DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES					FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OM	B NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION		DATE SURVEY COMPLETED
		345181	B. WING				C 04/28/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE / GRE			2	2578 WEST 5TH STREET		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		0	GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 157 SS=G			F	157			5/25/17
	(g)(14) Notification of	Changes.					
	consult with the resid	nediately inform the resident; lent's physician; and notify, r her authority, the resident en there is-					
		ving the resident which nas the potential for requiring n;					
	(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);						
	a need to discontinue	erse consequences, or to					
	(D) A decision to tran resident from the faci §483.15(c)(1)(ii).						
	(14)(i) of this section, all pertinent informati	ification under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ided upon request to the					
		also promptly notify the dent representative, if any,					
	(A) A change in room	or roommate assignment					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE
Electroni	cally Signed						05/25/2017

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.

TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		C 04/28/2017	
		345181	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETI	
F 157	Continued From page	e 1	F 15	7		
	as specified in §483.					
		ent rights under Federal or ns as specified in paragraph				
	update the address ( phone number of the	record and periodically mailing and email) and resident representative(s). 「 is not met as evidenced				
	Physician interviews,	iew and staff, family and the facility failed to notify the two newly identified wounds nd failed to notify the		F-157 Immediate Action: Resident 65 is no longer a resident i building. He was discharged on	n the	
	Physician of one new which resulted in lack	ly identified wound (heel)		3/27/2017. Identification of others:		
		rsening of a wound for 1 of 3 or notification of condition 5).		100% audit of all active resident⊡s medical records to include clinical documentation, physician orders and resident⊡s assessments completed,		
	Findings included:			started on 4/28/17 and completed or 5/20/2017, by the Administrator, Dire	ו ו	
	admitted to the facility			of Nursing and/or Medical Record Cl ensure that notification of change wa	as	
	-	uded Stage 3 Chronic ertension and Diabetes.		done appropriately for all other resid Any condition that warranted notifica to resident⊡s responsible party and	ition	
	updated on 12/6/2010	eviewed and noted as last 6. The Care Plan revealed a Pressure Ulcers related to		attending physician was corrected u discovery promptly by the charge nu or director of nursing.	pon	
	impaired mobility with of skin breakdown the	n the goals listed as no areas rough the next review.		100% skin audit was initiated on 5/15/2017 and completed on 5/20/20		
	with routine care, floa	d daily observation of skin at heels on pillows at all e eschar (a dry dark scab		by Director of Nursing, Assistant Dire of Nursing, and charge nurse. This a focus on identification of any skin		
		el and notify the doctor if any		alteration and whether or not resider attending physician and responsible		

Event ID: RIQU11

Facility ID: 923482

If continuation sheet Page 2 of 45

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVI	38-039 EY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· /	G	COMPLETED	)
					С	
		345181	B. WING		04/28/20	17
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET		
	1			GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COM THE APPROPRIATE	(X5) IPLETIO DATE
F 157	Continued From page	e 2	F 15	57		
		mum Data Set (MDS) dated		condition was reported to	both attending	
	3/6/2017 indicated Re	esident #65 was cognitively		physician and responsible	Ū,	
		e assistance of 1 person for				
	-	₋iving (ADLs) and was and bladder. The MDS		Systemic Changes: Effective 5/25/2017, the 2	A hour change	
		65 was at risk for pressure		of condition report sheet		
		re ulcers were present on		licensed nurses on duty to	2	
	assessment.			alteration in resident s st	e e e e e e e e e e e e e e e e e e e	
				scheduled shift. Licensed		
		ort assessments dated		notify attending physician	-	
		017 completed by Unit licated Resident #65's skin		party on the following are involving the resident, a s		
	was intact.			in resident condition, (suc		
				alteration in skin integrity		
		ng notes revealed a note		deterioration of existing w	-	
		:05 AM written by Nurse # 5.		alter treatment (such as n		
	-	quarter sized open area was t buttocks, barrier cream was		orders) decision to transfe resident from the facility a	<u> </u>	
		would be reported to the		resident s room changes		
	oncoming nurse.			Effective 5/25/2017 the n		
				changes tool will be utilize	-	
		nursing notes revealed a		nurses on duty to record		
	#1. The note reported	at 1:53 PM written by UM		significant change of cond that the attending physicia		
		it #65's right buttocks, barrier		responsible party were no		
	cream was applied a	-		100% of licensed nursing	-	
		ers were obtained from the		in-serviced on the importa	ance of timely	
	Physician.			notification of resident s	e e	
	A Dhysisian's Order a	tated 3/27/2017 was noted		condition to physician and	-	
	-	dated 3/27/2017 was noted edical record. The order		party. The Director of Nur Assistant Director of Nurs		
		65 be sent to the Emergency		and/or Administrator prov	<b>U</b>	
	Department (ED) to b	be evaluated for increased		education. The education	was initiated on	
	temperature and alter	red mental status.		4/28/17 for all licensed nu	-	
		a reviewed and revealed		include, full time, part time		
	-	e reviewed and revealed mitted to the hospital with a		employees. This education completed by 5/25/17, an		
		bacteria in the bloodstream		nursing staff not educated	-	
		on) secondary to a Urinary		not be allowed to work un	-	

Facility ID: 923482

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TID	LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:			· · /	IPLETED
						С
		345181	B. WING		04	4/28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				2578 WEST 5TH STREET		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 157	Continued From page	e 3	F 15	7		
		n Assessment note dated		This education will also be adde	ed to new	
		I from the ED revealed		hire process for all new license		
		luid filled DTI noted on the		staff effective 5/25/17 and also	-	
		ured 4 centimeter in length		provided annually.		
		dth and several small areas		p		
		which appeared to be from		Monitoring Process:		
	shearing.			Effective 5/25/2017 the Director	r of	
				Nursing, Assistant Director of N	lursing	
	A telephone interview	v was conducted with		and/or Unit manager will review	the 24	
		onsible Party (RP) on		Hour Change of Condition Rep		
		1. The RP stated she visited		daily during morning clinical me		
		d visited the resident at the		(Monday-Friday) to assure that		
	-	The RP stated she was at		of change is conducted appropri		
		artment (ED) with Resident ne RP further stated the		the corresponding documentation resident s medical records. In		
		ed to have a pressure sore		this review will be to assure that	•	
		dark, bloody looking area on		changes in condition is commu		
		orted she was unaware of		the physician and responsible p		
	these areas until the	observation in the ED.		warranted. This monitoring proc		
	A			continued by the charge nurses		
		nducted on 4/27/2017 at		Saturday and Sunday. This mo	-	
		DS nurse. The MDS nurse ed Resident #65 on 3/6/2017		process will be conducted daily then weekly x 4 weeks, then me		
	-	assessment and observed		thereafter, or until the pattern of	•	
		e-like area on his right heel.		compliance is achieved.	1	
		ed she thought she reported				
	the area to the staff n			Effective 5/25/2017 the Director	r of	
		se or if she reported it. The		Nursing, Assistant Director of N		
		e did not notify the Physician		and/or Unit Manager will review		
	or the RP of the area			Notification of Change Log dai		
				morning clinical meeting (Mond		
		v was conducted with Nurse		to assure that notification of cha	•	
		1:10 AM. Nurse #5 recalled		conducted appropriately with th		
		#65's buttock which was		corresponding documentation in		
		PM to 7AM shift. Nurse #5		resident⊡s medical records. In		
		was small with no drainage		this review will be to assure that		
		ream. Nurse #5 also stated		changes in condition is commu		
		nilies or Physicians during		the physician and responsible p		
	the hight shift unless	it was a serious situation.		warranted. This monitoring proc	cess will be	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
AND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		345181	B. WING		C 04/28/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/28/2017	
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO	
F 157	Nurse #5 indicated sl information to the one Nurse #5 stated she the information on to regarding the open a buttock. An interview was corr 4/27/2017 at 11:30 A recalled Resident #63 area on the buttock. wound physician norr residents' wounds an and recommendation he did not recall notif with Resident #65's h An interview was corr 4/27/2017 at 1:35 PM "usually" called the R Physician when a cha UM #1 also indicated the Physician and RF she observed a smal Resident #65's heel of assessments on 3/8/, not consider it a wou she did not notify any observation. UM #1 f assessing the area o and notifying the Phy remember if the RP v An interview was corr 4/27/2017 at 3:00 PM assessed the area or buttock on 3/22/2017	he would give the coming nurse for follow up. did not recall if she passed the oncoming nurse rea on Resident #65's aducted with the Physician on M. The Physician stated he 5 and was aware of the open The Physician reported the mally assessed the facility id he reviewed the orders is. The Physician indicated ication of any skin issues neel. aducted with UM #1 on A. UM #1 indicated she RP after she called the ange in condition is noted. I she would document when P were notified. UM #1 stated I purple bruise-like area on on his weekly skin 2017 and 3/15/2017 but did nd since it was not open and yone or document the urther stated she recalled n Resident #65's buttock rsician but could not	F 15		oring 4 weeks thly to the prmance tor of sing months. end any	

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		ND HUMAN SERVICES			PRINTED: 05/31/20 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345181	B. WING		C 04/28/2017	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		578 WEST 5TH STREET GREENVILLE, NC 27834		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 157	stated she did not no	ea on the buttock. UM #2 tify the Physician or the RP.	F 157			
F 241 SS=D	Administrator on 4/27 Administrator stated to for any resident chan thoroughly assessed stated the expectatio change assessment and the RP with docu condition change, an and notification.	Iducted with the facility 7/2017 at 4:15 PM. The the facility expectation was ige of condition to be . The Administrator further n included the condition be reported to the Physician umentation to include the y new orders or treatments Y AND RESPECT OF	F 241		5/25/17	
	resident in a manner promotes maintenand her quality of life reco individuality. The faci promote the rights of This REQUIREMENT by: Based on observation resident and staff inte treat residents in a di knock on door or ask resident room which	<b>,</b>		F241 Immediate Action: On 4/27/2017 an in-service was conducted by the Assistant Director of Nursing (ADON) to address how imperative it is for employees to knock and announce themselves before ente		
	admitted to the facility diagnoses which include	-		a resident⊟s room. On 05/5/2017, Resident #84 attended resident counci- meeting and stated she did not have a further issues. Identification of Others: The Social Worker conducted interview with 100% of active resident residing in	l ny vs	

