm stated insible party (RP) requested to ent to the hospital for esident #1 not being at her enote stated Resident #1's billows: blood pressure:	F 6	84		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	` '	ATE SURVEY DMPLETED
		345181	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST FIFTH STREET GREENVILLE, NC 27834	ı	11/13/2024
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 684	3:15pm. A review of Resider physical note dated arrived at the emery approximately 3:39 time or place. Her will blood pressure: 12 minute, and respiral The CBC lab was comproximately 4:03 had decreased to 4 decreased to 13.4. A progress note dailabs obtained on 11 populate into Reside record from the laboration of the populate into Residered on 11/4 facility had not receive completed on Residestated when lab results were populate electronic medical recalled with critically stated due to the recalled with critically stated from the low results. The DON stated on 11/4 populate in the populate in	Int #1's hospital history and 11/3/24 revealed Resident #1 gency department at pm was alert to person but not rital signs were as follows: 7/74, pulse: 82 beats per tions: 16 breaths per minute. ompleted and at pm Resident #1's hemoglobin .2 and her hematocrit had .2 and her hematocrit had .2 and her hematocrit medical bratory company. Interpretation of Nursing (DON). The sident #1 on 11/1/24 at irrector of Nursing (DON). The sident #1 on 11/1/24. The DON sults were completed the sted into the resident's record and the laboratory low lab values. The DON sults not populating into ronic medical record, the senot aware of the critically low tated the facility did not the lab regarding the critically DN stated nurses sident's acute issues and	F 68	34		
	low results. The DC communicated a re pending labs during them on a 24-hour	N stated nurses				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		OATE SURVEY COMPLETED
		345181	B. WING _			C 11/13/2024
	ROVIDER OR SUPPLIER	ENVILLE		STREET ADDRESS, CITY, STATE, ZIP CO 2578 WEST FIFTH STREET GREENVILLE, NC 27834	DDE	11/13/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684		#1's pending STAT labs were	F 6	684		
	was unable to locate alerting oncoming nu pending labs. A follow-up interview at 2:56pm with the D failure of Resident #communicate Reside	o shift between the nurses. The DON stated she a 24-hour Report Sheet urses of Resident #1's was completed on 11/13/24 ON. The DON stated the 1's assigned nurses to ent #1's pending labs shift to abs not being addressed				
	3:15pm with the facil Administrator stated nursing staff commu	ity's Administrator. The it was his expectation nicate shift to shift of any ompleted and results waiting				
	action plan with a da	the following corrective te of 11/4/24 to begin npletion date of 11/7/24.				
	Problem: Communic shift.	ation between nurses shift to				
	Immediate Response	e-what was done at the time.				
	The Resident is no lo	onger at the facility.				
	How to Identify other	residents.				
	24-hour report sheet	e potential to be affected. s were reviewed by the DON st 14 days to ensure all re followed up on.				
	What Measures were	e put in place to prevent				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3)	DATE SURVEY COMPLETED
		345181	B. WING _			C 11/13/2024
	ROVIDER OR SUPPLIER	ENVILLE	,	STREET ADDRESS, CITY, STATE, ZIP 2578 WEST FIFTH STREET GREENVILLE, NC 27834	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	-	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	in-serviced by the Reservices and the Ad on communication of report with the oncor communication on the all acuities. How to monitor to ensure a times per week for 2 week been reviewed and for the results will be recommittee meeting discussion to ensure a concert the Quality Asset determines the probereview will be completed and for the Committee meeting discussion to ensure a concert the Quality Asset determines the probereview will be completed and for the Committee meeting discussion to ensure a concert the Quality Asset determines the probereview will be completed and for the Committee will be	d medication aides were egional Director of Clinical ministrator on 11/5/24-11/6/24 uring verbal shift to shift ming shift and written ne 24-hour report to include assure the problem does not unager will monitor 24-hour per week for 4 weeks. Then a 4 weeks and finally 2 times as to ensure all acuities have followed up on. Exported to the monthly Quality (11/20/24) for review and a substantial compliance. Surance Committee lem no longer exists, then the eted on a random basis.	F	684		
	for 11/8/24, 11/10/24 concerns. A review of Audit-DON Monitorin	l, and 11/11/24 revealed no of the 24-hour Report ng tool was reviewed for d 11/10/24 revealed no				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345181	B. WING _		C 11/13/20	124
	ROVIDER OR SUPPLIER AL HEALTH CARE/GREE	ENVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST FIFTH STREET GREENVILLE, NC 27834	11/13/20	724
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	(X5) IPLETION DATE
F 684	Continued From page	e 7	F 6	84		
