PRINTED: 10/02/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 09/20/2012 345181 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST 5TH STREET UNIVERSAL HEALTH CARE / GREENVILLE GREENVILLE, NC 27834 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID. (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 312 483.25(a)(3) ADL CARE PROVIDED FOR F 312 "Submission of this response to DEPENDENT RESIDENTS SS=D the Statement of Deficiencies by the undersigned does not A resident who is unable to carry out activities of constitute an admission that the daily living receives the necessary services to deficiencies existed and/or were maintain good nutrition, grooming, and personal correctly cited and/or require and oral hygiene. correction". This REQUIREMENT is not met as evidenced by: Based on observations, record review, family and staff interviews, the facility failed to provide grooming services for 3 of 4 sampled dependent residents as evidenced by not shaving 1 of 4 sampled residents (Resident #45) and not trimming fingernails for 2 of 4 sampled residents (Resident #80 and #137). Findings include: 1. Resident #45 has been shaved. Residents #80 & #137 finger nails 1. Resident #45 was admitted to the facility on have been cleaned & trimmed. 10/20/06. Cumulative diagnoses included alzheimer 's disease. 2. All Residents residing in the Facility have had their nails & facial hair It was noted in the grooming section of the groomed appropriately. undated Resident Status Sheet (care guide outlining care needs) for Resident #45 that staff were to shave him. 10-11-12 The Annual Minimum Data Set (MDS)

LABORATORY DIRECTOR'S OR PROVIDER WAPLIER REAL SENTATIVE'S SIGNATURE

assessment of 08/20/12 indicated Resident #45 had long and short term memory problems as well as moderately impaired decision making skills. He needed extensive assistance with dressing, hygiene and bathing. According to the Care Area Assessment (CAA) summary, he

TITLE

(X6) DATE

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.

NAME OF PROVIDER OR SUPPLIER 345181 A SULDING B. WING C OR/20/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 2378 WEST STM STREET GREENVILLE, RC 'ZHSA' FROUNDER PLAN OF CORRECTION REQUIATORY OR ISC DENTIFYING INFORMATION) F 312 CONTINUED From page 1 triggered in 8 areas including activities of daily living. Resident #45's care plan, last reviewed 09/05/12, identified a problem with impaired physical mobility related to extensive assistance with al activities of daily living. Staff were to anticipate his needs. Included in the interventions was to anticipate and meet his needs. During an observation of Resident #45, on 09/18/12 at 11:00 AM, he was roted to have resident #46. The family member reported it was upsatting hat she had to ask 2 days in a row and he still was not shaved. It was reported that the dasire was for him to be clean shaven daily. During an observation of Resident #45, on 09/19/12 at 8:20 AM, he was noted in his wheelchair with factal hair to his upper lip, chin and neck area. (On 09/20/12 at 8:45 AM, Resident #45 was			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / GREENVILLE (X4) ID SUMMARY STATEMENT OF DEPICIENCIES (GREENVILLE, INC. 278 34 (X4) ID PREPIX (REGULATORY OR LSS IDENTIFYING INFORMATION) F 312 Continued From page 1 triggered in 8 areas including activities of daily living. Resident #45's care plan, last reviewed 09/05/12, identified a problem with impaired physical mobility related to extensive assistance with all activities of daily living. Staff were to anticipate his needs. Included in the interventions was to anticipate and meet his needs. During an observation of Resident #45, on 09/18/12 at 11:00 AM, he was noted to have facial hair on his upper lip, chin and neck area. During a family interview, on 09/18/12 at 11:40 AM, it was reported that the desire was for him to be clean shaven daily. During an observation of Resident #45, on 09/19/12 at 8:20 AM, he was noted that the desire was for him to be clean shaven daily. During an observation of Resident #45, on 09/19/12 at 8:20 AM, he was noted in his wheelchair with facial hair to his upper lip, chin and neck area.	*************			A. BUILT	DING	COMPC	
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09/19/12 at 8:20 AM, he was noted in his wheelchair with facial hair to his upper lip, chin and nack area. On 09/20/12 at 8:45 AM, Resident #45 was	and he still was not shaved. It was reported		shaved. It was reported that	! ! !			
On 09/20/12 at 8:45 AM, Resident #45 was		09/19/12 at 8:20 Al wheelchair with fac	VI, he was noted in his	· · · · · · · · · · · · · · · · · · ·			10-11-13
observed sitting in his wheelchair eating breakfast. The facial hair remained to his upper lip, chin and neck area.		observed sitting in breakfast. The fac	his wheelchair eating jal hair remained to his upper	· Paragraphic distribution of the control of the co			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			C C		
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	OVIDER OR SUPPLIER AL HEALTH CARE / GR	EENVILLE		2578	ADDRESS, CITY, STATE, ZIP CODE WEST 5TH STREET ENVILLE, NC 27834	;ODE		
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F 312	An interview was co (Nurse #1), on 09/2 Resident #45 was in shaved and his fam for staff to shave his 109/20/12 at 9:20 All present to the upper family member was stated it was most up day and still Resided An interview was co (NA#1) who was as 09/20/12 at 9:30 All with Resident #45. received his bath of that shaving was used were shaved, he readout every 2 days NA#1 stated if the labout shaving, he shaved to be shave had not asked him today. NA#1 also requested for the repast. He added the During an interview	onducted with the hall nurse 0/12 at 9:10 AM. She stated oot capable of asking to be ily had asked her last week	f-	312			10-11-12	
- Service Control	should be shaved	at least every 2 to 3 days. She residents could say when they						