Facility ID: 923482

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(EACH DEFICIENC) REGULATORY OR L Continued From page The most recent comp Set (MDS) dated 3/6/2 vas moderately cogni nake herself understo	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) e 6 prehensive Minimum Data 2017 indicated Resident #84	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST 5TH STREET GREENVILLE, NC 27834 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO
HEALTH CARE / GREI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page The most recent comp Set (MDS) dated 3/6/2 vas moderately cogni nake herself understo	ENVILLE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) e 6 prehensive Minimum Data 2017 indicated Resident #84	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST 5TH STREET GREENVILLE, NC 27834 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) 1	04/28/2017 3E (X5) COMPLETIC
HEALTH CARE / GREI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page The most recent comp Set (MDS) dated 3/6/2 vas moderately cogni nake herself understo	ENVILLE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) e 6 prehensive Minimum Data 2017 indicated Resident #84	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 2578 WEST 5TH STREET GREENVILLE, NC 27834 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) 1	BE (X5) COMPLETIC
SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From page The most recent comp Set (MDS) dated 3/6/2 vas moderately cogni nake herself understo	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) e 6 prehensive Minimum Data 2017 indicated Resident #84	ID PREFIX TAG	GREENVILLE, NC 27834 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO
SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From page The most recent comp Set (MDS) dated 3/6/2 vas moderately cogni nake herself understo	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) e 6 prehensive Minimum Data 2017 indicated Resident #84	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO
(EACH DEFICIENC) REGULATORY OR L Continued From page The most recent comp Set (MDS) dated 3/6/2 vas moderately cogni nake herself understo	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 6 6 prehensive Minimum Data 2017 indicated Resident #84	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO
the most recent comp Set (MDS) dated 3/6/2 vas moderately cogni nake herself understo	prehensive Minimum Data 2017 indicated Resident #84	F 24		
the most recent comp Set (MDS) dated 3/6/2 vas moderately cogni nake herself understo	prehensive Minimum Data 2017 indicated Resident #84			
Resident #84 required erson for all Activities on 4/27/2017 at 9:01 bserved in her room, eside the bed with the front of the wheelch assistant (NA) #6 enter laced a breakfast tra- emoved the lid from to she needed anything esident #84 told NA nything and began e a continues observative vas conducted on 4/2 :22 AM. During the of bserved entering 5 re- resent without knock the or purpose for enter an interview was condor /27/2017 at 11:30 AM taff were in and out of the other the room with explained it embarras	bod and understood others sion. The MDS indicated d the assistance of one s of Daily Living. AM, Resident #84 was , seated in a wheelchair he bedside table positioned hair. At 9:03 AM, Nursing ered resident #84's room, by on the bedside table, the tray, asked the resident g and exited the room. #6 she did not need eating. on of Resident #84's hall 27/2017 from 9:06 AM to observation NA #6 was ooms which had residents sting or revealing her name, trance. ducted with Resident #84 on M. Resident #84 stated the of her room all day. Resident unusual for the facility staff nout knocking. The resident sed her when they come in		<ul> <li>determine any issues with staff members knocking and announcing themselves. There were no identified issues.</li> <li>Systemic Changes:</li> <li>Effective 5/25/2017 active facility employees will knock and announce themselves before entering resident sroom.</li> <li>100% of all active facility staff, were in-serviced on the resident s dignity specifically knocking and announcing themselves. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Administrator provided education. The education was initiated 4/28/17 for all active facility staff to include, full time, part time and as nee employees. This education will be completed by 5/25/17, any active facilit staff not educated by 5/25/17 will not be allowed to work until educated. This education will also be added to new hi process for all new employees effective 5/25/17 and also will be provided annum Monitoring Process:</li> <li>Effective 5/25/17, the Social Worker, Activities Director, and Medical Record Clerk will conduct 10 random audits, d of staff members entering the resident room to determine compliance with knocking and announcing themselves. The weekend manager on duty will</li> </ul>	this don ded ity be re re Jally.
	n 4/27/2017 at 9:01 pserved in her room eside the bed with the front of the wheelch ssistant (NA) #6 ent aced a breakfast tra- emoved the lid from the she needed anythin esident #84 told NA nything and began end continues observation as conducted on 4/2 22 AM. During the of pserved entering 5 r resent without knock le or purpose for end in interview was condi- (27/2017 at 11:30 AI aff were in and out of 34 stated it was not of enter the room with explained it embarras ithout knocking, espletting dressed. Resi- as her home and fel	erson for all Activities of Daily Living. n 4/27/2017 at 9:01 AM, Resident #84 was beerved in her room, seated in a wheelchair eside the bed with the bedside table positioned front of the wheelchair. At 9:03 AM, Nursing ssistant (NA) #6 entered resident #84's room, aced a breakfast tray on the bedside table, emoved the lid from the tray, asked the resident she needed anything and exited the room. esident #84 told NA #6 she did not need hything and began eating. continues observation of Resident #84's hall as conducted on 4/27/2017 from 9:06 AM to 22 AM. During the observation NA #6 was oserved entering 5 rooms which had residents resent without knocking or revealing her name, le or purpose for entrance. n interview was conducted with Resident #84 on (27/2017 at 11:30 AM. Resident #84 stated the aff were in and out of her room all day. Resident 84 stated it was not unusual for the facility staff o enter the room without knocking. The resident kplained it embarrassed her when they come in ithout knocking, especially if she was bathing or eting dressed. Resident #84 added the facility as her home and felt it was disrespectful for the colity staff to walk in without knocking.	n 4/27/2017 at 9:01 AM, Resident #84 was beerved in her room, seated in a wheelchair eside the bed with the bedside table positioned front of the wheelchair. At 9:03 AM, Nursing ssistant (NA) #6 entered resident #84's room, aced a breakfast tray on the bedside table, emoved the lid from the tray, asked the resident she needed anything and exited the room. esident #84 told NA #6 she did not need nything and began eating. continues observation of Resident #84's hall as conducted on 4/27/2017 from 9:06 AM to 22 AM. During the observation NA #6 was beerved entering 5 rooms which had residents resent without knocking or revealing her name, le or purpose for entrance. n interview was conducted with Resident #84 on 27/2017 at 11:30 AM. Resident #84 stated the aff were in and out of her room all day. Resident 84 stated it was not unusual for the facility staff o enter the room without knocking. The resident kplained it embarrassed her when they come in ithout knocking, especially if she was bathing or etting dressed. Resident #84 added the facility as her home and felt it was disrespectful for the	room. 100% of all active facility staff, were in-serviced on the resident "s44 was served in her room, seated in a wheelchair eside the bed with the bedside table positioned front of the wheelchair. At 9:03 AM, Nursing ssistant (NA) #6 entered resident #84's room, aced a breakfast tray on the bedside table, moved the lid from the tray, asked the resident she needed anything and exted the room. esident #84 told NA #6 she did not need nything and began eating. Continues observation of Resident #84's hall as conducted on 4/27/2017 from 9:06 AM to 22 AM. During the observation NA #6 was oserved entering 5 rooms which had residents resent without knocking or revealing her name, le or purpose for entrance. n interview was conducted with Resident #84 on 27/2017 at 11:30 AM. Resident #84 stated the aff were in and out of her room all day. Resident 84 stated it was not unusual for the facility staff o enter the room without knocking. The resident stihout knocking, especially if she was bathing or titing dressed. Resident #84 added the facility as her home and felt it was disrespectful for the

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		3 NO. 0938-03 DATE SURVEY	
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
						С	
		345181	B. WING			04/28/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 241	Continued From page	e 7	F 24	1			
		ducted with NA #6 on		the Knocking & Announce			
	4/27/2017 at 10:13 A	•		These audits will continue of	•		
		ed to knock and announce lents' rooms. NA #6 stated		weeks, weekly for 4 weeks for 3 months or until substa	-		
		nock sometimes but not all		compliance is achieved.			
	the time. NA #6 repor	rted the only reason for not		Effective 5/25/2017, Social	Worker and/or		
		getfulness when she was		Activity Director will monito			
		hen resident's room doors		by discussing, knocking an	•		
	•	dents would see her coming idn't see a reason to knock.		requirement monthly during council meeting. Concerns			
				knocking and announcing of			
	An interview was con	ducted with the		council meetings will be do			
		operate representative on		resident council minutes.			
		1. The Administrator stated		Results of these audits me			
		for every facility employee to themselves when entering		will be reported to the facili Assurance Performance Im	• •		
	resident's rooms.			(QAPI) Committee by Activ	•		
				and/or Director of Social Se			
				x 6 months. The QAPI con			
				recommend any additional needs or modification of the	•		
				the committee deems appr			
F 242	483.10(f)(1)-(3) SELF RIGHT TO MAKE CH		F 24			5/25/17	
SS=D							
	(f)(1) The resident ha	s a right to choose activities,					
		sleeping and waking times),					
		ders of health care services					
		her interests, assessments, other applicable provisions					
	of this part.	approace providend					
	(f)(2) The resident be	a right to make choices					
		is a right to make choices or her life in the facility that					
	are significant to the						
	(f)(3) The resident ha	is a right to interact with					
	members of the com		1			1	

Facility ID: 923482

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/31/20 RM APPROVE O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C 04/28/2017	
		345181	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 242	community activities I facility. This REQUIREMENT by: Based on observation interviews, the facility choice of changing th the room (Resident # residents reviewed for Findings included: A review of the medic #61 was admitted 2/2 11/17/2016 with diagu side paralysis, anxiet hand and vascular de The 14 day Minimum 12/1/2016 noted Res impaired for cognition care or behaviors. Th #61 needed extensive Activities of Daily Livi assistance of one per In an interview on 4/2 Resident #61 stated I to the other bed in the	both inside and outside the T is not met as evidenced an, staff and resident (failed to honor a resident's ne placement of the bed in t61) for one of three or choices. cal record revealed Resident 21/2011 and readmitted noses of stroke with right y, contracture of the right ementia. 1 Data Set (MDS) dated ident #61 was moderately n and had no rejection of ne MDS indicated Resident e to total assistance for all ing (ADLs) with the physical rson.	F 242	<ul> <li>F242 Self Determination Immediate Action: Resident #61 bed was repositi way he requested on 4/28/201 PM.</li> <li>Identification of Others: 100% interviews of all active re residing in the facility conducte 5/17/17, 5/18/17 and 5/19/17 b Worker to determine each resi satisfaction and preferences or furniture placement in their roc other residents concerns relate accommodation of needs, spe furniture placement were voice Systemic Changes: Effective 5/25/2017, resident about aspects of his or her life facility that are significant to th like furniture location in resider be discussed during admission by the admission Director and/ services director. This discussi focus on accommodation of re</li> </ul>	7 at 6:30 esidents ed on by the Social dent □s f their oms. No ed to cifically ed. s choices in the e resident, nt room, will n process /or Social ion will	
	because a roommate by the bed in a wheel Resident #61 indicate because that was how be. On 4/27/2017 at 3:18	e pointed toward the window e would not have room to get I chair or specialty chair. ed he was disappointed w he really wanted his bed to B PM, in an interview, the the facility had tried to everal times. The		<ul> <li>choices while ensuring safety to residents, (i.e. ensuring that prolocation do not block the mean ingress/egress).</li> <li>Effective 5/25/17, residents an responsible party will be advised process to follow if they prefere the furniture placement in their through communicating such procest of the Director when they arise to the Director when they arise to the Director the furniture placement in the preferement in their through communicating such procest of the Director when they arise to the Director the furniture placement in the preferement in th</li></ul>	referred is of id/or ed on the to change r room preferences	