	2:47pm with Nurse #6 she received a lab or concerns with a resid notified the oncoming orders and acute con Sheet. The Nurse col education regarding of nursing staff shift to s An interview was con 2:50pm with Nurse #7 received education recommunication and co	npleted on 11/13/24 at 7. The Nurse verified he had egarding shift-to-shift completing the 24-hour y acute concerns or labs				
F 770 SS=D	to be completed as o Laboratory Services CFR(s): 483.50(a)(1) §483.50(a) Laborator §483.50(a)(1) The fac laboratory services to residents. The facility and timeliness of the (i) If the facility provide	y Services. cility must provide or obtain meet the needs of its is responsible for the quality services.	F 7	70		
	requirements for labor of this chapter. This REQUIREMENT by: Based on record rev facility staff, Nurse Pr	is not met as evidenced iew and interviews with ractitioner (NP), and the		Past noncompliance: no plan of correction required.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345181	B. WING _			C 11/13/2024
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST FIFTH STREET GREENVILLE, NC 27834		11/13/2024
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 770	communication betwo company to avoid a between the time Re (immediately) lab w results for a STAT cowere received result critically low laborated deficient practice occ (Resident #1) review. The findings include A progress note date the facility's NP was Resident #1 having gave an order to have and notify the provid were available for results dated 11 phlebotomist (medic blood) obtained the at 6:10pm on 11/1/2 blood sample at 7:15 and the result of the laboratory at 7:35pm follows: hemoglobin laboratory noted the level. A progress note date from STAT labs obtained the level. A progress note date from STAT labs obtained the level. An interview was continued the level. An interview was continued the lectronic medical recompany.	veen facility staff and the lab lapse of multiple days esident #1's STAT as obtained to when the complete blood count (CBC) ing in failure to identify ory results timely. This curred for 1 of 3 residents ved for laboratory services. d: d: d: d: d: d: d: d: d: d	F 7	70		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345181	B. WING _			C I 1/13/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 2578 WEST FIFTH STREET GREENVILLE, NC 27834	•	11/13/2024
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 770	Resident #1. The at approximately 2 order. The MDS C the Resident's ass STAT lab order. T discovered Resident in her electron stated the lab results are in. The the lab on 11/4/24 lab results did not medical record. An interview was 11:15am with the DON stated on 11 facility had not recompleted on Results were popule ectronic medical called with critical stated due to the Resident #1's election assigned nurse were sults. The DON receive calls from low results. The DON receive calls from low results. The DON resident #1's percommunicated she Resident's assign normally reviewed weekends, to assigned nursities and notifies she was unable to	and ordered stat labs for Nurse stated she called the lab 2:43pm to place the STAT lab coordinator stated she notified signed 7am-3pm Nurse of the he Nurse stated on 11/4/24 she ent #1's STAT lab results were interested into dical record. The Nurse ults are normally populated into dical record by the lab once the ent was stated she contacted to make it aware Resident #1's populate into her electronic completed on 11/12/24 at Director of Nursing (DON). The /4/24 it was discovered the served results from STAT labs sident #1 on 11/1/24. The DON esults were completed the lated into the resident's I record and the laboratory by low lab values. The DON results not populating into ctronic medical record, the as not aware of the critically low stated the facility did not the lab regarding the critically stated the facility did not the lab regarding the critically oon revealed she was unaware ending STAT labs were iff to shift between the ed nurses. The DON stated she d all pending labs daily, including ure the facility had received the d the provider. The DON stated of say why she did not review as to ensure the results were	F7	770		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345181	B. WING				0
		345161	B. WING			11/	13/2024
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/GREE	NVILLE			578 WEST FIFTH STREET		
				G	REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 770	Continued From page	e 10	F	770			
	now reviewing, printir	ator Nurse and herself are ng, and assuring medical ed regarding resident's lab					
	at 12:00pm with Nurs was assigned to Resi shift on 11/1/24. Nurs unable to recall if she 3pm-11pm nurse of th Nurse #3 stated it wa	was completed on 11/12/24 the #2. The Nurse stated she ident #1 during the 7am-3pm the #2 revealed she was a notified the oncoming the pending STAT labs. Is her routine to alert the anding labs during shift					
	at 1:43pm with Nurse was assigned to Resi 11pm-7am shift on 11 did not recall receivin laboratory regarding hemoglobin and hem she was unable to realerted her to Reside A telephone interview at 3:20pm with the fallaboratory's Regional	/1/24. Nurse #4 stated she g a phone call from the Resident #1's critically low atocrit. The Nurse stated call if the 3pm-11pm nurse nt #1's pending STAT labs. was completed on 11/1/24 cility's contracted Service Representative. stated at approximately					
