	-	ID HUMAN SERVICES			FOF	RM APPROVED
		MEDICAID SERVICES				IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY
			A. BUILDING	G		
		345523	B. WING		4	C 2/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	14	2/06/2016
				7166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		RAMSEUR, NC 27316		
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	00		
	survey was conducte	complaint investigation d on 12/2/18 through eopardy was identified at:				
	CFR 483.12 at tag F J	600 at a scope and severity				
	-	689 at a scope and severity				
	Tags F 600 and F 689 Quality of Care	9 constituted Substandard				
	Immediate jeopardy to removed on 12/6/18.	began on 6/2/18 and was				
E 600	An extended survey v Free from Abuse and		F 60	20		12/21/18
SS=J		Neglect				12/2 1/ 10
	Exploitation	m Abuse, Neglect, and right to be free from abuse.				
	neglect, misappropria and exploitation as do includes but is not lim corporal punishment,	ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to				
	§483.12(a) The facilit	y must-				
	physical abuse, corpo involuntary seclusion This REQUIREMENT					
	by: Based on record rev	iew and interviews with the		This plan of correction constitute	s a	
LABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					12/27/2018

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.

			0/00 1000			MB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
			A. BUILDIN	G		С
		345523	B. WING			-
	ROVIDER OR SUPPLIER	0.0020			CITY, STATE, ZIP CODE	12/06/2018
				7166 JORDON ROA	, ,	
UNIVERS	AL HEALTH CARE/RAMS	SEUR		RAMSEUR, NC 2		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PRC	VIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX		CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIC
F 600	Continued From page	e 1	F 6	00		
		T), physician, and staff, the			ation of compliance.	
		le the necessary care and		•	and submission of this plan of	of
		ed by the ST and ordered by			pes not constitute an	
		ecting to provide supervision		admission or	r agreement by the provider o	of
		wing precautions during		the truth of th	he facts alleged or the	
	meal time for a reside	ent at risk for aspiration for 1			of the conclusion set forth on	
	of 3 residents reviewe	•			nt of deficiencies. This plan o	of
		nt #89 was observed by			prepared and submitted	
	-	outh full of food making a			ise of requirement under stat	e
	vomiting noise after n				law, and to demonstrate the	
	transferred to the Em				tempts by the provider to	
	ambulance on the wa	Services and died in the		each resider	mprove the quality of life of	
		ly to the hospital.		Cacillesider	п.	
	Immediate Jeopardy	began on 6/2/18 at				
	approximately 1:30 P	M when Nursing Assistant		F 600		
	#1 observed Residen	t #89 making a vomiting		Based on the	e root cause analysis by the	
		unch meal that she had			nistrative staff and the facility	
		om. She was assessed by			lursing, facility staff did not	
	nursing staff to have			· ·	ct supervision for resident #8	9
	-	estimated at 4 ounces, in		during meal.		
	-	cy Medical Services (EMS)				
	were contacted by fac			Immediate		
		chief complaint of "choking".			at approvimately 1:20pm	
		route to the hospital with into cardiac arrest and			at approximately 1:30pm, s escorted from the dining	
		d was pronounced dead on			as noted making a vomiting	
		he cause of death was			Certified Nursing Assistant	
		cclusion of airway by bolus			took the resident to the	
		food and saliva) of food.		-	on where the nurse assessed	l t
	,	,			ing difficulty swallowing and	
	Immediate Jeopardy	was removed on 12/6/18			ns of aspiration with audible	
		ided and implemented an			The nurse attempted to	
		Illegation of Immediate		-	I particles from resident's	
		he facility remains out of			as unsuccessful in removing	
		r scope and severity of "D"			cles and therefore dentures	
	(isolated and no harm	n with the potential for more			ed to perform a mouth sweep	
	than minimal harm th				process the resident continue	d
	jeopardy) to ensure n	nonitoring systems put in		to try to chev	w and swallow. At this time	

Facility ID: 991059

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	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED D. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	COM	E SURVEY PLETED
		345523	B. WING				C / 06/2018
NAME OF PRO	OVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7'	166 JORDON ROAD		
UNIVERSA	L HEALTH CARE/RAMS	SEOR		R	AMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETION DATE
F 600	Continued From page	22	F	500			
	place are effective.	,		000	regident's line became evenetic and		
	place ale ellective.				resident's lips became cyanotic and showing signs of difficulty breathing s	o the	
					Heimlich maneuver was initiated by th		
	The findings included	:			nurse without success. Resident		
					remained conscious and was moving	air.	
		mitted to the facility on			The resident was taken from the nurs		
		es that included dysphagia			station to her room in wheelchair by th		
		following cerebral infarction, y to understand or express			Nurse supervisor, Nurse and Certified Nursing Assistant. Nurse supervisor	1	
		paralysis of one side of the			suctioned resident to attempt to remo	Ve	
	body) affecting right c				remaining food particles unsuccessful		
	Alzheimer's disease.				Resident's oxygen saturation was 79	,	
					percent, oxygen at 5 liters was applied	d via	
		ated 4/17/17 indicated the			non-rebreather face mask. Physician		
		dietary order recommended			Assistant and Responsible Party were	e	
	by Speech Therapist				notified at 1:40pm. The Physician		
		39, "needs [one on one] room supervision to cue			Assistant stated to call Emergency Management Services. Emergency		
	[resident] to take sma	-			Services was called at 1:45pm and		
		s, and to alternate solids			arrived at 2:00pm. First Responders t	ook	
		/17/17 order remained in			over care of the resident. Facility Nu		
		remainder of Resident #89's			staff remained in room for support. F		
!	stay at the facility.				Responders applied oxygen with their		
					regulator at fifteen liters per minute.		
		ation Risk Assessment dated			2:10pm, the Emergency Managemen	t	
		dent #89 had severely			Technicians (EMT) arrived. They	oility	
		king, she was rarely/never had impairment on one side			discussed with first responders and fa staff resident's condition and decision	-	
		es. She was assessed as			suction resident in ambulance. First	.0	
		r assistance with eating.			Responders and Emergency		
		ted to have no swallowing			Management Technicians assisted the	е	
	disorders.	_			resident to the hall in her wheelchair,		
					placed her on the gurney and proceed		
		of care indicated she needed			to the ambulance. The EMTs remain		
	-	al status and weight status			the ambulance for a few minutes and	left	
	related to a diagnosis				the facility at 2:15pm. At 2:48pm the		
		This care plan, initiated on ently reviewed/revised on			EMTs called to get next of kin contact information and informed the staff that		
		ions included, in part:			resident had died prior to reaching the		