Facility ID: 923482

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/31/2017 MAPPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345181	B. WING				C 28/2017
NAME OF P	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE			578 WEST 5TH STREET REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	Administrator indicate were moved parallel t there would not be er to get by the end of th motorized wheel chai Resident #61 did not Administrator stated t residents in the facilit ambulatory, and prev sharing a room with F Administrator stated t working with Residen On 4/28/2017 at 3:00 former roommate of F interviewed, and state problems with Reside along just fine.	ed if Resident #61's bed to the other bed in the room, nough room for a roommate he bed in a specialty chair or r. The Administrator noted have a roommate The there were very few y that were bedbound or ious roommates had issues Resident #61. The the facility would try to keep t #61. PM, in an interview, the Resident #61 was ed he never had any ent #61 and they had gotten PM, the bed in Resident repositioned in the way the	F	242	Services and/or Administrator. This communication to resident and/or responsible party will take place during the admission process. Effective 5/25/2017, the Social Service Director and/or Activity Director will interview each resident and/or respon party quarterly during the care plan process to ensure that resident choice and preferences of furniture placemer and/or room arrangement are accommodated without compromising any safety needs of all residents. Any identified problems with furniture placement will be addressed by the director of social Services and/or Activity director for promptly. Administrator conducted an education with the Admission Director, Director of Social services and the Activity director 5/22/2017 on the new process of determining resident s choices and preferences. This was to ensure that or resident is accommodated, resident safety would not be compromised. Monitoring Process: Effective 5/25/17, the Director of Social Services, and/or Activity Director will monitor and interview newly admitted residents from previous business day (Monday-Friday) to ensure choices at aspects of resident is life in the facility that are significant to the resident, like furniture placement in residents room discussed during admission process.	es sible es nt vity of or on while e t al pout ( ; , are Any	

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		MEDICAID SERVICES				IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
					С	
		345181	B. WING		0	4/28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834		
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 242	Continued From page	e 10	F 243	Social Services Director. This process will take place daily (N Friday) for 4 weeks, weeks for weeks then monthly for three of until the pattern of compliance achieved. Effective 5/25/17, the Director Services, and/or Activity Direct interview all active residents in to determine satisfaction of fur placement in their rooms. Find monitoring process will be doo Furniture Placement Tool. Thi monitoring process will take pl 100% of active residents for 1 50% of active resident for ano month, and then 25% of active for another month or until a pa compliance is achieved. Results of the monitoring proc mentioned above will be repor facility Quality Assurance Perf Improvement (QAPI) Committee recommend any additional mon needs or modification of these	Monday thru 4 more months or is of Social tor will tor will the facility initure lings of this sumented on is ace for month, ther one e residents ittern of ess ted to the ormance ee by the hly for 6 e will mitoring plans as	
F 272 SS=G	483.20(b)(1) COMPF ASSESSMENTS	REHENSIVE	F 272	the committee deems appropr		5/25/17
	(b) Comprehensive A	ssessments				
	must make a compre resident's needs, stre	ment Instrument. A facility hensive assessment of a engths, goals, life history and re resident assessment				

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Facility ID: 923482

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & MI					RINTED: 05/31/2017 FORM APPROVED MB NO. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	TIPLE CONSTRUCTION		3) DATE SURVEY COMPLETED
	345181	B. WING _		_	C 04/28/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
			2578 WEST 5TH STREET		
UNIVERSAL HEALTH CARE / GREEN	NVILLE		GREENVILLE, NC 2783	4	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	E PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
<ul> <li>(i) Identification and d</li> <li>(ii) Customary routine.</li> <li>(iii) Cognitive patterns.</li> <li>(iv) Communication.</li> <li>(v) Vision.</li> <li>(vi) Mood and behavio</li> <li>(vii) Psychological well-</li> <li>(viii) Physical function</li> <li>problems.</li> <li>(ix) Continence.</li> <li>(x) Disease diagnosis</li> <li>(xi) Dental and nutrition</li> <li>(xii) Activity pursuit</li> <li>(xiv) Medications.</li> <li>(xvi) Discharge plan</li> <li>(xvi) Discharge plan</li> <li>(xvii) Documentation</li> <li>regarding the additional on the</li> <li>care areas tri</li> <li>of the Minimum Data Se</li> <li>(xviii) Documentation</li> <li>assessment. The asses</li> <li>include direct</li> <li>observation a</li> <li>the resident, as well as</li> <li>licensed and</li> <li>non-licensed</li> <li>on all shifts.</li> </ul>	de at least the following: demographic information r patterns. being. ioning and structural and health conditions. nal status. t. and procedures. nning. n of summary information I assessment performed iggered by the completion et (MDS). n of participation in issment process must and communication with communication with direct care staff members ss must include direct unication with the resident, ion with licensed and	F	272		

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Facility ID: 923482

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TATEMENT (	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/28/2017	
		345181	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
UNIVERS	AL HEALTH CARE / GRE	ENVILLE			578 WEST 5TH STREET REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 272	This REQUIREMENT by: Based on observation interviews and record accurately assess and 3 residents reviewed (Resident #65). Findings included: Record review reveal admitted to the facility diagnoses which inclu- Kidney Disease, Hyp The Care Plan was re- updated on 12/6/2010 problem of a risk for 1 impaired mobility with skin breakdown throu Interventions includer with routine care, float times and monitor the like area) on right head change noted. The Skin Inspection F 2/22/2017 and 3/1/20 Manager (UM) #1 inco- was intact. The Quarterly Minimu-	F is not met as evidenced on, staff and resident d review, the facility failed to resident's skin status for 1 of for Pressure Ulcers led Resident #65 was y on 8/22/2012 with uded Stage 3 Chronic ertension and Diabetes. eviewed and noted as last 6. The Care Plan revealed a Pressure Ulcers related to n a goal of no new areas of	F	272	F272 Immediate Action Resident 65 is no longer a resident in building. He was discharged on 3/27/2017. On 4/28/2017, the MDS nurse and Un Manger #1 were in-serviced on the importance of documenting accurate findings related to alteration in skin integrity. UM #1 was also in-serviced related to recognition of deep tissue ir as a pressure ulcer by the Administrat Identification of Others: 100% skin audit was initiated on 5/15/2017 and completed on 5/20/201 by Director of Nursing, Assistant Director of Nursing and unit manager. This aud focused on identification of alteration in skin integrity. Any changes in the over skin condition of a resident was assess thoroughly, reported to the physician a treatment orders received. The responsible parties were also notified any alteration in skin integrity. 100% wound assessment were initiate on 5/15/2017 and completed on 5/20/2017, of all active residents that currently reside in the facility by the Director of Nursing, Assistant Director Nursing and/or the Unit Manager. The assessments focused on identification	hit hjury tor. 17, ctor dit in rall ssed and of ed	
	all Activities of Daily I incontinent of bowel a indicated Resident #6	Living (ADLs) and was and bladder. The MDS 65 was at risk for pressure re ulcers were present on			wound types, measurement and whet or not wounds were coded appropriate in section M of MDS assessment per guidelines. Any negative finding of thi audit was addressed appropriately by	her ely RAI is	

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		MEDICAID SERVICES				OMB NC	
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING	o			С
		345181	B. WING				28/2017
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE / GRE	ENVILLE			WEST 5TH STREET		
				GRE	ENVILLE, NC 27834		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 272	Continued From page	e 13	F 27	72			
					MDS nurse.		
	Review of the clinical	record further revealed			100% audit of all active residents mos	t	
		mitted to the hospital on			ecent minimum data set (MDS)	-	
		nosis of Sepsis (bacteria in			assessments were conducted by the		
		an infection) secondary to			acility s MDS coordinator and MDS		
	Urinary Tract infection	n.			consultant, on 5/17/2017, 5/18/2017,		
					5/19/2017 and 5/20/2017, to ensure		
	-	e reviewed and revealed			accurate coding of section M, per	N	
		mitted to the hospital on nosis of Sepsis (bacteria in			Resident Assessment Instrument (RA guidelines. Any identified issues were	1)	
	the bloodstream caus				addressed at time of discovery.		
		ry Tract Infection. A Skin			Systemic Changes:		
	-	Assessment note dated 3/27/2017 at 4:16 PM			Effective 5/25/2017, the Director of		
	from the Emergency	Department revealed			Nursing revised the skin assessment		
	Resident #65 had a f	luid filled Deep Tissue Injury		s	schedule utilized in the facility. The		
	noted on the left heel				resident s' weekly skin assessments		
	centimeter in length b	by 6 centimeter in width.			schedule will show residents		
					assessments due between the days o		
		ducted on 4/27/2017 at DS nurse. The MDS nurse			Sunday and Thursday, every week. Th vill allow monitoring of completion of	nis	
		ed Resident #65 for his			scheduled assessments by members	of	
		sment and observed a small			nursing administration Monday-Friday		
		ea on his right heel. The			Any identified skin integrity issues	•	
		e documentation in the			pressure ulcers including deep tissue		
		3/6/2017 was an "error			njuries {DTI}) discovered during skin		
		el area was not eschar as			assessments will be reported daily		
		Care Plan. The MDS nurse			Monday-Friday in the morning clinical		
	•	skin assessment was			meeting. The MDS nurse will attend th	ne	
	incorrect.				daily morning meeting and ensure		
		ducted with UM #1 on			accurate coding of MDS per RAI guidelines of any reported skin integrit	-v	
	4/27/2017 at 2:30 PM			-	ssues.	y	
		assessment on Resident			Effective 5/25/17, the MDS nurse will		
		ection Report on 3/8/2017			enter documentation related to the		
	-	ocumented the skin was		p	pressure area including DTI based on		
	intact. UM #1 stated s	she saw a small dark purple			observation and communication with c		
		65's heel on both dates but			icensed and non-licensed staff memb	ers.	
		eel. UM #1 further stated			The MDS nurse will update the		
	since the area was no	ot open she did not consider		n	esident□s' care plan related to skin		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/31/2017 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345181	B. WING				C / <b>28/2017</b>
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE / GRE			25	578 WEST 5TH STREET		
				G	REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 272	it a problem and did r area. UM #1 could no heels were floated or to the right foot. On 4/27/2017 at 4:15 conducted with the A Administrator stated to the MDS assessment	not document it or report the ot recall if Resident #65's if he wore a heel protector FPM an interview was dministrator. The the facility expectation was	F	272	alterations and any preventive measu or assistance devices, such as heel protectors, skin barrier cream, low air mattress or other positioning devices Effective 5/25/2017, the Certified Nur Assistants (CNA) will be responsible inspection and documentation of any identified skin issues on shower/bath sheets, report findings to the charge and document such findings on the shower/bath sheet. Monitoring Effective 5/25/2017 the DON will more the daily shower/bath sheets and rep any pressure area including DTI to the MDS nurse and/or wound nurse durin daily clinical meeting. The charge nu each unit will monitor shower/bath sho on Saturday and Sunday and report a alteration of skin integrity to the DON DON will assure that the weekend che nurses obtains an appropriate order a the care plan is updated by the charge nurse on each unit to accurately reflect the identified skin integrity alteration. monitoring process will take place da 2 weeks, then weekly x 4 weeks ther monthly x 3 months or until the patter compliance is maintained The DON will compile data obtained the daily shower/bath sheets and reconcile her findings with the care p daily (Monday-Friday) during the more meeting. The DON, wound nurse, an Assistant Director of Nursing will aud MDS weekly to assure that residents identified alteration in skin integrity (pressure ulcers, DTI) are accurately	r loss rsing for nurse hitor ort he ng rse of heets any the harge and ge ct This hilly x n rn of from lan, rning d/or it the with	