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F 312	wanted to be shaved staff should be shavi even if a resident wa should still be shave some reason that resident be passed on observation on 09/20 of Resident #45, she shaving. The UM co	but for those who couldn't, and them. UM #1 stated is bathed on third shift, they id. She added that if for sident was not shaved, it to the day shift. Upon 1/12 at 9:50 AM with the UM is stated he was in need of immented that his family had about Resident #45 not being	F 312			
	diagnoses of diabete stage dementia. Resident #80's curre 07/25/12 addressed daily living with staff. An annual Minimum completed 09/03/07 as having short term severe cognitive im documented as bein activities of daily living care.	s admitted to the facility with es, osteoporosis, and end ent care plan updated dependency for activities of provision for hygiene. Data Set (MDS) assessment documented Resident #80 en and long term memory and pairment. Resident #80 was and dependent on staff for all and and having no rejection of Activity of Daily Living) flow				

CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	1 '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 312	sheet (tool used to de Resident #80 as bein bathing, and dressin An observation mad revealed Resident # Resident #80's finger approximately 0.5 confingers with black matter under the nails. Observations made 11:35 AM revealed approximately 0.5 con with black matter under the lack matter under total assist daily living and hyging #80 did not refuse a An observation made (DON) on 09/19/12 #80's nails to be lor under the nails. The was for the residen The DON said Resand cleaned. In an interview on 0 said the facility did procedure for nail of was a part of routin the policy was a part of routin the part of routin the part of routin was a part of routin the part of routi	irect care) documented ng dependant for grooming, g. e on 09/18/12 at 10:32 AM 80 sitting in a wheelchair. It is important to be entimeters past the tip of the atter present under the on 09/19/12 at 8:05 AM and Resident #80's nails to be impast the tip of the fingers inder the fingernails. Nurse Aide (NA) #2 on M, she said Resident #80 ance with all her activities of ene. NA #2 said Resident any care. Ide with the Director of Nurses at 4:10 PM revealed Resident ing with black matter present in e DON said her expectation it's nails to be cut and cleaned. Ident #80 needed her nails cut in the care and should be done as said Resident #80 's	F	312			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
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	OVIDER OR SUPPLIER	ENVILLE	2578	ADDRESS, CITY, STATE, ZIP CODE WEST 5TH STREET ENVILLE, NC 27834		
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F 312	O8/16/12 with diagno and anemia. An admission Minimulassessment complete Resident #137's cognextensive assistance daily living and hygie of care. Review of an ADL (A sheet (tool used to diagram) Resident #137 needs activities of daily living On 09/18/12 at 10:25 fingernalls were observed they were would like to have the shook her head "no" offered to cut them for On 09/19/12 observed 3:10 PM, Resident # the same. In an interview with 1 09/19/12 at 3:55 PM required total assistate daily living and had represented the same of the company of the same. An observation made (DON) on 09/19/12 at 3:55 PM required total assistate daily living and had represented to the company of the company	s admitted to the facility on ses of Parkinson's disease am Data Set (MDS) ed on 08/13/12 identified nition as intact, requiring from staff for all activities of ne, and having no rejection and having no rejection ctivity of Daily Living) flow rect care) documented ed staff assistance for g and hygiene. 6 AM, Resident #137's erved to be approximately 0.5 fingers. Resident #137 too long for her and she em shorter. Resident #137 when asked if staff had or her. 1 Ations made at 8:05 AM and 137's fingernails remained 1 Aurse Aide (NA) #2 on NA #2 said Resident #137 ince with all her activities of not rejected any care. 2 With the Director of Nurses at 4:15 PM revealed Resident be the same. When the	F 312			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C		
	OVIDER OR SUPPLIER	345181 EENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST 5TH STREET GREENVILLE, NC 27834				20/2012
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F 312	wanted staff to cut he nodded her head, "In an interview with AM, the DON said Femember had cut her should have offered documented that far care. The DON said written policy and prexpectation was it we should be done as reshould have offered she had been able to The DON said staff fingernail care on 04 (483.25(g)(2)) NG TRESTORE EATING. Based on the compresident, the facility who is fed by a nas receives the appropagate to prevent aspiration vomiting, dehydratic and nasal-pharynge possible, normal eat This REQUIREMENT by: Based on observation to prove the facility abdominal binder for the said of the compresident of the said of the	asked by the DON if she er fingernails, Resident #137 yes." the DON on 09/20/12 at 10:05 tesident #137's family fingernails at home but staff since it had not been mily would provide fingernail defeated. The DON said staff nail care to Resident #137 as o make her needs known. provided Resident #137 with 19/19/12. EEATMENT/SERVICES - SKILLS rehensive assessment of a must ensure that a resident to-gastric or gastrostomy tube wriate treatment and services in pneumonia, diarrhea, on, metabolic abnormalities, and ulcers and to restore, if ting skills. AT is not met as evidenced see gastrostomy tube had		322	1. Resident #38's abdon was applied per Physi		10-11-12

