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	345181	A. BUILDING _____ B. WING _____	C 01/30/2025

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UNIVERSAL HEALTH CARE/GREENVILLE	2578 WEST FIFTH STREET GREENVILLE, NC 27834

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/27/25 through 1/30/25. Event ID# BVWQ11. The following intakes were investigated: NC00221777, NC00221949, NC00223005, NC00223055, NC00223286, NC00223387, NC00223603, NC00223636, NC00223978, NC00225402, NC00225804, NC00225795, NC00225842, and NC00225882. 1 of the 36 complaint allegations resulted in deficiency.	F 000		
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 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.	F 585		2/14/25

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

Electronically Signed | 02/13/2025

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F 585	Continued From page 1 §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; (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	F 585		

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F 585	Continued From page 2 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 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 record review and staff interviews, the facility failed to maintain documentation of grievances and evidence of the result of all grievances for 7 of 7 months reviewed. Findings included:	F 585	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies	

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F 585	Continued From page 3 Review of the facility policy dated 1/23/2020 titled "Grievances" read in part: (4) The Administrator will maintain a file for tracking and referencing grievances received and responses provided for a period of 3 years. A review of the grievance logs from June 2024 to January 2025 revealed all logs from June 2024 to January 2025 were unavailable. In a telephone interview with previous Administrator #2 on 1/28/25 at 2:40 PM he stated when he left employment at the facility two weeks ago the grievance log binder was on the shelf behind the desk in the Administration office. In an interview with current Administrator #1 on 1/28/25 at 3:30 PM she stated she had been unable to locate the grievance log binder for the time period of June 2024 to January 2025. She stated she would continue to search for it. In a follow-up interview with Administrator #1 on 1/30/25 at 11:00 AM she stated she still had not located the missing grievance log binder covering the time frame of June 2024 to January 2025. She was aware complete grievance logs including the result of the grievance investigation were to be maintained for three years or longer.	F 585	cited have been or will be corrected by the date or dates indicated. F585 Grievances 1. The facility failed to follow the policy and procedure for the documentation and completion of grievances to include receiving, investigating, correcting if needed and the documentation of any actions taken by the facility to the persons making the grievance. 2. The administrator reviewed the grievances since 1/15/2025 to ensure follow-up and documentation of resolution have been completed. This was completed on 2/102025 with no other issues noted. 3. On 2/10/2025 the facility leadership team will be in-serviced by the administrator on the grievance process including addressing all concerns and the documentation of corrective actions outlined in the grievance. This in-service will be completed by 2/11/2025. This education will also be added to the new hire process for any leadership member. 4. Grievances will be addressed in daily stand up meeting Monday through Friday to ensure department heads are aware of grievances filed. Grievances will be monitored by the Administrator daily Monday through Friday x4 weeks, then weekly x 4weeks, then monthly thereafter. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then the review will be completed on a	

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F 585	Continued From page 4	F 585	random basis. 5. Compliance 2/14/2025	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews and Pharmacist interviews, the facility failed to provide care according to professional standards when Nurse #1 borrowed medication from Resident #6 to administer to Resident #5. The findings included: Resident #6 was admitted to the facility on 9/10/24 with diagnoses that included diabetes with neuropathy (nerve pain). Physician orders dated 10/19/24 for Resident #6 revealed an order for gabapentin (a medication used to treat nerve pain) 100 milligrams (mg) to be administered once a day. The admission Minimum Data Set (MDS) assessment for Resident #6 dated 10/22/24 revealed she was cognitively intact. Resident #6 was no longer at the facility and was not available for interview. Resident #5 was admitted to the facility on 10/18/24 with diagnoses that included pain of	F 658	Past noncompliance: no plan of correction required.	

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F 658	Continued From page 5	F 658		

lower extremities.

Physician orders dated 10/19/24 for Resident #5 revealed an order for gabapentin 100 mg to be administered 3 times a day for pain.

The admission Minimum Data Set (MDS) assessment for Resident #5 dated 10/22/24 revealed he was moderately cognitively impaired.

Review of the Medication Administration Record (MAR) for Resident #5 for the month of October 2024 revealed the ordered gabapentin 100mg had been signed off as administered by Nurse #1 on 10/19/24 at 9:00 am and 2:00 pm.

Resident #5 was no longer at the facility and was not available for interview.

During an interview with Administrator #2 on 1/29/25 at 11:43 am he stated he was the Administrator in October of 2024 and recalled that Resident #5's family member had a concern that Nurse #1 borrowed 2 pills of gabapentin (not sure of the dosage) from Resident #6 and administered them to Resident #5. He stated Nurse #1 told the facility she borrowed the gabapentin from Resident #6 to administer to Resident #5 because gabapentin was not in the ADS. Administrator #2 stated Nurse #1 should not have borrowed the gabapentin and should have called the on-call pharmacist if the gabapentin was not available.