Event ID: RIQU11

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/31/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345181	B. WING		C 04/28/2017
NAME OF P	ROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 272 F 278 SS=G	483.20(g)-(j) ASSESS ACCURACY/COORD (g) Accuracy of Asses must accurately reflect (h) Coordination A registered nurse mu each assessment with participation of health (i) Certification (1) A registered nurse the assessment is con (2) Each individual wh assessment must sign that portion of the ass (j) Penalty for Falsification	SMENT DINATION/CERTIFIED ssments. The assessment of the resident's status. Ust conduct or coordinate in the appropriate professionals. a must sign and certify that mpleted. no completes a portion of the in and certify the accuracy of sessment.	F 27	<ul> <li>coded in the MDS system. This monitoring process will take place of 2 weeks, then weekly x 4 weeks the monthly x 3 months or until a patter compliance is achieved.</li> <li>Effective 5/25/2107, this practice v occur daily for 4 weeks, weekly for weeks and monthly for 3 months. T DON, ADON and/or charge nurse v report findings from shower/bath sh care plans and MDS monthly durin Quality Assurance Performance Improvement Committee for addition monitoring needs or modifications or requirement. Any negative finding v addressed promptly.</li> </ul>	en rn of vill 4 'he will neets, g the onal of this

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/31/201 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345181	B. WING		C 04/28/2017	
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
	AL HEALTH CARE / GRE			2578 WEST 5TH STREET		
UNIVERSI	AL HEALTH CARE / GRE			GREENVILLE, NC 27834		
(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 DEFICIENCY)	SHOULD BE COMPLETION	
F 278	Continued From page	e 16	F 27	78		
	who willfully and know		. 21			
	.,	I and false statement in a is subject to a civil money han \$1,000 for each				
	and false statement i	ndividual to certify a material n a resident assessment is ey penalty or not more than essment.				
	material and false sta	nent does not constitute a atement. Γ is not met as evidenced				
	facility failed to accur	views and record review, the ately code section M (skin		F278 Immediate Action		
		nimum Data Set (MDS)		Resident 65 is no longer a res		
		t a deep tissue injury (DTI) I which resulted in lack of		building. He was discharged of 3/27/2017.	1	
		ession in the size of the		On 4/28/2017, the MDS nurse	and Unit	
		dents reviewed for Pressure		Manger #1 were in-serviced o		
	Ulcers (Resident #65			importance of documenting ac findings related to alteration in	i skin	
	Findings included:			integrity. UM #1 was also in-se related to recognition of deep	tissue injury	
		led Resident #65 was		as a pressure ulcer by the Adr	ministrator.	
	admitted to the facility			Identification of Others		
		uded Stage 3 Chronic ertension and Diabetes.		Identification of Others: 100% skin audit was initiated	on	
	Nulley Disease, Hyp			5/15/2017 and completed on 5		
	The Care Plan last u	pdated on 12/6/2016 was		by Director of Nursing, Assista		
		Plan revealed a problem of a		of Nursing and unit manager.		
		ers related to impaired		focused on identification of alt		
	mobility with a goal o	f no new areas of skin		skin integrity. Any changes in		
	breakdown through th	he next review.		skin condition of a resident wa		
				thoroughly, reported to the ph		
	I ne Quarterly Minimu	um Data Set (MDS) dated		treatment orders received. The	e	

Facility ID: 923482

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		MEDICAID SERVICES				OMB NO. 0	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SU COMPLET	
						С	
		345181	B. WING			04/28/	/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS,	, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH S GREENVILLE, N			
	CUMMADY CT	ATEMENT OF DEFICIENCIES			OVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 278	Continued From page	e 17	F 27	8			
-		esident #65 was cognitively			parties were also notified o	f	
		e assistance of 1 person for			on in skin integrity.	•	
	-	_iving (ADLs) and was		-	nd assessment were initiated	d l	
	-	and bladder. The MDS			17 and completed on		
		65 was at risk for pressure			of all active residents that		
		re ulcers were present on			side in the facility by the	_	
	assessment.				Nursing, Assistant Director o		
	The Olive Issues at an I			•	d/or the Unit Manager. Thes		
		Report Assessments dated 017 completed by Unit			ts focused on identification of s, measurement and whether	-	
		licated Resident #65's skin			ids were coded appropriatel		
	was intact.				I of MDS assessment per R	-	
		record further revealed			Any negative finding of this		
	Resident #65 was ad	mitted to the hospital on			ddressed appropriately by the		
	3/27/2017 with a diag	nosis of Sepsis (bacteria in		MDS nurse.			
		an infection) secondary to			of all active residents most		
	Urinary Tract infection	n.			mum data set (MDS)		
					ts were conducted by the		
	reviewed and reveale	Department records were		-	IDS coordinator and MDS on 5/17/2017, 5/18/2017,		
		tal on 3/27/2017 with a			and 5/20/2017, to ensure		
		bacteria in the bloodstream			oding of section M, per		
		n) secondary to a Urinary			ssessment Instrument (RAI)		
	-	n Assessment note dated			Any identified issues were		
	3/27/2017 at 4:16 PM	1 from the Emergency		-	at time of discovery.		
	Department revealed	Resident #65 had a fluid		Systemic Cl	hanges:		
		ury (DTI) noted on the left			25/2017, the Director of		
		1 4 centimeters in length by 6		-	rised the skin assessment		
	centimeters in width.				tilized in the facility. The		
	An interview was can	ducted on 4/27/2017 at			weekly skin assessments ill show residents□		
		DS nurse. The MDS nurse			ts due between the days of		
		ed Resident #65 on 3/6/2017			d Thursday, every week. Thi		
	-	assessment. The MDS			onitoring of completion of		
		pleted a skin assessment			assessments by members o	f	
		//////////////////////////////////////		nursing adm	ninistration Monday-Friday.		
		ike area on his heel. The			ed skin integrity issues		
		e documentation of the skin			Icers including deep tissue		
	assessment she ente	ered in the Quarterly MDS		injuries {DT	I}) discovered during skin		

Facility ID: 923482

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	-	ID HUMAN SERVICES MEDICAID SERVICES					INTED: 05/31/2017 FORM APPROVED IB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3	) DATE SURVEY COMPLETED
		345181	B. WING				C 04/28/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE			78 WEST 5TH STREET REENVILLE, NC 27834		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	Nurse further reporte identified suspected I 3/6/2017 physical ass MDS assessment wh The MDS nurse repo assessment informati did not indicate Resic have a suspected DT nurse did not give an inaccuracy. An interview was con 4/27/2017 at 2:30 PM completed a full body #65 for the Skin Inspe and 3/15/2017 at 4:30 PM completed a full body #65 for the Skin Inspe and 3/15/2017 at de intact. UM #1 stated s area on Resident's #4 did not recall which h since the area was no it a problem and did r area. On 4/27/2017 at 4:15 conducted with the A Administrator stated for the MDS assessment	hot accurate. The MDS d Resident #65 had an DTI on the heel during the sessment for the Quarterly ich she failed to document. rted the 3/6/2017 skin ion was inaccurate as she dent #65 was observed to T on 3/6/2017. The MDS explanation for the ducted with UM #1 on 1. UM #1 stated she v assessment on Resident ection Report on 3/8/2017 ocumented the skin was she saw a small dark purple 55's heel on both dates but eel. UM #1 further stated of open she did not consider not document it or report the PM an interview was dministrator. The the facility expectation was	F 2	78	assessments will be reported daily Monday-Friday in the morning clin meeting. The MDS nurse will atter daily morning meeting and ensure accurate coding of MDS per RAI guidelines of any reported skin intri issues. Effective 5/25/17, the MDS nurse enter documentation related to the pressure area including DTI based observation and communication wilicensed and non-licensed staff more The MDS nurse will update the rescare plan related to skin alteration any preventive measures or assist devices, such as heel protectors, as barrier cream, low air loss mattress other positioning devices. Effective 5/25/2017, the Certified I Assistants (CNA) will be responsit inspection and documentation of a identified skin issues on shower/b sheets, report findings to the charg and document such findings on the shower/bath sheet. Monitoring Effective 5/25/2017 the DON will r the daily shower/bath sheets and any pressure area including DTI to MDS nurse and/or wound nurse d daily clinical meeting. The charge each unit will monitor shower/bath on Saturday and Sunday and report alteration of skin integrity to the DD DON will assure that the weekend nurse obtains an appropriate order the care plan is updated by the ch nurse on each unit to accurately re-	ical ind the egrity will d on vith other embers. sident sident sident sis and tance skin so or Nursing ole for any ath ge nurse e monitor report o the uring nurse of o sheets ort any ON. The I charge er and iarge	5 F

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/31/2017 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345181	B. WING		C 04/28/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	AL HEALTH CARE / GRE			2578 WEST 5TH STREET	
UNIVERS	RE HEAEIN CARE / GRE			GREENVILLE, NC 27834	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 278	Continued From page	RE PROVIDED FOR	F 273	the identified skin integrity alteration. monitoring process will take place dai 2 weeks, then weekly x 4 weeks then monthly x 3 months or until the patter compliance is maintained The DON will compile data obtained f the daily shower/bath sheets and reconcile her findings with the care pl daily (Monday-Friday) during the mor meeting. The DON, wound nurse, and Assistant Director of Nursing will audi MDS weekly to assure that residents identified alteration in skin integrity (pressure ulcers, DTI) are accurately coded in the MDS system. This monitoring process will take place dai 2 weeks, then weekly x 4 weeks then monthly x 3 months or until a pattern compliance is achieved. Effective 5/25/2107, this practice will occur daily for 4 weeks, weekly for 4 weeks and monthly for 3 months. The DON, ADON and/or charge nurse will report findings from shower/bath sheet care plans and MDS monthly during to Quality Assurance Performance Improvement Committee for additionation monitoring needs or modifications of requirement. Any negative finding will addressed promptly.	ily x in of from lan, ning d/or it the with ily x of l ets, the al this
0.0	(a)(2) A resident who activities of daily living services to maintain g personal and oral hyg	is unable to carry out g receives the necessary good nutrition, grooming, and			