Facility ID: 991059

If continuation sheet Page 3 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/03/2019 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
		345523	B. WING			12	C 2/06/2018
NAME OF P	ROVIDER OR SUPPLIER	L		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	SEUR			66 JORDON ROAD MSEUR, NC 27316		
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	 Provide Resident #8 ensure optimal and s Remind Resident #8 precautions. The quarterly Minimu assessment dated 5// #89's cognition was s short-term and long-t severely impaired der was assessed as req assistance of 1 for ea mechanically altered disorders. Resident # Therapy during this M Resident #89's Nursii (care guide), undated she required one to c dining room supervision A review of the NA dor #89's eating assistant - 8 meals were docur no set up 8 meals were docur set up only 10 meals were docur assistance of 1 28 meals were docur assistance of 1 	39 with assist at meals to afe oral intake. 39 of swallowing m Data Set (MDS) 9/18 indicated Resident severely impaired. She had erm memory problems and cision making. Resident #89 uiring the extensive ating. She was on a diet and had no swallowing 489 had not received Speech 4DS period. mg Assistant (NA) Kardex 4, indicated Resident #89 one (1:1) supervision or ion. boumentation of Resident ce for May 2018 indicated: mented as supervision with umented as limited ented as extensive umented as dependent of 1 boumentation of Resident ce for 6/1/18 through 6/2/18 e documented with 1 noted	F 6		hospital. On 6/2/18 an investigation initiated immediately by the Director Nursing and the Administrator and statements received from staff pres- the dining room, at the nurse's staft the conclusion of the investigation determined that the Certified Nursi Assistance was at the table providi assistance to another resident. Acc to the Certified nursing assistant's statement she followed aspiration precautions by setting up her tray, chicken was in small pieces and sa eating while helping another reside During the facility investigation, the did not state or document in her sta that she did not provide supervision Identification A 100% audit of Residents diagnos conducted by Director of Nursing (Staff Development Coordinator (SI Assistant Director of Nursing (ADC Unit Manager (UM) and Director of Rehabilitation (DOR) for diagnosis Dysphagia and Aphasia on 12/5/18 43 were identified with diagnosis o Dysphagia or Aphasia, 26 were ide with recommendations with swallow guidelines. An information sheet, Swallowing Guidelines sheet, was implemented on 12/6/18 with currer recommendations for those 26 ider with swallowing guidelines requirin supervision. The Swallowing Guide sheets (name, room number, diet, recommendation from physician ar speech therapist) are located in an	or of sent in iton. At it was ng ng cording the aw her ent. e C.N.A. atement n. sis was DON), DC), NN), of 3 and f entified wing nt ntified g elines and nd	

Event ID: BQIO11

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/03/20 FORM APPROVI OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345523	B. WING		C 12/06/2018
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODI	
	AL HEALTH CARE/RAM	SEUR	7	166 JORDON ROAD	
		520K	F	RAMSEUR, NC 27316	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO
F 600	Continued From page	e 4	F 600		
F 600	An incident report da Nurse #1 indicated R of "substance ingesti The incident was initi narrative of the incide [Resident #89] out of station, stating ' I thi Nurse assessment co oral cavity. Another some food particles f There was a large ar and [Nurse #2] contir longer visible. As [R wheeze, Heimlich ma resident. Mouth chere noted." Resident #89 noted as temperature 28, blood pressure (E 0. The physician wa immediate actions ta sweep, Heimlich, VS and Emergency Med	documented, and it was stance of 1 ted 6/2/18 completed by tesident #89 had an incident on" on 6/2/18 at 1:30 PM. ally reported by NA #1. The ent read, "[NA #1] brought dining room to nurses nk she needs some help '. completed with food noted in nurse [Nurse #2] removed from mouth and dentures. nount of well ground food nued to remove food until no esident #89] began to aneuver was performed on ck repeatedly with no food 9's vital signs (VS) were e 95.7, pulse 75, respirations B/P) 100/70, and pain scale s notified at 1:40 PM. The ken were noted as a mouth , oxygen (O2), 911 called, ical Services (EMS)	F 600	aspiration precaution binder lo each dining room and each re kiosk. The swallowing guidelir and the kiosk are reconciled b Assistant Director of Nurses a are updated when indicated b physician or speech therapist. residents with diagnosis of Dy Aphasia care plans were revie Assistant Director of Nursing v revisions required. CNAs will I to residents identified requiring aspiration precautions by the nurse at the beginning each s Training of licensed and certific provided by SDC and DON or aspiration precautions and res initiated on 12/6/18. All license certified nursing staff will rece training will be included in new and certified nursing staff orie process. Systemic Measures put in place to ensu	esident care ne sheets by the and changes y the . All 43 rsphagia and ewed by the with no be assigned g cueing and charge hift. ied staff in cueing and sponsibilities ed and ive this shift. This v licensed intation
	transported Resident	#89. The immediate indicated Resident #89 was		of correction is effective and re compliance are: On 12/5/18 a	emains in
	sent to the Emergend			implementation of a dining roc sign-in sheet to include sign ir	om staff
	#1 indicated the follo "1:30 PM - [Resident hallway by [NA #1] o	6/2/18 completed by Nurse wing: #89] was brought into ut of the dining room and choking. Upon assessment		out times as well as aspiration and supervision to be provided information is located in a bind dining room and resident care Management, Licensed Nursin	n precaution d. This der in each e kiosk.
	[Resident #89] had a trying to chew and sw resident to spit out fo	mouth full of food and was vallow the food. Encouraged od and resident refused to eeth together while still trying		Department Head will monitor supervision, utilizing Dining St Manager Observation sheet. S is being provided to ensure as	r meal upervision Supervision