	contacted the facility 1's nurse of a criticall Representative stated answered the phone laboratory employee the name of Resident The hospital laborato	by phone to notify Resident y low lab result. The d a facility staff member and revealed to the there was no Resident by t #1 residing in the facility. ry attempted to contact the approximately 5:22am on					

NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/GREENVILLE (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 770 Continued From page 11 C 11/13/2024 STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST FIFTH STREET GREENVILLE, NC 27834 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 770 Continued From page 11 F 770		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	C	X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/GREENVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 770 Continued From page 11 STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST FIFTH STREET GREENVILLE, NC 27834 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETION TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) F 770 Continued From page 11 F 770			345181	B. WING _			
UNIVERSAL HEALTH CARE/GREENVILLE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 770 Continued From page 11 GREENVILLE, NC 27834 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETION TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) F 770 Continued From page 11 F 770	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE	11/10/2024
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 770 Continued From page 11 GREENVILLE, NC 27834 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 770 Continued From page 11	LINIVEDO	AL UEALTH CARE/ORE			2578 WEST FIFTH STREET		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 770 Continued From page 11 PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 770 Continued From page 11	UNIVERS	AL HEALIH CARE/GREE	ENVILLE		GREENVILLE, NC 27834		
	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATI	COMPLETION
	F 770	Continued From page	e 11	F	770		
approximately 6:01am the hospital laboratory contacted the facility's contract aboratory company regarding the inability to communicate to the facility Resident #1's critically low lab result. On 11/2/24 at approximately 6:08am the contracted lab attempted to contact the facility without success. The Representative stated there were no further attempts made by the contracted laboratory to notify the facility of the critically low lab result. A telephone interview was completed on 11/12/24 at 3:30pm with the facility's NP. The NP stated she was in the facility's NP. The NP stated she was in the facility on 11/1/24 completing resident visits. The NP stated during her visit she reviewed Resident #1's hospital records for her 10/22/24-10/30/24 stay and spoke to the Resident's assigned nurse on that day. The NP stated that because of Resident #1's abnormal lab values during her hospital stay and multiple health diagnoses, she ordered STAT labs to be completed. The NP stated she requested the facility contact her or the provider on-call when the lab results were received. The NP stated she idin dnt receive a call from the facility nor was there a notation that the on-call provider received a telephone call regarding the lab results. An interview was completed on 11/12/24 at 4:30pm with Nurse #5. The Nurse stated she was assigned to Resident #1. The Nurse stated she did not receive a telephone call regarding the lab results. A follow-up interview was completed on 11/13/24		approximately 6:01ar contacted the facility's company regarding the to the facility Resident On 11/2/24 at approximately 6:01ar approximately 12/24 at approxima	in the hospital laboratory is contract laboratory in einability to communicate at #1's critically low lab result. It imately 6:08am the oted to contact the facility. Representative stated there apts made by the contracted in efacility of the critically low are was completed on 11/12/24 collity's NP. The NP stated from 11/1/24 completing in the provider records for her and spoke to the facility and spoke to the facility and multiple in error of the nurse on that day. The NP of Resident #1's abnormal thospital stay and multiple in error of the NP stated she requested the the provider on-call when the facility nor was the on-call provider received and the lab results. In pleted on 11/12/24 at 55. The Nurse stated she was #1 during the 3pm-11pm are #5 revealed she did not ing her of pending STAT. The Nurse revealed she did not call from the laboratory alts for Resident #1.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345181	B. WING		C 11/13/2024	
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/GREENVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST FIFTH STREET GREENVILLE, NC 27834	11/13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 770	Continued From page 12		F 770			
	Resident's electronic	ults to populate into the common medical record and the ation between the laboratory and the lab to not be				
	3:15pm with the faci Administrator stated	mpleted on 11/13/24 at lity's Administrator. The it was his expectation lab and follow up on timely.				