STATEMENT OF DEFICIENCIES (2 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	COMPLET	
		345181	B. WING		09/2	0/2012
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F 322	Resident #38 was re 7/12/11 with cumulat hemiplegia (weaknes and dysphagia required and dysphagia required ated 8/28/12 showe short and long term is severely impaired in Resident #38 needed 1 person for eating (Inutrition/fluids through A review of the Treat for 8/1/12-8/31/12 showed recome out. A review of the Nurs 5:00 PM showed Recome out. A review of the Physicated 8/7/12 showed ated 8/7/12 showed	admitted to the facility on the diagnoses of diabetes, as on one side of the body), ing a gastrostomy tube. Terly Minimum Data Set d that Resident #38 had memory problems and was daily decision making.		 No other resident in the been affected by this depractice or have orders abdominal binders. All Nurse's & C.N.A's serviced on the importate following Physician ord wearing an abdominal by 9/21/12 an order to discabdominal binder for Rewas obtained and new o safe-lock was initiated. I had no other instance of dislodgement since obtained order. 	have been in- ice of ers related to inder. On ontinue the esident # 38 rder for a Resident has	
	A review of the Physical dated 8/8/12 shower binder to protect the	•				10-11-12
With a state of the state of th	dated 8/8/12 showe	ication Administration Record d an order for a waist binder all times with an FYI (for te.				
	A review of the Nurs 3:10 PM showed Re	es Notes dated 8/8/12 at esident #38 had received a				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 322	new order for an ab G-tube from becom Clerk had been notice. A review of the Nurshowed no notes the binder was in place. A review of the Nurshowed R binder was not in the laundry. The note in on order and should a review of the Phy 9/1/12-9/30/12 showaist binder G-tube FYI was written new A review of the Meter 9/1/12-9/30/12 binder G-tube process. A review of the Traffor 9/1/12-9/30/12 Resident #38's G-water. A review of Reside 9/5/12 showed a general showe	dominal band to protect the ing dislodged. The Supply fled to order an X-large band. ses Notes from 8/9/12-8/14/12 lat Resident #38's abdominal resident #38's abdominal late resident's room or in the indicated that 2 binders were distributed a rive in 1 week. Assician Orders for wed a hand written note for a lap proctor to be on at all times.	F	4.	DON and/ or designee will MD orders weekly times is order to ensure appropriate followed for any future or abdominal binders. All fir addressed in the monthly months or until deemed not be a superior or and the month of the mo	s months in e measures are ders of ading will be QA meeting X 3 ecessary.	10-11-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/02/2012 FORM APPROVED

	OF DEFICIENCIES CORRECTION	(X1) "PROVIDER/SUPPLIER/CLIA" IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	COMPLETED		
		345181	8. WING		09/20/2012		
	OVIDER OR SUPPLIER	REENVILLE	2578	FADDRESS, CITY, STATE, ZIP CODE WEST 5TH STREET ENVILLE, NC 27834			
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F 322	as evidenced by a genterventions include tube, verifying the refeedings per physic medications as ordered Plans did not list the Care Plan. A review of the Nureman Service of the Nureman Service of the Nureman Service of the Nureman Service of the Physical Service of t	gastrostomy tube. ed verifying placement of the ate of administration of ian order and crushing ered. Resident #38's Care e abdominal binder on the ses Notes dated 9/10/12 at at NA #7 notified the nurse G-tube had come out. est was made to speak to the working on 9/10/12 and had dgement of the tube. The NA hone call to the facility and interview. estician Telephone Orders wed an order to send Resident for replacement of the G-tube. 2/17/12 at 1:40 PM a family at #38 indicated that an which was to be in place at all slodgement of Resident #38's	F 322				

STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	1	.DING			С
	345181		B. WiN			09/20/2012	
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / GREENVILLE				257	ET ADDRESS, CITY, STATE, ZIP CODE 8 WEST 5TH STREET EENVILLE, NC 27834		
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F 322	that the binder could that she knew Resid abdominal binder to coming out. In an observation of 4:10 PM by NA #7 a Resident #38 up and on the G-tube. The Resident #38's abdominal stated the abdolocated. In an interview on 9 indicated that Resid abdominal binder of the stated Resident #38 abdominal binder a place. She indicated dislodged twice recisioneged twice recisioneged twice recisioneged the stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place. In an interview on 9 stated she knew Rean abdominal binder a place.	ked for it. NA #7 indicated be in the laundry. She stated ent #38 needed the keep her G-tube from repositioning on 9/19/12 at nd NA #8, they carefully lifted do to the left avoiding pulling NA's placed a towel acrossomen to protect the G-tube minal binder could not be /19/12 at 4:15 PM NA #8 ent #38 usually had the nobut it was missing that day. /19/12 at 4:20 PM Nurse #5 should be wearing an tall times to hold the G-tube in do that the G-tube had become ently. She stated that ave noticed the binder was not ently. She stated that are noticed the G-tube from ently 19/20/12 at 7:45 AM NA #6 esident #38 should be wearing ently to prevent the G-tube from 19/20/12 at 7:45 AM Resident nabdominal binder.	F	322			10-11-12
	cleansed every day	nt #38's G-tube site was y. She indicated that she had luring the 3 days of					

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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / GREENVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) F 322 Continued From page 11 observations where Resident #38 was not wearing the abdominal binder. She stated that she did not notify nursing or replace the binder on Resident #38. She indicated that she was aware Resident #38 needed to wear the binder at all times and that if it was not worn the G-tube could become dislodged again. In an interview on 9/20/12 at 9:50 AM with the Supply Clerk she stated that on 8/9/12 she picked up an abdominal binder from a medical supply facility. She indicated that she ordered 2 more binders and they were delivered on or about 8/24/12. She stated that they were available in the supply room. In an interview on 9/20/12 at 10:00 AM the laundry room attendant stated every now and then an abdominal binder would be sent to laundry. She indicated that there were no abdominal binders in the laundry room at that time and that it had been "awhile" since one had been sent. In an interview on 9/20/12 at 10:58 AM Nurse #4 stated the staff had trouble keeping up with Resident #38's abdominal binder. She indicated that she had looked for the binder in the laundry room and the Physical Therapy room the	Count cares
CAN ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDENCIAL PROVIDENCIAL	09/20/2012
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observations where Resident #38 was not wearing the abdominal binder. She stated that she did not notify nursing or replace the binder on Resident #38. She indicated that she was aware Resident #38 needed to wear the binder at all times and that if it was not worn the G-tube could become dislodged again. In an interview on 9/20/12 at 9:50 AM with the Supply Clerk she stated that on 8/9/12 she picked up an abdominal binder from a medical supply facility. She indicated that she ordered 2 more binders and they were delivered on or about 8/24/12. She stated that they were available in the supply room. In an interview on 9/20/12 at 10:00 AM the laundry room attendant stated every now and then an abdominal binder would be sent to laundry. She indicated that there were no abdominal binders in the laundry room at that time and that it had been "awhile" since one had been sent. In an interview on 9/20/12 at 10:58 AM Nurse #4 stated the staff had trouble keeping up with Resident #38's abdominal binder. She indicated that she had looked for the binder in the laundry room and the Physical Therapy room the	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
previous afternoon, but was unable to locate Resident #38's abdominal binder. Nurse #4 stated she went to supply for a new binder and placed it on Resident #38. She indicated that it was a problem that Resident #38 was not wearing the binder as the G-tube could become dislodged more easily if not in place. She Indicated she would expect any staff who worked	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
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F 327 SS=D	about the binder if In an interview on of Nurses (DON)'s someone to have a abdominal binder on the facility must p sufficient fluid inta and health. This REQUIREMED by: Based on observinterviews, the facility interviews, the facility interviews, the facility interviews, the facility who had on findings include: The Resident State outlined care to be which was undated restriction. Resident #128 was 03/10/11. Cumular congestive heart alzheimer's disease.	to have gone to laundry to ask it was not in place. 9/20/12 at 3:30 PM the Director tated she would expect noticed Resident #38's was not in place and to have ENT FLUID TO MAINTAIN rovide each resident with ke to maintain proper hydration ENT is not met as evidenced ations, record review and staff sility failed to monitor the actual f1 sampled residents (Resident ders for a fluid restriction. tus Sheet (care guide which e provided) for Resident #128, ad, indicated he was on a fluid as admitted to the facility on lative diagnoses included failure, hypertension and see.	F 327	1. Resident #128 now hensure total fluid into period noted on the M	ake in a 24 hr	. 10-11-12	
	The quarterly Mir 07/31/12 indicate	nimum Data Set (MDS) of d Resident #128 had long and					_