Facility ID: 991059

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/03/201 MAPPROVE D. 0938-039
TATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345523	B. WING			C / 06/2018
NAME OF PF	OVIDER OR SUPPLIER	•	· ·	STREET ADDRESS, CITY, STATE, ZIP COL	DE	
UNIVERSA	L HEALTH CARE/RAM	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
(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 ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	the Heimlich maneuw remove dentures and of food in mouth and well as food stuck to #89] began to have a oxygen saturation wa rate 75, respirations 2 [(bluish discoloration circulation)]. [Reside oxygen applied at 5 [1:40 PM - Notified [P [Responsible Party] of to send to ER. 1:45 I transport services. 2 oxygen saturation is [respirations] 32, B/P transported [Residen A physician's order d indicated "send to ER request and [physicia A Resident Transfer I completed by Nurses was transferred to a I for the transfer was n eating chicken". The EMS record date record indicated the f The chief complaint f "choking". While EM facility the first respon-	At this time writer attempted er with no results. Able to a resident had large amount pockets of food in cheek as the top denture. [Resident nudible wheezing noted, as 79% on [room air], heart 28, lips were cyanotic indicating poor oxygen ent #89] taken to room and liters per minute] via mask. hysician's Assistant] and of incident. New order given PM - Called EMS for :00 PM - EMS arrived - VS 79%, [heart rate] 104, 100/70. 2:15 pm EMS t #89] to ER at this time". ated 6/2/18 for Resident #89 R for evaluation per family m]". Form dated 6/2/18 #1 indicated Resident #89 ocal hospital. The reason toted to be "choking while ed 6/2/18 was reviewed. The following: or Resident #89 was 1S were en-route to the nders on scene advised vas "condition red" (critical) on. The first responders	F 600		followed oms and for ms. The n managers e resident site licensed tment heads information utions and on to ensure eing followed. a binder in nt care kiosk. neuver with oper use of ted as well. by the elopment ed staff and ined prior to cy equipment d 12/5/18 in completed o Licensed B education C for nursing being nsure afety is being fied Nursing the signs and ective facility abuse ed for all staff on was pment	

Facility ID: 991059

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		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY
						С
		345523	B. WING	·····	1	2/06/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
UNIVERS	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 600	Continued From page	2 6	F 60	00		
1 000		all they could from Resident	F 00	providing supervision d	uring meals to	
		at. Resident #89 was		ensure aspiration preca	-	
		air to EMS stretcher and		is added to all new emp		
		ity onto the transport.		This education will also	•	
		to the ER Resident #89 was		annually by SDC for all	staff. CNAs will be	
	examined and was for	ound to have chicken in her		assigned to residents in		
		n was removed. Resident		cueing and aspiration p	-	
		vith decreased respiratory		charge nurse at the beg		
		te was decreasing into an		Training of licensed and		
	extremely bradycardi	utes prior to arrival at the ER		provided by SDC and D aspiration precautions a	-	
		ted with cardiac arrest and		initiated on 12/6/18. All		
		valid Do Not Resuscitate		certified nursing staff w		
		vith the resident and no		training prior to working		
		vere made. Resident #89's		training will be included		
	death was pronounce	ed on 6/2/18 at 2:29 PM.		and certified nursing sta	aff orientation	
		R the physician advised that		process.		
		xpired prior arrival that she				
		to the morgue. Resident		Monitoring		
		contacted, and he advised		Effective 12/6/18, The I		
		un-natural death" it needed		Assistant Director of Nu	-	
	to be a Medical Exam	nsported to the morgue and		Development Coordina Management, Licensed		
	was to be examined l			Department Head will n	•	
				supervision, utilizing Di		
	A death certificate, si	gned by the Medical		Manager Observation s		
		indicated Resident #89		is being provided to ens		
		ball-like mixture of food and		safety precautions are I	being followed	
		he facility resulting in an		during meals in the dini	-	
		5/2/18 with the immediate		residents that eat in the		
		isphyxia - occlusion of		mentioned above will be	•	
	airway by bolus of foo	Ju .		meal for supervision uti	-	
	A phone interview wa	is conducted with ST #1 on		Assignment calendar. T Nursing will assign mar		
		ST #1 indicated she no		rooms to include reside		
		facility and she was unable		monitoring process will		
	-	about Resident #89 without		the Charge nurses on S		
	reviewing the speech			Sunday. This monitori	-	

Facility ID: 991059

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE	PLE CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		IPLETED
						С
		345523	B. WING	<u>-</u>	12	2/06/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
JNIVERSA	L HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
				-		
(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 / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 7	F 60	00		
		lietary order for Resident		weekly x4, then monthly	thereafter.	
	#89 were reviewed with ST #1. The speech			Findings will be reported		
		dated 3/28/17 completed by		Nursing in the monthly C	Quality Assurance	
		ch therapy was necessary		and Performance Improv		
		to dysphagia and aphasia.		committee meeting for re		
		dated 4/17/17 indicated a		or modifications until a p		
	dietary order recomm	[one on one] supervision or		compliance is achieved. Effective 12/6/18 the fac		
		ion to cue [resident] to take		Director and the Director		
		and swallow between bites,		be ultimately responsible	-	
		s [and] liquids". Resident		implementation of this p		
		y discharge instructions		to ensure the facility atta		
		eted by ST #1 indicated		substantial compliance.		
	aspiration precaution	s were to be continued with		Compliance Date 12/21/	/18	
		ensatory strategies for				
		strategies to maximize				
		#1 was asked about her				
		to meal supervision for tated that if Resident #89 ate				
	in her room that 1:1 s					
		ted if Resident #89 ate in the				
	•	ected a staff member to be in				
		for the staff member to				
	provide compensator	y strategy cues/aspiration				
	-	e resident throughout the				
		that these cues included				
	reminders to take sitt					
		nall sips, taking small bites,				
	swallow her food.	olids and liquids, and to				
		hedule, the assignment				
		rview with the Director of				
	-	t 8:20 AM the NAs that were				
		e dining room during lunch				
		1, NA #2, and NA #3. The				
	DON reported that N/ Resident #89 at the ti	me of the incident. The				
	INCOLUCI #09 dl li le li	me or me incluent. The	1			1