In a telephone interview with Nurse #1 on 1/29/25 at 7:25 pm she stated she borrowed 2 capsules of gabapentin 100 mg from Resident #6 and administered the capsules to Resident #5 on 10/19/24, one capsule at 9:00 am and one

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F 658	Continued From page 6	F 658		

capsule at 2:00 pm, for a total of 2 capsules borrowed and administered. Nurse #1 stated she borrowed the gabapentin because Resident #5 was a new admission, his medication supply had not yet come in, and the gabapentin was not available in the automated dispensing system (a pharmacy device designed to provide secure surplus medication storage on patient care units). She further stated that she should have called the on-call pharmacist to have the gabapentin called into the back-up pharmacy but did not. Nurse #1 stated she did not know she could not borrow medications from one resident to give to another resident.

An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 9:55 am. The DON stated Administrator #2 told her on 10/21/24 that Nurse #1 borrowed 2 gabapentin 100 mg capsules from Resident #6 and administered them to Resident #5 on 10/19/24. The DON further indicated she completed an investigation that revealed Nurse #1 borrowed 2 gabapentin 100 mg capsules for Resident #5 on 10/19/24 because he was newly admitted, and his medication supply had not yet arrived from the pharmacy. The DON stated the facility had a process in place to ensure residents did not miss any doses of prescribed medications while they waited for the pharmacy to deliver their medications. She stated Nurse #1 should not have borrowed medications from Resident #6 but should have first attempted to obtain the needed medication from the on-site automated dispensing system and if it was not available to call the on-call pharmacist to have the medication called in to a local pharmacy for delivery to the facility.

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F 658	Continued From page 7	F 658		

During an interview with the Regional Director Clinical Consultant on 1/29/25 at 10:15 am she stated she was contacted by Administrator #2 on 1/22/24 and asked to assist with an investigation where Nurse #1 borrowed gabapentin from Resident #6 and administered it to Resident #5. The Regional Director Clinical Consultant stated she assisted the DON in the completion of the investigation and formulated a plan of correction on borrowing medications and the use of the back-up medication system. She further indicated that the nurse had borrowed the gabapentin for Resident #5 because a family member had demanded that it be administered right away, and the medication was not available in the automated dispensing system.

During an interview with the Pharmacist on 1/30/25 at 10:00 am he stated Resident #5 was admitted to the facility on the evening of 10/18/24 and his order for gabapentin 100 mg was received in the pharmacy on 10/19/24 at 12:31 am, was filled and sent out to the facility for the next night's delivery on 10/20/24. The interview revealed Nurse #1 should not have borrowed medications from Resident #6 to administer to Resident #5. The Pharmacist went on to explain Nurse #1 should have obtained the medication from the automated dispensing system and if it was not available, she should have called the on-call pharmacist, and the medication would have been called into a local back-up pharmacy for the medication to be delivered to the facility.

The facility provided the following corrective action plan with a completion date of 10/24/2024:

Address how the facility will correct the deficiency as it relates to the individual.

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F 658	Continued From page 8 Nurse #1 was suspended by the Administrator on 10/21/2024 pending investigation. The Administrator submitted a report to North Carolina Department of Health and Human Services (NCDHHS). Medications for Resident #5 were delivered on 10/19/2024. Medications were replaced for Resident #6 by the facility at the facility's cost. Address how the facility will act to protect residents in similar situations. A 100% admissions audit for the last 14 days (October 8-22) was performed by the Regional Director of Clinical Services on 10/22/2024 for medication delivery within 24 hours of admission. All residents admitted in the last 14 days had all ordered medications on the medication cart. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur. All licensed nurses and medication aides were educated by the Staff Development Coordinator and DON on using the automated dispensing system (a pharmacy device designed to provide secure surplus medication storage on patient care units) for medications and never borrowing medications from one resident to give to another resident on 10/22/2024 and 10/23/2024. The DON ensured all licensed nurses had access to the automated dispensing system on 10/21/2024. Indicate how the facility will monitor its performance to make sure that solutions are sustained.	F 658		