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS	FOR MEDICARE &	MEDICAID SERVICES	CX21 M	ULTIPLI	E CONSTRUCTION	(X3) DATE SURV	EY
TATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	A. BUILDING			
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	OVIDER OR SUPPLIER	345181 EENVILLE		25	ET ADDRESS, CITY, STATE, ZIP CODE 78 WEST 5TH STREET REENVILLE, NC 27834 PROVIDER'S PLAN OF CORREC	TION	(X5)
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F 327	There were no behing up only for eating. Resident #128's ca 08/08/12, identified risk for dehydration	problems as well as d decision making skills. aviors noted. He needed set re plan, last reviewed on a problem with him being at related to a fluid restriction. In on it was noted to monitor tion daily and encourage fluids		327	2. The Registered Dieticiar all Residents on fluid resorders have been obtained total of fluid consumptions calculated on a 24 hr bas	strictions and ed to ensure on are	
	medication admini Resident #128's cl a 1500cc (cubic co an original date of being provided 96 the 7:00 AM to 3:0 3:00 PM to 11:00 11:00 PM to 7:00	une, July and August 2012 stration records (MAR) in nart, there was on an order for entimeter) fluid restriction with 04/08/11. It indicated he was 0 cc from dietary, 235 cc during 0 PM shift, 235 cc during the PM shift and 70 cc during the AM shift. The date blocks had here were no fluid amounts 10 MAR's to indicate how much 11 MAR's to indicate how much 12 MAR had consumed.			3. Facility has implemente protocol for all residents restriction diet. All nurs in-serviced on the new p	d this new s on a fluid es have been	10-11-
	record for Reside	August 2012 meal consumption nt #128, his meal intake ranged ned to 100% consumed for 3 re was no indication on this much fluid Resident #128 had					
	The September 2	2012 MAR included the same triction order with initials from the				If continuation si	

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLA TATEMENT OF DEFICIENCIES COMPLETED . . . IDENTIFICATION NUMBER: NO PLAN OF CORRECTION A. BUILDING C B. WING 09/20/2012 345181 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2579 WEST 5TH STREET UNIVERSAL HEALTH CARE / GREENVILLE GREENVILLE, NC 27834 (X4) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) lD (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 327 F 327 Continued From page 14 nurses in the date blocks but no actual amounts consumed. This MAR also included an order with an original date of 08/20/12 to offer liquids and monitor the percentage consumed at 9:00 AM, 2:00 PM and 8:00 PM. In the date blocks, 100 had been documented to indicate percentage consumed in the date blocks from 09/01/12 until 09/20/12. There were no actual amounts noted to indicate how much fluid Resident #128 had consumed. 4. DON and/ or designee will review daily Physician orders weekly times 3 months The September 2012 physician's order sheet for and identify any residents on fluid restriction receive the appropriate protocol. Resident #128 included a 1500 cc fluid restriction All findings will be reviewed in the order. Also included on the order sheet was to monthly QA meeting X 3 months on until offer liquids and monitor the percent consumed at 9:00 AM, 2:00 PM and 8:00 PM. deemed necessary. During a breakfast meal observation, on 09/19/12 at 8:25 AM, Resident #128 was noted to have a cup of coffee (240cc), a carton of milk (240cc) and a glass of juice (120cc) on his tray. There was no water pitcher noted at bedside. 10-11-12 During a lunch meal observation, on 09/19/12 at 1:10 PM, Resident #128 was noted to have a cup of brown liquid (240cc) and a bowl of vegetable soup (approximately 120cc fluid) on his tray. During an interview with the hall nurse (Nurse #2), on 09/19/12 at 4:30 PM, she stated the nurse aides were responsible for recording the fluid amounts residents consumed in the ADL book at the nursing station. She stated the nurses reported the amounts of fluid consumed during