Facility ID: 991059

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/03/2019 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			LETED
		345523	B. WING		_		C 06/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			7	166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAMS	EUR	F	RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	the time of the incider A written statement (ii completed by NA #1 v indicated that betwee 6/2/18 she was in the out trays and feeding she set up Resident # had grilled chicken the pieces. NA #1 wrote, was helping feed and indicated that around and another NA remo #1 reported she then #89 in her wheelchair indicated that when si door with Resident #8 "making a noise like si NA #1 wrote that she the hall in her wheelc Nurse #4 to help her. she reached the nurse #2, and Nurse #4 wer the nurses removed a Resident #89 's mout A phone interview wa 12/5/18 at 5:08 PM. written statement rela substance ingestion of was reviewed with NA describe the seating a room for herself and F during the lunch meal Resident #89 was sea rectangular table that	lunch in the dining room at ht (6/2/18). hcorrectly dated 5/2/18) was reviewed. NA #1 n 12:15PM and 1:30 PM on dining room helping pass residents. She noted that #89's tray reporting that she at was cut up into small "I saw her eating while I ther resident". She 1:30 PM lunch was over, ved Resident #89's tray. NA started pushing Resident out of the dining room. She he reached the dining room 89 she heard the resident she was trying to throw up". pushed Resident #89 down hair and started yelling for She indicated that when e's station Nurse #1, Nurse e there. She indicated that about 4 ounces of food from th. s conducted with NA #1 on The incident report and her ted to the incident of on 6/2/18 for Resident #89 A#1. NA #1 was asked to arrangements in the dining Resident #89 on 6/2/18 . She reported that	F 600				
		eats were on each side of to n each end of the table.					

Facility ID: 991059

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		IO. 0938-039
	F CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	IPLETED
						С
		345523	B. WING		1:	2/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	
				7166 JORDON ROAD		
UNIVERS	AL HEALTH CARE/RAM	SEUR		RAMSEUR, NC 27316		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETION
F 600	Continued From page	e 9	F 6	:00		
		ecall if all 6 of the seats were	10			
		s on 6/2/18 during the lunch				
		that she was assisting				
		eating on this date (6/2/18)				
		believed the resident she				
	-	eated next to Resident #89.				
	NA #1 was unable to	recall with certainty if she				
	was seated between	Resident #89 and the				
		sisting or if she was seated				
		of the resident she was				
		d that she recalled setting up				
	-	She reported that Resident				
		en that had been cut up into				
	-	as some vegetables. She 89 ate independently after				
		n the dining room on 6/2/18.				
		ooked over at Resident #89				
		ake sure she was eating, but				
		erved her during the whole				
		ping someone else. NA #1				
	was asked if she noti	iced if Resident #89 was				
	eating fast, if she was	s swallowing, if she was				
		nouth, or if she required any				
		vas safely eating. NA #1				
		with you I don't recall". She				
		nows that Resident #89 was				
	-	g any unusual sounds during				
		n't think there was anything				
		eported that after Resident				
		room to lay down. She				
		n to push Resident #89 by				
		dining room when the				
	resident started coug					
		aking a noise like she was				
		She reported she called out				
		to help and that it was				
		•				
	Nurse #1 who first re	alized Resident #89 had				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	01/03/2019 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
		345523	B. WING				C 12/0	6/2018
NAME OF P	ROVIDER OR SUPPLIER	·		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
	AL HEALTH CARE/RAMS	SELID		716	6 JORDON ROAD			
		SEON		RA	MSEUR, NC 27316			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 600	observed Resident #8 transporting her out of revealed she had not would've approached and then from behind wheelchair. She reve Resident #89 from the room. She additional noticed during the lun was not swallowing h This interview with N/ asked if Resident #89 eating. She stated the #89 ate independent! no assistance. She v had any specific dieta interventions related to She stated that Resid observed while eating not 1:1 observation it make sure she was e Resident #89 required she stated that the or required was encoura sometimes she just s herself. The physician was an active order of Resident #89 needed eat slow, swallow bet solids liquids was rev revealed she was not had not provided any #89 on 6/2/18 or on a A written statement d NA #2 was reviewed. walked into the dining	89's mouth prior to of the dining room and she . She stated that she l Resident #89 from the side l, so she could push her ealed she had not observed e front before exit the dining lly revealed she had not nch meal that Resident #89 er food. A #1 continued. NA #1 was 0 required assistance with hat most of the time Resident y after set-up and required was asked if Resident #89 ary orders or care plan to aspiration precautions. Sent #89 was supposed to be g but explained that this was was just checking on her to eating. She was asked if d any specific cueing and hly cueing Resident #89 agement to eat as at there rather than feeding n's order dated 4/17/17 and on 6/2/18 that indicated d cueing to take small bites, ween bites, and to alternate iewed with NA #1. NA #1 t aware of this order and she of these cues to Resident	F	600				

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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:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345523	B. WING				C / 06/2018
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	fingers. The resident pieces of chicken in h that NA #1 told her sh room. NA #2 then lef An interview was com 12/5/18 at 10:37 AM. written statement rela ingestion on 6/2/18 for reviewed with NA #2. and out of the dining room independently. This interview with NA asked if Resident #89 eating. She stated that ate independently after assistance, but other and not eat so she ne encouragement. She had any specific dieta interventions related to NA #2 stated that the watch Resident #89 to She indicated that this was just checking on NA #2 was asked if R specific cueing and sh cueing Resident #89 encouragement to ea physician's order date active order on 6/2/18 needed cueing to take swallow between bite liquids was reviewed	was noted to be putting her mouth. NA #2 indicated he would stay in the dining t the dining room. ducted with NA #2 on The incident report and her ited to incident of substance or Resident #89 was She stated that she was in room during the lunch meal he had not assisted Resident reported she saw Resident in and that she was eating A #2 continued. NA #2 was required assistance with at some days Resident #89 er set-up and required no days she would just sit there heded some verbal was asked if Resident #89 any orders or care plan to aspiration precautions. NAs were just supposed to o ensure she was eating. s was not 1:1 observation it her throughout the meal. esident #89 required any he stated that the only required was	F	600			