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F 658	Continued From page 9 The DON or Unit Manager will audit all new admissions to verify that medications were received within 24 hours of admission as they are admitted to the facility. These audits will occur 5 times a week for 2 weeks then 3 times a week for 2 weeks to ensure compliance has been achieved. The plan of correction must provide dates when corrective action will be completed: Compliance date: 10/24/2024 The facility's corrective action plans date of compliance of 10/24/24 was verified on 1/30/2025 by review of the following: Interviews and record review verified Resident #6's gabapentin was replaced on 10/25/24 by the facility at the facility's expense. Record review revealed a 100% admissions audit was completed 10/8/24 through 10/22/24 to ensure new admission medications were received. Interviews with Nurses revealed they were educated on how to obtain medications for new admissions and not to borrow medications from one resident to administer to another. Record reviews and interviews confirmed audits were performed 5 times a week for 2 weeks and then 3 times a week for 2 weeks to ensure compliance was achieved. The compliance date of 10/24/2024 was validated.	F 658		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		2/14/25

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(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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F 842	Continued From page 11 §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a complete and accurate Medication Administration Record (MAR) for 1 of 3 residents (Resident #11) reviewed for record accuracy. Findings included: Resident #11 was admitted to the facility on 10/21/24. Resident #11's Physician's orders included: - Administer enteral feed Jevity 1.5, 237 milliliters	F 842	F842 Resident Records 1. The facility failed to follow the policy and procedure for the documentation of providing resident with tube feeding and flushes leaving holes in the MAR. Tube feeding and flushes are being documented as administered. Nurse # 2 no longer works with the facility. Nurse # 3 was inserviced on 2/14/2025 and nurse #4 was educated on 2/10/2025 concerning ensuring all tube feedings and flushes administered are immediately signed out on the Medication	

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F 842	Continued From page 12 (mls) (1 carton) twice a day at 5:00 AM and 11:00 PM with an order date of 10/23/24. - Flush feeding tube every 6 hours at midnight, 6:00 AM, noon and 6:00 PM with 150 mls of free water with an order date of 10/23/24. Resident #11's December 2024 MAR revealed the enteral feed had not been documented as given or refused on: -12/10/24 at 5:00 AM by Nurse #2 -12/19/24 at 5:00 AM by Nurse #3 -12/24/24 at 5:00 AM by Nurse #4 -12/26/24 at 6:00 AM by Nurse #2 The December 2024 MAR further revealed the 150 mls of free water was not documented as given or refused on: -12/10/24 at 6:00 AM by Nurse #2 -12/12/24 at 6:00 AM by Nurse #4 -12/19/24 at 6:00 AM by Nurse #3 -12/24/24 at 6:00 AM by Nurse #4 -12/26/24 at 6:00 AM by Nurse #2 In a telephone interview on 1/28/25 at 3:10 PM with Nurse #3 she stated she forgot to sign the MAR after giving the enteral feed and 150 ml free water flush to Resident #11 on 12/19/24. She further stated she was aware all medications should have been signed off in the MAR as soon as they were given. In a telephone interview on 1/28/25 at 6:40 PM with Nurse #4 she stated she must have forgotten to sign the MAR after giving the 150 ml free water flush on 12/12/24 and the enteral feed and free water flush to Resident #11 on 12/24/24. Nurse #1 revealed she was aware all medications were to be signed off in the MAR as soon as they were given.	F 842	Administration Record 2. The Director of Nursing reviewed the last 14 days of all tube feed residents on 2/10/2025 to ensure all feeding and flushes have been documented. 3. Beginning on 2/10/2025 the Director of Nursing will in service the nurses on ensuring all tube feedings and flushes administered are immediately signed out on the Medication Administration Record. This in-service will be completed by 2/14/2025. Anyone not in serviced will not be allowed to work until completed. This Inservice will be added to the orientation of all nurses. 4. Missed documentation will be monitored by the DON or unit manager daily in the morning clinical meeting Monday through Friday for four weeks then weekly for four weeks. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then the review will be completed on a random basis. 5. Compliance 2/14/2025	

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 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 13 In a telephone interview on 1/29/25 at 9:27 AM with Nurse #2 she stated she must have forgotten to sign the MAR on 12/10/24 and 12/26/24 after giving the enteral feed and 150 ml free water flush as well as after giving the free water flush on 12/12/24 to Resident #11. Nurse #2 revealed she was aware all medications needed to be signed off in the MAR as soon as they were given. An interview with the Director of Nursing (DON) was conducted on 1/29/25 at 9:40 AM. The DON stated all medications were to be signed off in the MAR as soon as they were given. She further stated that if a medication was not given, the Nurse was to use one of the codes available in the MAR to indicate why it was not given. There should not have been empty spaces in the MAR where it should have been signed off by the Nurse. In an interview with Administrator #1 on 1/29/25 at 9:50 AM she revealed all medications were to be signed off in the MAR as soon as possible, and available coding was to be used if medication was not given. The signature space for the medication should never be left empty. She stated all new hires including agency staff are educated regarding signing the MAR.	F 842		