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE		
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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE / GREENVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST 5TH STREET GREENVILLE, NC 27834				
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F 327	medication pass by the aides and they include ADL book. Nurse #2	e 15 ne resident to the nurse led it in their totals in the 2 stated the third shift nurse otaling at the end of their	F	327				
	on 09/19/12 at 4:40 Fithe percentage of footrays in the activities kept at the nursing stated if a resident would be noted on him would let them know separate hydration stresident who was on document the actual commented that the amounts they provide sheet. NA#3 commented having assignment. She reported having assignment.	with Nurse Aide #3 (NA#3), PM, she stated she recorded ods and liquids from the meal of daily living books (ADL) ation. She commented that e not documented separately the percentage totals. She as restricted in their fluids, it is care guide plus the nurse as well. NA#3 stated a meet was used for any a fluid restriction for them to amounts consumed. She nurses also recorded the ed to the resident on this ented that she had no one in was on a fluid restriction. Resident #128 in her corted she had been ent fluids given during snack						
	8:30 AM, she stated restrictions, the kitch they were allotted on the total fluid consun separately in the AD with the food intake a	with NA#4, on 09/20/12 at when residents were on fluid en provided the amounts their meal trays. She stated aption was not documented book as it was included as a percentage. NA#4 ets were not for all residents	The state of the s					

	IDER/SUPPLIER/CLIA IFICATION NUMBER;	A. BUII		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
	345181	B. WIN	G		1	C 0/2012
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F 327 Continued From page 16 just those who needed to have monitored. NA#4 stated resider restrictions did not have water rooms. She stated Resident # restriction but did not self proponot obtain extra fluids. NA#4 at there was no water pitcher in the aware not to offer fluids during. Resident #128 was observed expo/20/12 at 8:30 AM. He had a (240cc) and a small juice (120c). The tray slip indicated he was restriction. Nurse #1 was interviewed about on 09/20/12 at 10:10 AM. She document the actual amounts acconsumed while on fluid restriction the amounts they were allowed listed on the MARs. The hall nurse (Nurse #3) was fluid restrictions on 09/20/12 at stated when residents had phy fluid restrictions, the nurses taken nursing was allowed to provide between the three shifts. She aides document the resident's book at the nursing station. Not did not document the amount from the consumed during medication per medications to him twice on he that she probably gave him hall with each medication pass. No	ents with pitchers in their 128 was on a fluid el himself so could lso commented if the room staff were snack times. ating breakfast on a carton of milk the colon his tray. On a fluid at fluid restrictions stated she did not of fluids residents tion. She stated I to provide were interviewed about 10:30 AM. She sician's orders for the the amount and divide it stated the nurse intake in the ADL urse #3 stated she Resident #128 ass as she passed or shift. She added of a cup of liquid	F	327			

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*	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 327	Resident #128 was de fluids. She also state amounts consumed a amount on his meal to much fluid Resident # shift, she stated she or recording amounts con Nurse #3 stated she or needed adjusting and to reflect amounts of the nurses would beg. During an interview w (DM), on 09/20/12 at residents had physicia fluid restriction she prothe three meals trays. 240cc per meal tray to co. The DM commenco was provided by the stated she did not trained what they we DM stated usually residents for amounts provided what they we DM stated usually residents for amounts provided what they we DM stated usually residents for amounts provided what they we DM stated usually residents for amounts provided what they we call the soup on his DM stated there should in the soup or a very received soup on his DM stated there should in the soup was reprovided for him as it	ependent upon staff for d dietary did not track s they only provide a certain rays. When questioned how 128 had consumed on her could not say as no one was insumed. After discussion, agreed that the system she would change the MAR duids consumed per shift so in documenting amounts. If the Dietary Manager 10:45 AM, she stated when an's orders for a 1500 cc ovided a total of 960 cc on She stated she provided to add up to the total of 960 ted the balance of the 1500 re nursing department. She ck or monitor those is consumed, she only ere allowed to have. The sidents who were restricted vatermelon or soup on their sported that Resident #128 funch tray on 09/19/12, the ld not have been any liquid minimal amount but in either ot included in the totals she was a chunky soup.	F 327		
	interviewed on 09/20/	r of Nurses (ADON) was 12 at 11:15 AM. He stated on a fluid restriction the total e allowed to have was			

Event ID:FDMU11

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/02/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION ... **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 345181 09/20/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST 5TH STREET UNIVERSAL HEALTH CARE / GREENVILLE GREENVILLE, NC 27834 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION Ю (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 327 Continued From page 18 F 327 broken down per shift. He stated the nursing staff was expected to adhere to those amounts. The ADON stated the nurse aides should be reporting the fluid amounts consumed from meals to the nurses for them to document on the resident's MAR. He also stated totals should be included on the MAR. Upon observation of Resident #128's September 2012 MAR, he stated he could not say how much fluid Resident #128 had consumed during any time period. The ADON stated the facility did not have a system in place to monitor or track the amount of fluids Resident #128 was consuming on a daily basis and he would not know whether or not he received the full 1500 cc. The Director of Nurses (DON) reported during an interview on 09/20/12 at 11:30 AM that nurses were initialing the MAR to attest to the fact that they did not provide more than the amount that was allotted for them to provide. She stated there 10-11-12

allowed per the MAR.