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/03/2019 ORM APPROVED 3 NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345523	B. WING				C 12/06/2018	
NAME OF P	ROVIDER OR SUPPLIER	•	•	STF	REET ADDRESS, CITY, STATE, ZIP CODE			
				716	6 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAMS	SEUR		RA	MSEUR, NC 27316			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 600	provided any of these she assisted her with An interview was con 12/4/18 at 2:45 PM. S being in the dining ro She reported that she resident eat and that Resident #89. NA #3 required assistance w that sometimes she for she needed assistance encouragement. She had and specific dieta interventions, or cues precautions. NA #3 r Resident #89 needed was eating just to ma	e cues to Resident #89 when meals. ducted with NA #3 on She stated that she recalled om during lunch on 6/2/18. e was helping another she had not observed b was asked if Resident #89 with eating. She indicated ed herself and sometimes ce in the form of e was asked if Resident #89 ary orders, care plan	F	600				
	herself. A written statement d Nurse #1 was review approximately 1:30 P #89 out of the dining needs some help". S was assessed with a trying to chew and sw mouth". Nurse #1 wr Resident #89 to spit of had not done so. Nur Resident #89 to spit of had "clamped her mo chewing the food in h removed the dentures and performed a mou "large amount" estimation	ote that she encouraged but the food, but the resident se #2 was noted to also tell but the food, but the resident buth shut and was still						

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If continuation sheet Page 13 of 110

	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/03/201 DRM APPROVE NO. 0938-039	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		ATE SURVEY OMPLETED	
		345523	B. WING			C 12/06/2018		
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/RAM	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316			
0.015	CUMMADY C							
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 600	Continued From pag	e 13	F	600				
		ntinue to sweep Resident		000				
		visible food was seen in her						
) was then noted to begin						
	wheezing and her "lip indicated she perform	os were blue". Nurse #1						
	-	more food expelled from						
		nd Nurse #3 took Resident						
		lurse #1 contacted the						
		(PA) and the Responsible						
	gave the order for tra	imately 1:40 PM. The PA nsfer to the ER.						
	on 12/5/18 at 12:20 F	as conducted with Nurse #1 PM. The incident report, r written statement related to						
	-	8 incident of substance						
	-	ved with Nurse #1. She						
		completed all of these rmed the information as						
		ated that when NA #1 brought						
		ught out to the nurse's station						
		d see [Resident #89] had a						
		nd that she wouldn't spit the vas asked if Resident #89						
	required any assistar							
		d Resident #89 had an order						
	•	e eating and that she,						
	needed to be remind	ded to chew and swallow".						
	A written statement,	undated, completed by						
		hat she was standing at the						
		2/18 at approximately 1:30						
		ught Resident #89 up to the tated that something was						
		nought the resident was						
	choking. Nurse #2 ir	dicated Resident #89 had a						
	-	in her mouth and that she						
		the food. She wrote that she						
	askeu resident #89	to spit the food out, but she						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345523	B. WING				C /06/2018
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE/RAMS	EUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	had not done so. She able to do a mouth sw amount of well ground remove food until no indicated that Resider and had a "noted cha reported that Nurse # Resident #89. Reside her room by Nurse #3 A phone interview wa on 12/4/18 at 4:11 PM her handwritten state Nurse #2. She verifie was brought out to the and that it was appare alone that the residen A written statement da Nurse #3 was reviewed around 1:30 PM on 6/ toward the nurse 's s Nurse #2 called her o Resident #89 who wa and were removing cf Nurse #3 wrote that N her that Resident #89 mouth to allow her to audible wheezing and discolored. Nurse #3 #4 took Resident #89 with a mask at 5 lpm A phone interview wa on 12/5/18 at 4:32 PM her written statement 6/2/18 incident of sub reviewed with Nurse #	e reported that she had been veep and removed a large d food and continued to visible food was seen. She nt #89 then began wheezing nge in color". Nurse #2 1 performed the Heimlich on ent #89 was then taken to	F	60			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		345523	B. WING				06/2018
	ROVIDER OR SUPPLIER	SEUR			STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	<u> </u>	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	consciousness at any She reported Resider wheezing throughout waiting for first respon A written statement di Nurse #4 was review 6/2/18 at approximate Resident #89 out of th that she thought the r Nurse #4 wrote that F cheeks were full of fo on the food. Residen the food and the resid would not spit it out. and Nurse #2 remove Resident #89's mouth A phone interview wa on 12/5/18 at 1:45 PM unable to recall any s substance ingestion of A phone interview wa #89's physician on 12 physician reported that recommendations of be followed. He indic were expected to be a An interview was con Nursing (DON) on 12 revealed that when sl incident of substance she determined the re- stated that her expect	Resident #89 had no loss of point while at the facility. nt #89 continued with audible the time period they were nders. ated 6/4/18 completed by ed. Nurse #4 indicated on ely 1:30 PM NA #1 brought ne dining room and stated esident was choking. Resident #89's mouth and od and she was still chewing t #89 was asked to spit out dent just kept chewing and Nurse #4 indicated Nurse #1 ed all visible food from n by hand. s conducted with Nurse #4 A. She stated she was pecifics about the incident of on 6/2/18 for Resident #89. s conducted with Resident t/6/18 at 2:36 PM. The at he expected the ST as well as his orders to iated aspiration precautions mplemented for any	F	600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3) DATE	
		345523	B. WING				C 106/2018
NAME OF PI	ROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/RAMS	EUR			7166 JORDON ROAD		
UNIVERS	AL HEALTH CARE/RAWS	BEOR			RAMSEUR, NC 27316		
(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 600	Continued From page		F	60	ο		
	that she expected as	the physician, and as blan. She additionally stated biration precautions to be esidents identified as at risk					
		d DON were notified of the on 12/5/18 at 3:03 PM.					
	On 12/6/18 at 7:06 PI following credible alle Jeopardy removal:	VI the facility provided the gation of Immediate					
	Address how correcti accomplished for the affected by the deficie	resident found to have been					
	was escorted from the noted making a vomit Nursing Assistant imm to the nurse 's station resident having difficu- signs of aspiration with nurse attempted to re resident 's mouth but removing all food part	ximately 1:30pm, Resident e dining room and was ing noise. The Certified nediately took the resident n where the nurse assessed ulty swallowing and showing th audible wheezing. The move food particles from twas unsuccessful in ticles and therefore dentures form a mouth sweep. During					
	this process the resid and swallow. At this ti cyanotic and showing so the Heimlich mane nurse without success conscious and was m taken from the nurse	ent continued to try to chew ime resident 's lips became signs of difficulty breathing euver was initiated by the					