	action plan with a da	the following corrective ate of 11/4/24 to begin mpletion date of 11/5/24.				
	Problem:					
	vomiting. The NP as ordered STAT labs to facility's contracted I and sent them to the approximately 7:32p called and reportedly resident in the facility 11/2/24 at 5:22am the facility, and no o approximately 6:01a called the facility's or them of the unsucce facility. On 11/2/24 a contracted laborator was no answer. The to the facility. On 11/ noticed a change in requested for her to department. The ass	dent had an episode of sessed the Resident and be drawn that day. The aboratory obtained the labs hospital laboratory. At my the hospital laboratory was told there was no y by the Resident's name. On the hospital laboratory called the answered. On 11/2/24 at my the hospital laboratory contracted laboratory to notify ssful attempts to notify the st approximately 6:08am the y called the facility and there are were no further calls made (3/24 the Resident's RP) the Resident's condition and be sent out to the emergency signed nurse assessed the vital signs, called emergency				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345181	B. WING		C 11/13/2024	
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/GREENVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST FIFTH STREET GREENVILLE, NC 27834	11110/2024	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	SHOULD BE COMPLETION	
F 770	The Resident is no local How to identify other On 11/4/24 the Minim Coordinator and DON last 30 days to ensur results that had not be on. On 11/4/24 the Micontracted laboratory populating in electron What measures were reoccurrence. One 11/4/24 and 11/5 MDS Coordinator, Ur and Charge Nurse or lab results each more thought to monitor to en reoccur. The DON or MDS Coresults daily and comfor 12 weeks. The residincal meeting to en been reported and had the results will be recommittee meeting (e-what was done at the time. Inger at the facility. Iresidents. Inum Data Set (MDS) In reviewed all labs for the ender the were no critical even reported or followed up DS Coordinator emailed the reported in Iregard to lab results not nic medical records. In place to prevent In the process of accessing	F 77	0		
	Committee meeting (discussion to ensure Once the Quality Ass determines the proble	11/20/24) for review and substantial compliance.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		345181			C 11/13/2024		
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/GREENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST FIFTH STREET GREENVILLE, NC 27834			1/13/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 770	through staff interview reviews. Inservice was on lab tracking and F results. Staff were intin-service was compl Provider notification. conducted with the M regarding steps to tal orders labs. A review on 11/7/24, 11/8/24, a concerns. A review on audit tool for 11/5/24, revealed no concerns. An interview was con 9:30am with the MDS Nurse revealed every ordered by the facility results for that day an notified of the results. An interview was con 2:47pm with Nurse # she received an order shift, she contacted to order for the lab, com the resident's medical and when the lab wall end of her shift, she in the shift i	scompleted on 11/13/24 ws, observations, and record as confirmed to be provided crovider notification of lab derviewed to validate the eted on lab tracking and A review of education IDS Nurse Coordinator when a facility Provider of labs ordered on residents and 11/9/24 revealed no of the Lab Monitoring Tracker of 11/6/24, and 11/724 s. Inpleted on 11/13/24 at S Nurse Coordinator. The of day she reviewed labs of Providers, printed all lab ond ensured the Provider was of the Nurse stated when or for a STAT lab during her of laboratory to place an onleted a progress note in all record regarding the order, or not collected prior to the onotified the oncoming nurse.	F 7	70			