was no need for staff to document on a hydration sheet as the nurses were signing off that the resident received the allotted amounts on that shift. When questioned if she could report the total amount of fluids that Resident #128 had consumed over a 24 hour time period, she responded she could not show actual fluid intake but he was not receiving more than he was

PRINTED: 11/05/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A BUILDING --- 01 - MAIN BUILDING 01 -IDENTIFICATION NUMBER MON 8 3 AND PLAN OF CORRECTION 10/31/2012 345181 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2578 WEST 5TH STREET GREENVILLE, NC 27834 UNIVERSAL HEALTH CARE / GREENVILLE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) K 000 INITIAL COMMENTS K 000 Surveyor, 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, and no automatic sprinkler system. The deficiencies determined during the survey Unscaled openings have are as follows: been closed in walls NFPA 101 LIFE SAFETY CODE STANDARD K 012 located.@ laundry room K 012 and by fire alarm control SS=E Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, panel on 100 hall. Building has been 19.3.5.1 assessed for any unsealed openings. Will add to the monthly P.M. schedule. This STANDARD is not met as evidenced by: A walk thru will be done Surveyor: 27871 on a monthly basis, any Based on observations and staff interview at negative finding will be approximately 8:00 am onward, the following brought to the monthly Items were noncompliant, specific findings include; found unsealed openings in walls located QA meeting. 11-6-12 at laundry room and by fire alarm control panel on 100 hall. 42 CFR 483.70(a) K 038 NFPA 101 LIFE SAFETY CODE STANDARD K 038 Exit access is arranged so that exits are readily SS=F accessible at all times in accordance with section 19.2.1 7.1. (XI) DATE ABORATORY DIRECTOR'S OR PRODUCENSURVER REPRESENTATIVES SIGNATURE any deficiency statement ending with an asterisk (") denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patiente. (See instructions.) Except for nursing homes, the findings stated above are disclosuble 90 days. sites sateguards provide summering protocular to the patients, (see manufactories). Except for hursing fromes, the above findings and plans of correction are disclosable 14 ollowing 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 Viscosing the date of survey visitation of not a plan of contaction is provinced. For noticing findings, the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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rogram participation.

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Facility ID: 923482

If continuation sheet Page 1 of 5

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DEPARTMENT OF HEALTH AND HUMAN SERVICES $\sim 4.3 \pm 0.0$ OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A BUILDING - 01 MAIN BUILDING 01 AND PLAN OF CORRECTION 11.00 10/31/2012 345181 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2578 WEST 6TH STREET GREENVILLE, NC 27834 A Comment of the Comment of th UNIVERSAL HEALTH CARE / GREENVILLE ... (XS) COMPLETION PROVIDER'S PLAN OF CORRECTION BUMNARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TEACH CORRECTIVE ACTION SHOULD BE ıh DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Requested waiver, see K 051 letter attached. Continued From page 2 K 051 Until system upgrade, 4,040 . . ^ . . . nurses will check for . 7, flashing lights down the hallways every two hours this will be done on a daily basis. Any This STANDARD is not met as evidenced by: negative findings will Surveyor: 27871 Based on observations and staff interview at be brought to the approximately 8:00 am onward, the following monthly QA meeting. items were noncompliant, specific findings include: when fire alarm system was activated, 30 corroded sprinkler the audite/visual signal form horn/strobe devices have been identified. were not synchronize through out facility. Sprinkler heads have been ordered and to 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD K 062 be replaced. K 062 New sprinkler system SS=E Required automatic sprinkler systems are continuously maintained in reliable operating to be installed by condition and are inspected and tested August 2013. 19.7.6, 4.6.12, NFPA 13, NFPA 5 77 A walk thru will be periodically. 25, 9.7.5 done on a monthly basis to ensure there are No signs of This STANDARD is not met as evidenced by: corrosion to existing Surveyor: 27871 Based on observations and staff interview at heads. approximately 8:00 am onward, the following Any negative findings items were noncompliant, specific findings will be addressed and include; all sprinkler heads located in kitchen area and brought to the show signs of corrosion. monthly QA meeting. 12-2-12 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD K 144 K 144 SS=E