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		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	3		
						С
		345523	B. WING		1	2/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
				7166 JORDON ROAD		
UNIVERS	AL HEALTH CARE/RAM	SEUR		RAMSEUR, NC 27316		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLETIO
F 600	Continued From page	e 17	F 60	0		
	Certified Nursing Assistant. Nurse supervisor suctioned resident to attempt to remove					
	remaining food partic	•				
		saturation was 79 percent,				
		s applied via non-rebreather				
		Assistant and Responsible				
		t 1:40pm. The Physician				
		all Emergency Management				
		y Services was called at				
		at 2:00pm. First Responders				
	-	resident. Facility Nurse				
	staff remained in room	•				
		oxygen with their regulator at				
	fifteen liters per minu					
	-	ment Technicians (EMT)				
		sed with first responders and				
		's condition and decision to				
		nbulance. First Responders				
		agement Technicians				
		to the hall in her wheelchair,				
		rney and proceeded to the				
	ambulance. The EM	• •				
		minutes and left the facility				
		m the EMTs called to get				
		formation and informed the				
	staff that the resident	t had died prior to reaching				
	the hospital. On 6/2/1	18 an investigation was				
	initiated immediately	by the Director of Nursing				
	and the Administrator	r and statements received				
	from staff present in t	the dining room, at the nurse				
	's station. At the con	clusion of the investigation it				
	was determined that	the Certified Nursing				
	Assistance was at the	e table providing assistance				
		According to the Certified				
	nursing assistant 's	statement she followed				
		is by setting up her tray, the				
		pieces and saw her eating				
	while helping another	r resident. Upon interview				
		3 by Director of Nursing and	1			1

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/03/2019 RM APPROVED IO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION		TE SURVEY MPLETED
		345523	B. WING			1	C 2/06/2018
NAME OF PF	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS/	L HEALTH CARE/RAMS	SEUR			166 JORDON ROAD		
		ATEMENT OF DEFICIENCIES		г	RAMSEUR, NC 27316 PROVIDER'S PLAN OF CORREC		(15)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	Continued From page	<u>-</u> 18	E f	600			
	Administrator, she wo			000			
	providing supervision						
	Address how the faci	lity will identify other					
		potential to be affected by					
	the same deficient pr	actice:					
	A 100% audit of Resi	0					
		r of Nursing (DON), Staff nator (SDC), Assistant					
	-	ADON), Unit Manager (UM)					
		bilitation (DOR) for diagnosis					
		hasia on 12/5/18 and 43					
		iagnosis of Dysphagia or					
	Aphasia, 26 were ide recommendations wit	th swallowing guidelines. An					
		vallowing Guidelines sheet,					
	was implemented on						
		those 26 identified with					
		s requiring supervision. The es sheets (name, room					
	number, diet, and rec						
	physician and speech	n therapist) are located in an					
		binder located in each					
	-	n resident care kiosk. The sheets and the kiosk are					
		sistant Director of Nurses					
		lated when indicated by the					
		herapist. All 43 residents					
		phagia and Aphasia care					
		by the Assistant Director of ions required. CNAs will be					
	-	identified requiring cueing					
	and aspiration precau	utions by the charge nurse at					
		hift. Training of licensed and					
		d by SDC and DON on					
	cueing and aspiration	ed on 12/6/18. All licensed					
	•	staff will receive this training					

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	· · ·	TE SURVEY MPLETED
						С
		345523	B. WING		1	2/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
UNIVERS	AL HEALTH CARE/RAM	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 600	Continued From pag	e 19	F 60			
		shift. This training will be	1 000			
		ised and certified nursing				
	staff orientation proc	•				
		are will be put into place or				
		ade to ensure that the				
	deficient practice will	not recur:				
	On 12/5/18 an imple	mentation of a dining room				
		include sign in times/sign out				
		iration precaution and				
	supervision to be pro	ovided. This information is				
		each dining room and				
		Management, Licensed				
		ent Head will monitor meal				
		Dining Supervision Manager Supervision is being provided				
		and safety precautions are				
		g meals in the dining rooms				
		t eat in their rooms. The				
	Director of Nursing w	vill assign managers to the				
	-	de resident rooms. Effective				
		ised staff, certified staff and				
		ere trained by SDC on the on aspiration precautions				
		ng supervision to ensure that				
		re being followed. This				
		d in a binder in each dining				
	room and resident ca	are kiosk. Training on the				
		with return demonstration				
	and proper use of su					
		his education was provided				
		urse, Staff Development b Licensed staff and other				
		trained prior to next shift				
	worked. Emergency	•				
		d 12/5/18 in the dining rooms,				
	1	12/3/10 in the uning rooms,				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					PRINTED: 01/03 FORM APPR MB NO. 0938	ROVE
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		ſ
		345523	B. WING			C 12/06/2018		
NAME OF P	ROVIDER OR SUPPLIER		I		REET ADDRESS, CITY, STATE, ZIP CO	DDE		
UNIVERS	AL HEALTH CARE/RAMS	SEUR			6 JORDON ROAD MSEUR, NC 27316			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPL	
F 600	education was also p nursing staff to ensur provided during meal precautions and safe Licensed and Certifie educated on the sign aspiration. Effective facility abuse and neg all staff and complete neglect policy reflects accordance with the n constitute neglect. Th by RN Staff Developr educated by 12/6/18 until educated. Effec providing supervision aspiration precautions new employee orients also be conducted an CNAs will be assigne requiring cueing and charge nurse at the b Training of licensed a SDC and DON on cu precautions and resp 12/6/18. All licensed a receive this training p This trainingwill be in certified nursing staff Indicate how the facil performance to make sustained: and includ action will be complet Effective 12/6/18, The Assistant Director of	aff by the SDC. On 12/5/18 rovided by the SDC for e supervision is being s and ensure aspiration ty is being provided. d Nursing staff were also s and symptoms of 12/6/18, re-education on the glect policy was initiated for red. The facility Abuse and s that not providing care in resident care plan maybe his education was provided ment Coordinator. Staff not will not be allowed to work tive 12/6/18, education on during meals to ensure s and safety is added to all ation. This education will mually by SDC for all staff. d to residents identified aspiration precautions by the beginning each shift. and certified staff provided by eing and aspiration onsibilities initiated on and certified nursing staff will prior to working next shift. cluded in new licensed and orientation process.	F	500				