Facility ID: 923482

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · ·	OMPLETED
						С
		345181	B. WING			04/28/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				2578 WEST 5TH STREET		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		GREENVILLE, NC 27834		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 312	Continued From page	e 20	F 31	2		
	by:			-		
		n, staff interviews and		F312		
	record review, the fac	cility failed to provide oral		Immediate Action:		
		able to do oral care for		Resident #46 was provided w		
		t #46) out of 35 residents		on 4/28/2017, oral care suppl	lies were	
	reviewed for oral state	us.		placed at the bedside.		
	Findings included:			Identification of Others:		
	A maximum of the meadia	al record revealed Desident		100% audit of all active reside		
		al record revealed Resident /30/2016 with diagnoses of		facility completed by the Dire nursing, Assistant Director of		
		n injury and hemiplegia		and/or unit manager on 5/1/2		
	(paralysis on one side			determine if any other resider		
				unable to carry out activities of		
	The care plan, dated	1/16/2017, noted a focus of		receives the necessary service		
		d assistance for all Activities		maintain good oral care is ide		
	of Daily Living (ADLs)	), and a goal of increased		affected by this alleged nonce	ompliance.	
	· ·	be achieved. Interventions		No other resident identified as	s being	
		al Therapy will work with the		affected.		
		aining. Give resident verbal		On 5/1/2017, 100% of resider		
		esident. Break tasks into		unable to do their own oral ca		
		est breaks between tasks.		care was completed by certifi	ed nursing	
	One person to assist	resident with bathing.		aides. Systemic Changes:		
	The Quarterly Minimu	um Data Set (MDS) dated		Effective 5/25/2017, certified	nursina aide	
		ident #46 was severely		will complete oral care for all		
		and needed extensive to		residents unable to carry out		
		ADLs with the physical		daily living, daily during morn		
		wo persons. The range of		refusal of oral care will be rep		
	motion in the MDS in	dicated Resident #46 as		nurse in charge timely.		
		both sides of the upper and		Effective 5/25/17 certified nur	-	
	lower extremities.			assistants will document com		
				oral care in resident⊡s clinica	al records as	
		served on 4/25/2017 at		rendered routinely.	ida ligaraad	
		e slimy appearing substance at #46 did not respond when		100% of nursing staff, to inclu		
	asked if staff cleaned	-		nurses and certified nursing a were in-serviced on the impo		
	asheu ii sidii Uledheu			completing oral care on daily		
	An observation was n	nade on 4/27/2017 at 10:30		resident who are unable to do		
		having a light colored, slimy		own. This education also emp		1

Facility ID: 923482

		MEDICAID SERVICES				NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	ATE SURVEY OMPLETED	
		345181	B. WING			C 04/28/2017	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		04/20/2017	
	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET			
				GREENVILLE, NC 27834			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 312	Continued From page	e 21	F 31	2			
		on her teeth. Resident #46		importance of communication	ting with the		
		and neatly dressed and her		charge nurses if a residen	-		
	hair was combed and	l neat.		care.			
	On 1/28/2017 at 10.0	0 AM an observation was		The education was provide			
		0 AM, an observation was Resident #46. The Nursing		Director of Nursing (DON) Director of Nursing (ADON			
		ive Resident #46 a bed bath		Administrator. The education	,		
		ter care. NA #1 finished this		initiated on 4/28/17 for all	nursing staff to		
		was finished. When asked		include, full time, part time			
		1 stated "I didn't know you		employees. This education			
	wanted to see everyt	•		completed by 5/25/17, any			
		de table, opened the drawer thbrush, toothpaste or oral		not educated by 5/25/17 w allowed to work until educ			
	swabs sometimes us	•		education will also be add			
				process for all new nursing			
		/2017 at 11:20 AM, with NA		5/25/17 and also will be pr	ovided annually.		
		on Resident #46's hall,					
	stated ADL care cons	sisted of a bath, hair and oral		Monitoring Process: Effective 5/25/2017, the c	harde nurses		
				will monitor compliance to			
	On 4/28/2017 at 11:2	5 AM, the Director of		assistance for the activity			
	Nursing (DON) was in	nterviewed and stated her		being provided to each res			
		are was a complete bath		needed. The charge nurse			
		ything else the resident		daily, on the assignment s			
	desired, such as bein	ig snaved.		mouth care is completed. issues related to oral care	-		
				corrected promptly. This m			
				process will take place dai	•		
				weekly for 4 more weeks,	then monthly for		
				3 months, or until the patter	ern of		
				compliance is maintained.	iraatar of		
				Effective 5/25/2017, the D Nursing, Assistant Directo			
				and/or unit managers will	-		
				care supplies at the reside			
				daily for 2 weeks, weekly	for 4 weeks,		
				then monthly for three mon			
				pattern of compliance is a Effective 5/25/2017, the D			

Event ID: RIQU11

Facility ID: 923482

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/31/20 FORM APPROVE OMB NO. 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345181	B. WING		C 04/28/2017		
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834			
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO		
F 312 F 314 SS=G	483.25(b)(1) TREATM PREVENT/HEAL PRI (b) Skin Integrity - (1) Pressure ulcers. comprehensive asses facility must ensure th (i) A resident receives professional standard pressure ulcers and o ulcers unless the indi demonstrates that the (ii) A resident with pre necessary treatment professional standard	MENT/SVCS TO ESSURE SORES Based on the ssment of a resident, the	F 312	Nursing, Assistant Director of Nursi and/or unit managers will monitor a randomly selected residents from d assignments to assure oral care is provided. This monitoring process of take place daily for 4 weeks, then w for 4 weeks, then monthly for 3 mon until the pattern of compliance is maintained. Results of the monitoring process mentioned above will be reported to facility Quality Assurance Performa Improvement Committee by the Dir of Nursing and/or Assistant Directo Nursing monthly x 6 months. The C Committee will recommend any add monitoring needed or modification of these plans as the committee deem appropriate.	5 lifferent being will veekly nths or o the nce rector r of QAPI ditional of		

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 05/31/201 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		SURVEY PLETED C	
		345181	B. WING			28/2017
NAME OF P	ROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	from developing. This REQUIREMENT by: Based on record rev and staff interviews, f comprehensive wour treatment and monito Suspected Deep Tiss heel resulting in wors also failed to assess and delayed treatment was discovered and f a skin assessment fo for pressure ulcers (F Findings included: Record review reveal admitted to the facility diagnoses which inclu- Kidney Disease, Hyp A review of the Care Pressure Ulcer dated #65 required extensive mobility and spent tim almost daily which pu- increased risk for Pre-	T is not met as evidenced iew and responsible party the facility failed to provide a nd assessment, initiate or a newly identified sue Injury (DTI) to the left sening of the DTI. The facility a wound caused by shearing nt for 2 days after the wound failed to thoroughly complete or 1 of 3 residents reviewed Resident #65). led Resident #65 was y on 8/22/2012 with uded Stage 3 Chronic ertension and Diabetes. Area Assessment (CAA) for I 6/10/2016 noted Resident ve assistance for bed ne up in his wheelchair ut Resident #65 at an	F 314	F314: Immediate Action: Resident 65 is no longer a reside building. He was discharged on 3/27/2017. Identification of others: 100% skin audit was initiated on 5/15/2017 and completed on 5/20 by Director of Nursing, Assistant of Nursing and unit manager. Thi focused on identification of altera skin integrity. Any changes in the skin condition of a resident was a thoroughly, reported to the physic treatment orders received. The responsible parties were also not any noted alteration in skin integr 100% wound assessment was ini on, 5/15/2017 and completed on 5/20/2017, for all residents with w who reside in the facility by the D Nursing, Assistant Director of Nur and/or the Unit Manager. These assessments focused on identific wound types, measurement and	D/2017, Director s audit tion in overall issessed cian and ified of ity. itiated vounds irector of rsing eation of	
	updated on 12/6/2014 problem of a risk for l impaired mobility with of skin breakdown the Interventions includer with routine care, floa times and monitor the like area) on right her change noted.	6. The Care Plan revealed a Pressure Ulcers related to in the goals listed as no areas rough the next review. d daily observation of skin at heels on pillows at all e eschar (a dry dark scab el and notify the doctor if any imum Data Set (MDS) dated		or not wound treatment were initia within 24 hours of wound discover negative finding of this audit was addressed appropriately by the n management team. 100% audit of all active resident treatment administration records and medication administration rec (MAR) was completed by Medica Records Clerk on 5/17/17, 5/18/1	ated ery. Any ursing s (TAR), cords	

Event ID: RIQU11

Facility ID: 923482

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TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	i	· · ·	PLETED
						С
		345181	B. WING	· · · · · · · · · · · · · · · · · · ·	04	/28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
	AL HEALTH CARE / GRE	ENVILLE	2578 WEST 5TH STREET			
				GREENVILLE, NC 27834		-1
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 314	Continued From page	e 24	F 31	4		
		e assistance of 1 person for		may have been effected by	/ this alleged	
		_iving (ADLs) and was		deficient practice. Any neg		
		and bladder. The MDS		this audit was addressed a		
		65 was at risk for pressure		the nursing management te	eam.	
	-	re ulcers were present on		Systemic Changes:		
	assessment.			The facility will institute the		
	a) Nuraina notos war	e reviewed from 1/1/2017		measures to ensure that th	0	
		th no entries which reported		deficient practice will not re Effective 5/25/2017, the Di		
	skin issues with Resi			Nursing will revised the ski		
		s for March 2017 were		schedule utilized in facility.		
	-	ed an order to float heels on		weekly skin assessments s		
	pillows at all times an	nd to wear pressure relieving		show resident assessment	s due between	
		t foot at all times. The		the days of Sunday and Th		
		ation Record (MAR) for		week. This will allow monit	-	
		entries for Resident #65 to		completion of scheduled as	•	
	-	ng heel protector to right blocks for the 7 AM-3 PM, 3		members of nursing admin Monday-Friday. Any identif		
		<i>I</i> -7 AM nurse to initial. There		integrity issues (pressure u		
		/1/2017 to 3/26/2017 without		tissue injuries {DTI}) discov		
		o revealed Resident #65 was		skin assessments will be re	-	
	to float heels on pillov	ws at all times with blocks for		Monday thru Friday in the r	•	
	the nurse on each sh	ift to initial. Five of those		meeting. The MDS nurse w	vill attend the	
		itials from 3/1/2017 to		daily morning meeting and		
	3/26/2017.			accurate coding of MDS pe		
	The Chin Increation [	Depart Assessments dated		guidelines of any reported	skin integrity	
		Report Assessments dated 017 completed by Unit		issues. Effective 5/25/2017, a desi	anatod liconsod	
		licated Resident #65's skin		wound nurse will oversee t	•	
	was intact.			program in the facility. The		
		lated 3/27/2017 to send		will be responsible for iden		
		Emergency Department (ED)		staging of wounds and ens		
		creased temperature and		appropriate treatments are		
		was noted in the medical		physician s orders. The li		
	record.			nurse will also ensure that		
		e reviewed and revealed		attending Physician and re		
		mitted to the hospital with a bacteria in the bloodstream		is made aware of resident Effective 5/25/2017, Certifie		
	caused by an infectio			Assistants will be responsil		