PRINTED: 11/05/2012 FORM APPROVED

ENTERS	ENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICARD SERVICES DEFICIENCIES (XI) PROVIDE RUSUPPLIERICUA. ORBECTION NUMBER.			e construction completed
ATEMENTO.	OFFICIENCIES (XI) PROVIDER/SUPPLIER/CUA.	A BUI		01 - MAIN BUILDING 01
%10\$\;	and the second s	B, WIN		The second secon
A 411 4 4 14 16 22	17 . 17		STRE	ET ADDRESS, CITY, STATE, ZIP CODE
AME OF PRO	VIDER OR SUPPLIER L HEALTH CARE / GREENVILLE		257	Allegation for Mrs. 97834 and described the first the first terms of t
INIVERSA	L HEALTH GAME	sa Tri-u ID	F	PROVIDERS PLANOF CORRECTION : COMPLETE
(XX) D'	SUMMARYSTATEMENT OF DERICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LESS IDENTIFYING INFORMATION)	PRE		HEROVIDER SPLANIOR CORRECTION: OF CONTROL OF CONTROL OF COMPLETE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY).
TAG.	REGULATOR OR LOSS DENTIFYING INFORMATION	المراد وعامدا محالتها العامدا	h.ii.; / 1 h .	New generator has
	the second section and the second section sect			been installed
K 144 C	Continued From page 3	1	144	generator cranks and
- 11.	honacted weekly and exercised	1	٠.	transfers when tested. 12-8-
	Jenerators are inspirites per month in accordance with NFPA 99: 3.4.4.1.			- Generator will be
)	accordance trans			inspected and
		· [<u>}</u> ·	exercised under load
· [1		for 30 minutes per
<u> </u>		-	<u> </u>	month in accordance
		3		with NFPA99. Any negative findings
\ .	얼마요 그 어린 상태를 보고 있다.	:		will be addressed and
	This STANDARD is not met as evidenced by:		:, ;:	brought to the monthly
			1 .	OA meeting.
	Surveyor, 27871 Based on observations and staff interview at approximately 8:00 am onward, the following approximately 8:00 am onward, the following		÷	The rest of the second of the
		S.W. S.	:	ANNONE STRUCTURE COURT STRUCTURE
	include: generator falled to classic and desired		. }.	Separation of the second secon
	when tested			- Extension cords have
	42 CFR 483.70(a)	· .	к 147	16
K 147	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	i.	;	room 408 and 409.
\$S=E	Electrical wiring and equipment is in accordance	ce ·		Electrician into add
(with NFPA 70, National Electrical Code, 9.1.2		,	more receptacles to
k		; l.		rooms.
	1 The second second		:	- All rooms have been
,	This STANDARD is not met as evidenced by:		. \	assessed for extension
	Surveyor, 27871 Based on observations and staff interview at	:	. :	cords. Extension cords
·	TO THE PROPERTY OF THE PROPERT		. ! 1	discovered have been
	items were ribricompliant, specific induses			removed from those
1,	residents bedrooms 408 and 403 tot 1 v to 50	3	•	Prooms.
	plugged into.	- 1 d. 1.		to but two a gray or
		Tien.	بن نون	If continuation sheet Page

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		COMPLETED S:—01 - MAIN BUILDING 01		
The state of the s	345181	B. WING_		10/3	1/2012
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE!	342101				
(X4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)		(X5) COMPLETION DATE
			- Electrician so add more receive the rooms Monthly rour completed to deficient pracent re-occur Any negative will be broug monthly QA	eptacles to ads will be ensure the ctice does finding ht to the	12-2-12



GREENVILLE • 2578 West 5th Street • Greenville, NC 27834

Ph: 252-758-7100 • Fax: 252-758-1485

SIDE P. VOIN

11/17/12

Dear Mr. Washburn,

I am requesting a waiver for tag K051 in regards to the signal form horn/strobe devices were not synchronized. I am requesting this waiver until August 2013. Before August 2013 we will be adding on a new wing and sprinkling the entire facility. I am requesting to do a system upgrade during this time. All repairs and renovations will be capital expenses. Thank you for your consideration in this matter.

Heather G. McLamb, Administrator

FACILITY REQUEST FOR WAIVER OR VARIANCE

TO BE COMPLETED BY STATE AGENCY	
Life Safety Code (405.1134a)	Physical Environment
7-Day R.N. Requirement	Patient Room Size (405.1134c)
Medical Director (405,1911b)	Beds Per Room (405.1134e)
Name of Facility UNIVERSA Health Can Address 2578 West 5th Strut C	2/ Greenvilla
Type Facility: NH	3. Vendor No
Program: XVIII/XIX XIX	Provider No. 345181
Date of Survey: Life Safety Code 10/3//2012 General	5. Expiration Date of Current Agreement:
State Agency recommendation: Approved	Waiver/Variance Previously Approved
Reason for Recommendation: replacting horn, builting will be sprinkly 8	1 strok line poud when
Period for which Waiver/Variance is Recommended:	
1) 3/2 of 2 Date	10Authorizing Signature of State Agency
TO BE COMPLETED BY REGIONAL OFFICE	
Waivers/Variance Approved	I2. Waivers/Variance Not Approved
(a) (b) (c) (d)	(a) (b) (c)
Program Reviewer Signature	Date
Discipline Reviewer Signature	Date
Authorizing Signature Acting Director, Survey & Certification	Date

LSC Waiver