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DEPART		FORM	APPROVED 0. 0938-0391					
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345523	B. WING				C 06/2018	
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 600	Nursing or Departmen supervision, utilizing I Observation sheet. Si to ensure aspiration a being followed during and for residents that mentioned above will for supervision utilizin The Director of Nursin the dining rooms to in monitoring process w Charge nurses on Sa monitoring will be con then weekly x4, then will be reported by the monthly Quality Assur Improvement commit recommendations or of compliance is achie Effective 12/6/18 the and the Director of Nur responsible for the im correction to ensure t maintains substantial Compliance Date 12/0 The credible allegation removal was validated Record review indicat and there were 43 resi dysphagia or aphasia with recommendations The 26 residents ider for swallowing guideli Guidelines sheet impli	ht Head will monitor meal Dining Supervision Manager upervision is being provided and safety precautions are meals in the dining rooms eat in their rooms. Staff be assigned to each meal of the Assignment calendar. Ing will assign managers to icclude resident rooms. This ill be continued by the turday and Sunday. This iducted daily for four weeks, monthly thereafter. Findings e Director of Nursing in the rance and Performance tee meeting for modifications until a pattern eved. facility Executive Director ursing will be ultimately plementation of this plan or he facility attains and compliance. 6/18 n of Immediate Jeopardy d on 12/6/18 at 7:10 PM. ted an audit was conducted sidents with diagnoses of and 26 residents identified s for swallowing guidelines. tified with recommendations nes had a Swallowing	F	600				

Facility ID: 991059

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/03/20 FORM APPROVI OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		345523	B. WING		C 12/06/2018
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CC	
UNIVERSA	AL HEALTH CARE/RAMS	SEUR			
		ATEMENT OF DEFICIENCIES	I	ISEUR, NC 27316 PROVIDER'S PLAN OF C	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIO HE APPROPRIATE DATE
F 600	Continued From page	e 22	F 600		
		spiration precaution binder,			
		were all in place, a manager			
	meal, and residents r	le monitoring during the			
		s were assigned an NA. A			
		gn in sheets as well as staff			
	12/5/18 on aspiration	ucation was initiated on			
		igns and symptoms of			
	· · ·	sidents requiring supervision			
		autions were being followed, pervision is provided during			
	÷ .	so included the facility 's			
		blicy which reflected that not			
		ordance with the resident ' s ant neglect. Licensed staff			
		ducation on the Heimlich			
		r use of the suctioning			
		ot inserviced by 12/6/18 nserviced prior to working on			
	the floor.				
F 604 SS=D	Right to be Free from CFR(s): 483.10(e)(1)		F 604		12/21/18
	§483.10(e) Respect a	and Dignity.			
	The resident has a rig and dignity, including	ght to be treated with respect			
		Iht to be free from any			
	physical or chemical	restraints imposed for			
		e or convenience, and not esident's medical symptoms, 12(a)(2).			
	§483.12 The resident has the	right to be free from abuse,			
	neglect, misappropria	ation of resident property, efined in this subpart. This			

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/03/20 FORM APPROVE OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345523	B. WING		C 12/06/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	AL HEALTH CARE/RAM	SEUR		166 JORDON ROAD	
			R	RAMSEUR, NC 27316	
(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 COMPLETION
F 604	any physical or chem treat the resident's m §483.12(a) The facilit §483.12(a)(2) Ensure from physical or cher purposes of discipline are not required to tre symptoms. When the indicated, the facility alternative for the lea document ongoing re restraints. This REQUIREMENT by: Based on observation interview, the facility environment free of p a resident's hands w (Resident #53) review The findings included Resident #53 was ad 10/18/13 with diagno s disease, dementian and aphasia (loss of express speech). The quarterly Minimu assessment dated 10 #53 had severe cogn rarely/never understa	hited to freedom from involuntary seclusion and hical restraint not required to edical symptoms. ty must- e that the resident is free mical restraints imposed for e or convenience and that eat the resident's medical e use of restraints is must use the least restrictive ist amount of time and e-evaluation of the need for T is not met as evidenced on, record review, and staff failed to maintain an ohysical restraints by covered with socks for 1 of 2 residents wed for physical restraints. t: imitted to the facility on ses that included Alzheimer ' without behaviors, anxiety, ability to understand or im Data Set (MDS) D/19/18 indicated Resident itive impairment. She ands others and she was	F 604	F 604 Based on the root cause analysis by facility administrative staff and the fa Director of Nursing, the facility staff provided resident #53 a physical resi without appropriate indications to tre- medical condition. Immediate Removed sock on left hand of reside #53 after it was observed by the surv at approximately 10:00am on Decem 3, 2018. Identification 100% audit of all residents in the fac was conducted on 12/4/2018 by Dire of Nursing (DON), Assistant Director Nursing (ADON), and or Unit Coordin	cility traint at a nt reyor aber aber lity ctor of nator
	assessment dated 10 #53 had severe cogn rarely/never understa rarely/never understo had physical behavio	0/19/18 indicated Resident itive impairment. She		100% audit of all residents in the fac was conducted on 12/4/2018 by Dire of Nursing (DON), Assistant Director	ctor of nator vith out