Facility ID: 923482

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE	CONSTRUCTION	(X3) DATE	D. 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· /	PLETED
							С
		345181	B. WING			04/	/28/2017
NAME OF P	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE / GRE			25	78 WEST 5TH STREET		
				GF	REENVILLE, NC 27834		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 314	Continued From page	e 25	F 31	14			
		16 PM from the ED revealed			inspection and documentation of any		
		luid filled DTI noted on the			identified skin issues on the shower/ba	ath	
		ured 4 centimeter in length			sheets, report findings to the charge n	urse	
	by 6 centimeter in wi	dth.			and document such findings on the		
	A tolophono intonviou	was conducted with the			shower sheet.	10	
		/ was conducted with the P) of Resident #65 on			Effective 5/25/2017, during shift chang incoming and off going nurses will rev		
		1. The RP was present			treatment administration records (TAR		
		ED visit on 3/27/2017. The			electronic health records by checking		
	RP reported Residen	t #65's heel had a dark			unsigned records tab. This tab will list		
		area and there was an area			residents with treatment orders noted		
		as open. The RP reported			not signed off as rendered. The incom	ing	
		#65 often and did not recall d and did not recall the			nurse will not accept responsibility for resident care until those records are		
	resident had heel pro				rectified and treatment rendered per		
					orders.		
	An interview was con	ducted on 4/27/2017 at 9:25			Effective 5/25/2017, the Director of		
	AM with Nursing Assi				Nursing implemented Resident Care		
	-	5 was on the assignment			Cards as a communication tool to ale	rt	
		#2 stated she was unaware			nurse s aides of any skin protectant	_	
		on Resident #65's heels. NA I socks to Resident #65's			intervention for residents with pressure ulcers or with risk for developing press		
	feet daily after a bath				ulcers.	bure	
		floated sometimes and did			100% of nursing staff, to include licens	sed	
		otector was applied to the			nurses and certified nursing assistants		
		2 also reported she worked			were in-serviced on the importance of		
		3/26/17 and did not recall			completing weekly skin assessments		
	-	eels when he was bathed.			schedule, to ensure that alteration of s		
		dent #65 was discharged to er day shift on 3/27/2017.			integrity is documented, communicate the physician and responsible party ar		
		e night shift when Resident			that appropriate orders are received a		
		to the hospital no longer			rendered. The training also included t		
	worked at the facility	and was unavailable for			use of care cards as a communication		
	interview.				tool. The licensed nurses were in-serv		
	A				on the use of the Care Cards and initia		
		ducted with the MDS nurse			of cards with new admissions and revi	sion	
		5 AM. The MDS nurse ed an assessment on			with treatment changes. The certified nursing assistants were informed on		
		2017 for the quarterly review			where the cards are located and how	ło	

Facility ID: 923482

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		MEDICAID SERVICES					0.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDIN	IG			~
		345181	B. WING				_ 28/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	04/	20/2017
				2578 WEST 5TH STREET			
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		GREENVILLE, NC 27834			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETIC DATE
F 314	Continued From page	e 26	F 3	14			
	and discovered a sm	all dark purple area to his			use the cards.		
		e stated she thought it was			The Director of Nursing (DON), Assista	ant	
		s unable to recall. The MDS			Director of Nursing (ADON) and/or		
		ot eschar as indicated on the			Administrator provided this education.	The	
		formation she added to the			education was initiated on 4/28/17 for a		
		ror oversight". The MDS			nursing staff to include, full time, part ti	me	
		ned the nurse on duty during			and as needed employees. This	_	
	-	of the area observed on			education will be completed by 5/25/17		
		out could not recall the second the features for the stated the resident			any nursing staff not educated by 5/25, will not be allowed to work until educated		
		almost daily and recalled			This education will also be added to ne		
	times the resident's h			hire process for all new nursing staff			
	the heel protector not			effective 5/25/17 and also will be provide	ded		
					annually.		
		ducted with Nurse #4 on			Monitoring Process:		
		M. Nurse #4 stated she was the day shift on 3/6/2017.			Effective 5/25/17, DON, ADON and/or Unit Manager will review the completio	n of	
		ecollection no recollection of			the prior day weekly skin assessment of		
		ted by the MDS nurse.			daily clinical meeting (M-F) for the next		
		ing unaware of any issues			days then weekly for 4 weeks, then		
		on Resident #65's heels.			monthly for 3 months. Results of these		
	Nurse #4 reported sh	e thought the resident's			audits will be presented to the Quality		
	heels were floated ar	nd recalled the resident			Assurance and Performance		
	wearing heel protecto	ors at times.			Improvement committee monthly x 3		
					months for any additional monitoring		
		ducted with Unit Manager			needs or modification of this plan by th		
		7 at 2:30 PM. UM #1 stated			DON. Any negative findings noted will	be	
	she completed a full l	Skin Inspection Report on			addressed promptly. Effective 5/25/2017, the resident Care		
		17 and documented the skin			Cards will be reviewed by the DON,		
		ated she saw a small dark			ADON or MDS nurse daily		
		ent's #65's heel on both			(Monday-Friday), and by the charge nu	ırse	
		all which heel. UM #1 further			(Saturday and Sunday), to assure that		
		was not open she did not			available and accurate. This review wi		
	-	and did not document it or			take place daily (Monday-Friday) for 4		
	-	t1 could not recall if Resident			weeks then weekly for 4 weeks, then		
		ted or if he wore a heel			monthly for 3 months. Any negative		
	protector to the right	foot.			findings noted will be addressed by the		
					DON, ADON and/or MDS nurse. Resul	te	

Facility ID: 923482

If continuation sheet Page 27 of 45

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED
		345181	B. WING		04	C /28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
				2578 WEST 5TH STREET		
UNIVERS	AL HEALTH CARE / GRE			GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 314	Continued From page	e 27	F 31	14		
		ducted with the facility		of these audits will be pre	esented to the	
		on 4/27/2017 at 4:15 PM.		Quality Assurance and P		
	The Adm stated the f	acility followed the Pressure		Improvement committee	monthly x 3	
		vention and Treatment		months for any additiona	•	
		a healthcare consulting firm.		needs or modification of	this plan by the	
		and indicated a head to toe		DON. Effective 5/25/2107, the I		
		to be conducted weekly he overall skin condition of a		Medical Records Clerk a		
		sessed thoroughly, reported		will audit all new admissi		
		tment obtained and family		from the previous day (M		
	notified. The Adm als	so provided documentation		The weekend charge nur	ses will audit	
		reatment Modalities and		new admits on Saturday	-	
	stated the facility follo			audit will be completed d		
		s. The Modalities contained ds, treatments and frequency		weekly for 4 weeks, then months, or until a pattern	-	
	of treatments. The M			maintained. DON will rep	-	
		sue Injury and listed the		facility QAPI Committee		
		le or maroon localized area		monitoring needs or mod		
		r blood filled blister. The		requirement.		
		nent was listed as pressure				
		dressing (a non-breathable				
		ressing). The treatment also ne area daily for worsening				
		. The Adm stated the facility				
		pathway would be followed				
		ent modalities. The Adm				
		nt modality for a Suspected				
		becified the area should be				
	-	nanges. The Adm further				
	-	n was for all skin issues to eekly body assessments				
		iccurately and reported to				
		iately for treatment orders.				
	b) Review of the nurs	ing notes revealed a note				
		:05 AM written by Nurse #5				
	-	arter sized open area was				
		ttock of Resident #65. The				
	note reported barrier.	cream was applied and the				1

Facility ID: 923482

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	-	ID HUMAN SERVICES				FORM	MAPPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· /				PLETED
		345181	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	545161	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	04/	28/2017
					2578 WEST 5TH STREET		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE			GREENVILLE, NC 27834		
(X4) ID			ID				(X5) COMPLETION
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 314	Continued From page	N 20		244			
1 314		ed to the oncoming nurse.	F	314			
		ed a nursing note dated					
		I signed by Unit Manager					
		#1 was notified of an open					
		s right buttock by Nursing					
		e note indicated barrier ne Physician was notified					
	and no new orders we	-					
		nent Administration Record					
		led an order for Barrier					
		o buttocks every shift by					
	3/22/2017.	e order was documented on					
	A review of the Skin I	nspection Report for					
		ne skin status of Resident					
		ne information was entered					
	by UM #2.						
	A Physician's Order d	lated 3/27/2017 to send					
		Emergency Department (ED)					
		creased temperature and					
	altered mental status record.	was noted in the medical					
		ote dated 3/27/2017 at 4:16					
		ncy Department revealed					
		Stage 3 pressure ulcer on the					
		red 1 centimeter in length by					
		and several small areas on ch appeared to be from					
	shearing.	ch appeared to be nom					
	5						
		ducted on 4/27/2017 at 9:25					
		2 reported Resident #65 was					
	-	e worked daily. NA #2 d the open area to Resident					
		ock during bathing on the					
	-	. NA #2 reported it was					
	quarter sized and loo	ked like the skin was just					
	scraped off a little. NA	A #2 stated she covered the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345181	B. WING				C / <b>28/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE			2578 WEST 5TH STREET GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	resident and immedia #4 who was the hall r said she was instructed barrier cream. NA #2 with barrier cream ever resident went to the h she worked with Resi was admitted to the h was still there and loc A telephone interview #5 on 4/27/2016 at 11 she recalled the NA re an area on the lower recalled assessing the area was small and o just the top layer of sk cream. Nurse #5 state noted during the nigh oncoming nurse to fol and the family. Nurse included the skin area nurse and stated som night she may have for down. An interview was con 4/27/2017 at 11:45 Al the nurse for the day Resident #65. Nurse mention of any skin is the night nurse. Nurse the morning of 3/22/2 #1 as soon as it was 1 UM #1 assessed the to apply barrier cream	tely reported to the Nurse hurse on that day. NA #2 ed to cover the area with stated she covered the area ery day after that until the hospital. NA #2 also stated dent #65 the day before he hospital and recalled the area oked the same. was conducted with Nurse 1:10 AM. Nurse #5 indicated eporting Resident #65 had right buttock and also e area. Nurse #5 stated the pen and looked like it was kin so she applied barrier ed if a small skin area is t shift, she will report it to the llow up with the Physician #5 could not recall if she a in report with the oncoming netimes if it was a really busy brodten if she did not write it ducted with Nurse #4 on M. Nurse #4 stated she was shift on 3/20/2017 for #4 reported there was no asues for Resident #65 from e #4 stated she was made Resident #65's buttocks on 017 and reported it to UM reported. Nurse #4 stated wound and wrote the order	F	314			

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PRINTED: 05/31/2017 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 05/31 FORM APPR MB NO. 0938-	OVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345181	B. WING				C 04/28/2017	7
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE / GRE	ENVILLE			78 WEST 5TH STREET REENVILLE, NC 27834			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5 COMPLE DAT	ETION
F 314	being informed of the buttocks. UM #1 furth assessed and was a superficial with no de also stated the wound was about quarter siz Physician was notified cream for treatment. wounds were assess every Tuesday and R for the Wound Physic Resident #65 was ad 3/27/2017. An interview was con 4/27/2017 at 3:00 PM assessed the wound quarter sized open ar no drainage and apped drainage. UM #2 furth the lower right buttoc said she completed th Skin Inspection Repo wound. UM #2 also s the Wound Physician discharged to the hose An interview was con Administrator (Adm) of The Adm stated the fa Ulcer Prediction, Prev Pathway provided by A copy was reviewed skin assessment was and any changes in th resident was to be as to the Physician, trea	I. UM #1 stated she recalled wound on Resident #65's er stated the wound was small open area which was pth and was pink. UM #1 d was not measured but it red. UM #1 recalled the d and agreed with the barrier UM #1 indicated all new ed by the Wound Physician esident #65 was on the list tian on 3/28/2017 but mitted to the hospital on UM #2 stated she on 3/22/2017 and it was a ea to the right buttocks with eared pinkish red with no her stated she only assessed ks of Resident #65. UM #2 he documentation in the rt but did not measure the tated Resident #65 was on list for 3/28/2017 but	F	314				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		ECONSTRUCTION	(X3) DATE	
/			A. BUILDI	NG _			C
		345181	B. WING			04/	28/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE			2578 WEST 5TH STREET GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 314 F 371 SS=D	of Common Wound T stated the facility follo Modalities for wounds descriptions of wound of treatments. The Mo of a Stage 2 wound a dermis (second layer wound bed with the tr polyurethane film dres 3-7 days and as need facility expectation wa followed as well as th Adm further stated the skin issues to be iden assessments and to b reported to the Physic treatment orders. 483.60(i)(1)-(3) FOOE STORE/PREPARE/SI (i)(1) - Procure food fr considered satisfacto authorities. (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming foods (i)(2) - Store, prepare	reatment Modalities and wed the Treatment a. The Modalities contained ds, treatments and frequency odalities included description is a partial thickness loss of of skin) with a red, pink eatment listed as ssing to be changed every led. The Adm stated the as the pathway would be e treatment modalities. The e expectation was for all tified on the weekly body be classified accurately and cian immediately for D PROCURE, ERVE - SANITARY rom sources approved or ry by federal, state or local bod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable		314			5/25/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/31/ FORM APPRC OMB NO. 0938-	OVE	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345181	B. WING		04/28/2017	7	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLE	ETION	
F 371	Continued From page	e 32	F 37	1			
	service safety.						
	foods brought to residuation visitors to ensure safe handling, and consure	egarding use and storage of dents by family and other e and sanitary storage, nption. 「 is not met as evidenced					
	facility failed to remov	of 3 of medication rooms		F371 Immediate Action: On 4/28/2017, 5 cans of vanil supplement dated 2/2/2017 a			
	Findings included:			chocolate supplement dated were discarded by the license Identification of Others:			
	made of the 500 hall behind the 500 hall n	PM an observation was medication room located urses station. Nurse #8 was pservation. Seven cans of		100% audit of completed by the Supply Clerk to identify any or item. No other expired supple identified.	ther expired		
	nutritional supplement beside the refrigerator	nt were observed on a table or. Each can held 237		100% audit of all food storage inspected by dietary Manager	and/or		
	of chocolate supplem	pplement. There were 2 cans pent with the expiration date ans of vanilla supplement the of 2/2/2017.		Central Supply Clerk on 5/5/2 identify any other open item th to be expired. This audit cove supplements located in the m	nat is noted red all edication		
	the Medication room	ducted with Nurse #8 during observation. Nurse #8 supplement were used for		rooms, storage rooms, and fo (100/200 Halls; 300/400 Halls Hall). No other expired items	and 500		
	the residents on the h	nall and were kept in the normalised were kept in the normalised were kept in the normalised were were the stated		Systemic Changes Effective 5/25/2017, Central s	upplies clerk		
	Nurse #8 also stated	e supplements were expired. she was unsure who was king the supplements for		will ensure all supplement pla circulation, in the medication is storage rooms and/or pantries expired. Central supply Clerk	rooms, s are not will verify		
		ducted with the 3/2017 at 2:30 PM. The the facility expectation was		expiration dates upon receipt supplies, and before placing s in circulation. Effective 5/25/2017, Central s	supplements		

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 05/31/2017 DRM APPROVED NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		ATE SURVEY OMPLETED
		345181	B. WING				C 04/28/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		•
UNIVERS	AL HEALTH CARE / GRE	ENVILLE			78 WEST 5TH STREET REENVILLE, NC 27834		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 371	Continued From page for all expired supplet to expiration dates to consumption.	ments to be discarded prior	F 3	571	rotate all supplements places on the medication rooms, storage rooms an Pantries. This will ensure the oldest supplies will be used first. Effective 5/25/2017, a tickler system be used to identify supplements near its expiration date. Red will designate expiration within the next 2 weeks, ywill designate expiration within the next 2 weeks, ywill designate expiration within the next 2 weeks, ywill designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, you will designate expiration within the next 2 weeks, to be a monitoring process will assure no exitem is noted in the storage areas. The monitoring process will be conducted for 2 weeks, then weekly for 4 weeks monthly for 3 months or until the path of compliance id achieved. Effective 5/25/2017, the Dietary Man and/or Central Supplies Clerk will refindings of this monitoring process to facility S Quality Assurance Perform Improvement Committee for any additional monitoring needs or modifications of this requirement mox 6 months, Effective 5/25/2017, the central supple clerk will conduct weekly audits of the supplements in the medications roor process references.	will ring ellow ext ration ply tor in all t not ments pired d daily t then rem ager port o the ance nthly	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/31/2017 MAPPROVED D. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	COMF	ESURVEY PLETED C
		345181	B. WING				28/2017
NAME OF P	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE			778 WEST 5TH STREET REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 371 F 520 SS=G	COMMITTEE-MEMBI QUARTERLY/PLANS (g) Quality assessme (1) A facility must mai and assurance comm minimum of: (i) The director of nur- (ii) The director of nur- (ii) The Medical Direc (iii) At least three othe staff, at least one of w	(i)(ii)(h)(i) QAA ERS/MEET int and assurance. intain a quality assessment ittee consisting at a sing services; tor or his/her designee; er members of the facility's		520	storage rooms and pantries to ensure supplements are rotated and no expire supplement is noted. This monitoring system will also ensure a tickler system used appropriately to identify supplement nearing its expiration date. Any negative finding will be addressed promptly. This monitoring process will be completed of for 2 weeks, weekly for 4 weeks and the monthly for 3 months or until the patter of compliance is maintained. Effective 5/25/17, results of the monito process mentioned above will be report to the facility Quality Assurance Performance Improvement Committee Dietary Manager and/or Central Suppli Clerk monthly for 6 months. The QAPI committee will recommend any additio monitoring needs or modification of the plans as the committee deems appropriate.	n is ents re s laily len rn ted by es hal	5/25/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345181	B. WING	_			C 28/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				2	2578 WEST 5TH STREET		
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		C	GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 500		05					
F 520	· · · · · · · · · · · · · · · · ·		F f	520			
	individual in a leaders	ship role; and					
	(g)(2) The quality ass committee must :	essment and assurance					
	coordinate and evaluation	n respect to which quality					
		ement appropriate plans of tified quality deficiencies;					
	Secretary may not re- records of such comm such disclosure is relation	mation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this					
	by: Based on staff and fa review, the facility Qu Assurance (QAA) Co implemented procedu interventions that the pressure sores (tag F recertification survey investigation of 04/15 recertification survey	and correct quality e used as a basis for is not met as evidenced amily interviews and record tality Assessment and mmittee failed to maintain ures and monitor the committee put into place for '314) following the annual of 08/13/2015, the complaint /2016, the annual of 06/09/2016 and the			F520 Immediate Action: Resident 65 is no longer a resident in 1 building. He was discharged on 3/27/2 Identification of Others: All residents that resides at the facility a potential to be affected by this allege deficient practice. On 4/28/2017, the MDS nurse and Uni	017 has ed	
	the facility failed to m	survey of 04/24/2017. Also aintain implemented tor the interventions put into			Manger #1 were in-serviced on the importance of documenting accurate findings related to alteration in skin		

Event ID: RIQU11

Facility ID: 923482

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TATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MILLET		CONSTRUCTION	(¥3) 04	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				<b>I</b> ` /	MPLETED
			A BOILDING	<u> </u>			С
		345181	B. WING			0	4/28/2017
NAME OF PF	OVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				25	578 WEST 5TH STREET		
UNIVERSA	L HEALTH CARE / GRE	ENVILLE		G	REENVILLE, NC 27834		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 520	Continued From page	e 36	F 52	20			
1 020		of the responsible party and	F 52	20	integrity. UM #1 was also in-serviced		
	physician (tag 157) d				related to recognition of deep tissue inj	iurv	
		of 06/09/2016 and the			as a pressure ulcer by the Administrate		
		survey of 04/24/2017. The			100% skin audit was initiated on		
	re-citation of F314 ar			5/15/2017 and completed on 5/20/2013	7,		
	of federal survey hist			by Director of Nursing, Assistant Direct			
	facility's inability to su	ustain an effective QAA			of Nursing and unit manager. This aud		
	program.				focused on identification of alteration ir		
					skin integrity. Any changes in the overa		
	Findings included:				skin condition of a resident was assess		
	This tax is succe usfo			thoroughly, reported to the physician a	nd		
	This tag is cross-refe			treatment orders received. The	-f		
	1. F314 Pressure Uld			responsible parties were also notified of any noted alteration in skin integrity.	ונ		
	and staff interviews,			100% wound assessment was initiated	4		
		nd assessment, initiate			on, 5/15/2017 and completed on	•	
	treatment and monito				5/20/2017 of all active residents with		
		sue Injury (DTI) to the left			wounds that currently reside in the faci	ility	
	heel resulting in wors	sening of the DTI. The facility			by the Director of Nursing, Assistant		
		a wound caused by shearing			Director of Nursing and/or the Unit		
		nt for 2 days after the wound			Manager. These assessments focused	l on	
		failed to thoroughly complete			identification of wound types,		
		or 1 or 3 residents reviewed			measurement and whether or not would		
	for pressure ulcers (F			treatment were initiated within 24 hours			
	Review of the facility	's survey history revealed			wound discovery. Any negative finding this audit was addressed appropriately		
		g the facility's 08/13/2015			the nursing management team.	by	
		survey, during a 04/15/2016			100% audit of all active resident s		
		on, during the 06/09/2016			treatment administration records (TAR	),	
		survey and was re-cited			and medication administration records	-	
	during the current 04	/24/2017 annual			(MAR) was completed by Medical		
	recertification/ compl	aint survey.			Records Clerk on 5/17/17, 5/18/17 and		
					5/19/17 to identify any other resident th		
		anges: Based on record			may have been effected by this alleged		
		family interviews, the facility			deficient practice. Any negative finding		
		esponsible Party of two newly			this audit was addressed appropriately	ру	
	identified wounds and	d falled to notify the			the nursing management team. 100% audit of all active resident⊡s		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/31/201 FORM APPROVED OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345181	B. WING		04/28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	AL HEALTH CARE / GRE	ENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION
F 520	change (Resident #6 Review of the facility' F157 was cited durin annual recertification the current 04/24/201 recertification/compla In an interview on 04 Administrator acknow reciting of F314 and I	5). s survey history revealed g the facility's 06/09/2016 survey and re-cited during I7 annual iint survey. /28/2017 at 05:13 pm, the vledged understanding of the	F 52	<ul> <li>documentation, physician orders resident s assessments completed 5/20/2017 by the Administrator, Nursing and/or Medical Record 0 ensure that notification of changed done appropriately for all other main Any condition that warranted not to resident s responsible party a attending physician was corrected discovery promptly by the charged or director of nursing.</li> <li>100% skin audit was initiated on 5/15/2017 and completed on 5/2 by Director of Nursing, Assistant of Nursing, and charge nurse. The focus on identification of any skin alteration and whether or not rese attending physician and respons were notified. Any noted alteration condition was reported to both a physician and responsible party.</li> <li>Systemic Changes: The facility will institute the follow measures to ensure that alleged practice will not recur; The facility will diligently follow the and procedures of the quality as process to prevent a deficiency for recurring.</li> <li>On 5/19/2017, the Clinical Regice Consultant will conduct in-service with the Administrator and Direct Nursing regarding the QAPI proof education will include how to ide quality deficiencies specifically s management program and notificed and process to prevent and process to prevent and process to prevent and process to prevent a deficiency for education will include how to ide quality deficiencies specifically s</li> </ul>	ving deficient ving deficient he policies surance from and e training tor of cess. The ntify kin care

Event ID: RIQU11

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/31/2017 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			PLETED	
		345181	B. WING				C 1 <b>28/2017</b>
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	
	AL HEALTH CARE / GRE	:EN//II   E		257	78 WEST 5TH STREET		
	RE HEALTH CARE / GRE			GR	EENVILLE, NC 27834		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	e 38	F 52		DEFICIENCY) change of physician and responsible parties. Effective 5/25/2017, the 24 hour char of condition report sheet will be utilize licensed nurses on duty to record any alteration in resident s status during scheduled shift. Licensed nurses will notify attending physician and respon party on the following areas; an accid involving the resident, a significant ch in resident condition, (such as noted alteration in skin integrity and/or deterioration of existing wound) a nee alter treatment (such as new wound of orders) decision to transfer or dischar resident from the facility and/or any resident is room changes. Effective 5/25/2017, the notification of changes tool will be utilized by licens nurses on duty to record any resident significant change of condition and en that the attending physician and responsible party were notified timely 100% of licensed nursing staff were in-serviced on the importance of time notification of resident is change of condition to physician and responsibl party. The Director of Nursing (DON) Assistant Director of Nursing (ADON) and/or Administrator provided this education. The education was initiate 4/28/17 for all licensed nursing staff t include, full time, part time and as ne employees. This education will be completed by 5/25/17, any licensed nursing staff not educated by 5/25/17	ed by their hsible lent hange ed to care rge a f ed t with hsure r. ly e , ) ed on o eded	
					not be allowed to work until educated This education will also be added to r hire process for all new licensed nurs	new	

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CENTER	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345181	B. WING		C 04/28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	AL HEALTH CARE / GRE			2578 WEST 5TH STREET	
UNIVERS	AL HEALTH CARE / GRE	EENVILLE		GREENVILLE, NC 27834	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC
F 520	Continued From pag	e 39	F 52	20 staff effective 5/25/17 and also provided annually. Effective 5/25/2017, the Directo Nursing will revised the skin as schedule utilized in facility. Res weekly skin assessments sche show resident assessments du the days of Sunday and Thurso week. This will allow monitoring completion of scheduled asses members of nursing administra Monday-Friday. Any identified s integrity issues (pressure ulcers tissue injuries {DTI}) discovered skin assessments will be report Monday thru Friday in the morr meeting. The MDS nurse will a daily morning meeting and ens accurate coding of MDS per R/ guidelines of any reported skin issues. Effective 5/25/2017, a designat wound nurse will oversee the w program in the facility. The wou will be responsible for identifica staging of wounds and ensure appropriate treatments are initia physician □s orders. The licens nurse will also ensure that eact attending Physician and respor is made aware of resident □s w Effective 5/25/2017, Certified N Assistants will be responsible for inspection and documentation o identified skin issues on the shu sheets, report findings to the ch and document such findings or shower sheet. Effective 5/25/2017, during shift	br of sessment sident⊡s dule will e between day, every g of sments by tion skin s, deep d during ted daily ning clinical ttend the ure Al integrity ted licensed vound und nurse ation and that ated per sed wound n resident nsible party ounds. lursing or of any ower/bath narge nurse

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/31/2017 FORM APPROVED OMB NO. 0938-0391
-	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345181	B. WING		04/28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	NIVERSAL HEALTH CARE / GREENVILLE			2578 WEST 5TH STREET	
				GREENVILLE, NC 27834	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
F 520	Continued From page	e 40	F 52	0 incoming and off going nurses treatment administration recorn electronic health records by chunsigned records tab. This tab residents with treatment orders not signed off as rendered. The nurse will not accept responsit resident care until those record rectified and treatment renders orders. Effective 5/25/2017, the Direct Nursing implemented Resider Cards as a communication to nurse s aides of any skin prodintervention for residents with ulcers or with risk for developinulcers. 100% of nursing staff, to include nurses and certified nursing as were in-serviced on the import completing weekly skin assess schedule, to ensure that alteratintegrity is documented, comm the physician and responsible that appropriate orders are recorrendered. The training also in use of care cards as a commut tool. The licensed nurses were on the use of the Care Cards as of cards with new admissions with treatment changes. The conursing assistants were inform where the cards are located at use the cards. The Director of Nursing (DON) Director of Nursing (ADON) ar Administrator provided this education was initiated on 4/20 nursing staff to include, full times and control of the set of the care cards are located and the cards. The Director of Nursing (DON) ar Administrator provided this education was initiated on 4/20 nursing staff to include, full times and the cards.	ds (TAR) in hecking my b will list all s noted as he incoming bility for ds are ed per tor of ht Care ol to alert tectant pressure ng pressure de licensed ssistants tance of sments per ation of skin hunicated to party and ceived and cluded the inication e in-serviced and initiation and revision certified hed on nd how to b), Assistant hd/or ucation. The 8/17 for all

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		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/31/2017 MAPPROVED O. 0938-0391
-	EMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING		(X3) DAT	E SURVEY PLETED C		
		345181	B. WING		_ 04	./28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST		
UNIVERS	UNIVERSAL HEALTH CARE / GREENVILLE			2578 WEST 5TH STREET		
	-			GREENVILLE, NC 2783	4	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page	e 41	F 5	and as needed em- education will be co- any nursing staff no- will not be allowed This education will hire process for all effective 5/25/17 ar annually. Monitoring Process The Administrator ar will meet weekly to related to notification wound managemen Administrator and IC compile finding of co- notification of char bath/shower sheet, condition sheet rep and MDS accuracy will be reviewed for weekly audits will be monthly Quality Ass Improvement Comm process will continu- monthly for 4 mont Effective 5/25/17, IC Unit Manager will re- the prior day s we during daily clinical next 30 days then we then monthly for 3 of these audits will be Quality Assurance Improvement Comm months for any add needs or modificati	S: and Director of Nursing review daily audits on of change and nt program. The Director of Nursing will daily and weekly audits, ange audit tool, , and 24 hour change of ports, care plan audits r modification. The De reported during the surance Performance mittee meetings. This ue weekly for 4 weeks, hs. DON, ADON and/or review the completion of pekly skin assessment I meetings (M-F) for the weekly for 4 weeks, months. Results of a presented to the Performance mittee monthly x 3 ditional monitoring ion of this plan by the e findings noted will be	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
	CONTECTION	DENTRICATION NOWDER.	A. BUILDING	i	C
		345181	B. WING		04/28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E
UNIVERS	AL HEALTH CARE / GRI	EENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETI
F 520	Continued From pag	je 42	F 52	Effective 5/25/2017, the resider Cards will be reviewed by the ADON or MDS nurse daily (Monday-Friday), and by the w manager on duty or on call nur (Saturday and Sunday), to ass available and accurate. This r take place daily (Monday-Frida weeks then weekly for 4 week monthly for 3 months. Any neg findings noted will be addresse DON, ADON and/or MDS nurs of these audits will be presente Quality Assurance and Perforr Improvement committee month months for any additional mon needs or modification of this p DON. Effective 5/25/2107, the DON, Medical Records Clerk and/or will audit all new admissions C from the previous day (Monda The weekend manager on dut nurses will audit new admits o and Sunday. This audit will be daily for 4 weeks, weekly for 4 then monthly for 3 months, or pattern of compliance is maint DON will report findings to faci additional monitoring needs or modifications of this requireme Effective 5/25/2017 the Director Nursing, Assistant Director of I and/or Unit manager will revier hour change of condition repoi daily during morning clinical m (Monday-Friday) to assure tha of change is conducted approp the corresponding documental	DON, veek-end rse sure that it is eview will ay) for 4 s, then gative ed by the se. Results ed to the mance hly x 3 itoring lan by the ADON, MDS nurse care Cards y-Friday). y or charge n Saturday completed weeks, until the ained. ility QAPI for ent. or of Nursing w the 24 rt sheet eeting t notification priately with

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STATEMENT (	S FOR MEDICARE &	CTION IDENTIFICATION NUMBER: A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C	
		345181	B. WING _		04/28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	•
UNIVERS	AL HEALTH CARE / GR	EENVILLE		2578 WEST 5TH STREET GREENVILLE, NC 27834	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCEE	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETIO D TO THE APPROPRIATE DATE CIENCY)
F 520	Continued From page	ge 43	F 5	520 resident s medical react this review will to assur- in condition is commun- physician and respons warranted. This monitor continued by the charg Saturday and Sunday. process will be conduct then weekly x 4 weeks afterwards, or until the compliance is achieved Effective 5/25/2017 the Nursing, Assistant Dire and/or Unit manager w notification of changes morning clinical meetir to assure that notificati conducted appropriate corresponding docume resident s medical reac this review will to assur- in condition is commun- physician and respons warranted. This monitor continued by the charg Saturday and Sunday. process will be conduct then weekly x 4 weeks afterwards, or until the compliance is achieved Results of the monitori mentioned above will b facility Quality Assurant Improvement committee Nursing, Assistant Dire and/or Unit manager m The QAPI committee w additional monitoring m modification of these p	re that any changes hicated to the ible party as oring process will be jes nurses on This monitoring ted daily x 4 weeks a, then monthly pattern of d. a Director of bettor of Nursing will review log daily during ng (Monday-Friday) on of change is ly with the entation in each cords. In addition re that any changes hicated to the ible party as oring process will be ges nurses on This monitoring ted daily x 4 weeks a, then monthly pattern of d. ng process be reported to the he performance be by Director of ector of Nursing nonthly x 6 months. will recommend any needs or

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/31/2017 APPROVED . 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		345181	B. WING	07/20/20				
NAME OF PI	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	UNIVERSAL HEALTH CARE / GREENVILLE							
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	G	REENVILLE, NC 27834 PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 520	Continued From page	: 44	F	520	committee deems appropriate.			

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