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/03/ FORM APPRC OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345523	B. WING		12/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE
UNIVERSA	L HEALTH CARE/RAM	SEUR		7166 JORDON ROAD	
				RAMSEUR, NC 27316	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLE
F 604	Continued From page	- 2 <i>4</i>	Гсо		
1 004			F 60		
	4 to 6 days. She requ assistance of 2 or mo			symptom. No other resident identified with physical restra	
		nd toileting. She required		of this audit is located on the	-
		nce of 1 staff for personal		Restraint Audit Tool.	, injeloui
		3 was assessed with no		Systemic	
	physical restraints (de			Measures put into place to e	
	method or physical of			plan of correction is effective	
		t attached or adjacent to the		in compliance are: Effective	
	remove easily which	the individual cannot		the facility will complete a pr assessment for all residents	
	-	access to one 's body).		admission, readmission and	
				identify any resident for a ne	
	A nursing note dated	11/16/18 indicated Resident		restraint to treat a medical s	
		nawing" on her left hand and		restraint is indicated, an orde	
		to leave self-inflicted marks		obtained from the physician	
		o of hand, and the palm. A		consent from Responsible P	
	mechanism" without	he left hand as a "distraction		also be obtained. The interc team (IDT) to include the DC	
		any success.		Data Set Coordinator (MDS)	-
	Resident #53 ' s curre	ent care plan indicated the		Worker (SW) will meet to dis	
		isk for skin breakdown. This		need for any restraint prior to	
		tly updated on 11/16/18 with		being applied and the care p	
	an intervention that s	tated to apply socks to both		updated by the (MDSC) and	the certified
	hands when Residen	t #53 was agitated.		nursing assistant (CNA) kios	
				updated by the ADON or UC	
	Review of the resider	nt 's medical record ient for applying socks on		Effective 12/21/2018, the ID the DON, SW and MDSC, w	
		s was found in the record.		review any resident with a re	
		formation in the resident 's		in the Standards of Care Me	
	medical record that s			effectiveness and reduction	5
	restrictive methods of	r devices were attempted		All on-site licensed and certi	
	prior to applying sock	is to the resident ' s hands.		educated on definition of res	
	.			qualification of restraints and	
	•	11/18/18 indicated Resident		initiate a restraint by the Sta	
	#53 chewed on her h	anu al limes.		Development Coordinator (S 12/13/2018. All other license	
	A Social Work note d	ated 11/20/18 indicated the		certified staff will be educate	
		the hospice staff to discuss		working next shift. This train	
	-	us. A discussion was had		included in new staff orienta	

Facility ID: 991059

If continuation sheet Page 25 of 110

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/03/2019 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING _			1	C 2/06/2018
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP (TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	AL HEALTH CARE/RAMS	SELIP		71	166 JORDON ROAD		
		SEON		R	AMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 604	noted to most likely b related to over-stimul in place to protect Re A nursing note dated #53 bit at her hand fre had suggested her had began to bite at it. Re noted to be covered a 12/2/18. An observation was of PM of Resident #53. chair (wheelchair that in the hallway of the r was covering her entit was noted with her m hand. A nursing note dated #53 was rocking back her hand. An observation was of AM of Resident #53. chair in the dining roc and a sock was cove Resident #53 's mou covered hand. An observation was of AM of Resident #53. chair in the hallway of There were no socks	biting her hand which was e triggered by agitation us. Socks were noted to be sident #53 ' s hands. 12/2/18 indicated Resident equently and that her family and be covered when she esident #53 ' s hand was at the family ' s request on conducted on 12/2/18 at 5:30 She was seated in a broda t can tilt to change positions) memory care unit and a sock ire left hand. Resident #53 routh on the sock covered 12/3/18 indicated Resident c and forth and was biting conducted on 12/3/18 at 9:30 She was seated in a broda om of the memory care unit ring her entire left hand. th was not touching the sock conducted on 12/6/18 at 9:30 She was seated in a broda of the memory care unit ring her entire left hand. th was not touching the sock conducted on 12/6/18 at 9:30 She was seated in a broda f the memory care unit. covering either of her hands ot touching her hands. ducted with Nursing	F 6	604	will be provided annually. Monitoring Restraints will be added to daily clinic rounds daily Monday through Friday t discuss by the DON, ADON, UC the r and orders for restraints. This will be completed daily x 2 weeks, then weel 2 weeks, monthly x 3 months. Result be presented in Quality Assurance Performance Improvement meeting b DON for recommendations and modifications until substantial complia is achieved. Date of compliance 12/21/2018	o need kly x s will y the	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/03/2019 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345523	B. WING			(12/	; 06/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	EUR		166 JORDON ROAD RAMSEUR, NC 27316			
(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	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 604	the first shift (7:00 AW confirmed Resident # left hand during the m unsure how long the s stated that Resident # sock was put on so st NA #8 indicated she w Resident #53, but she unable to remove the was put in place. An interview was com Nursing (DON) on 12, revealed she was awa on Resident #53 ' s le making contact with h her hand. The DON f observed the sock in hand on the morning had the staff remove was a physical restrative would not have easily resident and that it re- her body. The DON explained th was implemented at t s family, but she expla- were not able to do ev requested and that th on Resident #53 ' s has she expected physical implemented when th to justify its use and for minimum amount of the stated that she expect be completed and a p	working on 12/3/18 during 1 to 3:00 PM). She 53 had a sock covering her norning of 12/3/18. She was sock was in place. She 453 bit at her hand and the ne couldn ' t bite her skin. vas not very familiar with a thought the resident was sock from her hand once it ducted with the Director of /6/18 at 8:00 AM. She are staff had placed a sock of thand to prevent her from her skin when she was biting further revealed that she first place on Resident #53 ' s of 12/3/18. She stated she it immediately because it int indicating that the sock been removed by the stricted normal access to hat she believed the sock he request of Resident #53 ' ained to the staff that they verything the family ey were not to place socks ands again. She stated that	F 604				

Facility ID: 991059

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	-	ND HUMAN SERVICES			PRINTED: 01/03/2 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345523	B. WING		12/06/2018
IAME OF PF	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CO	DDE
INIVERSA	AL HEALTH CARE/RAM	SEUR		JORDON ROAD ISEUR, NC 27316	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPLETIN HE APPROPRIATE DATE
F 604	Continued From pag	e 27	F 604		
	This interview with th	e DON continued. The care			
		nat indicated the intervention			
		Resident #53 ' s hands when s reviewed with the DON.			
	The DON revealed s				
		ed to Resident #53 ' s care			
		s going to revise the care intervention as it was not			
	•	ted that this intervention was			
		an by the facility 's previous			
		nducted with MDS Nurse #2			
	Resident #53 with a	M. The observations of sock covering her left on nd 12/3/18 at 9:30 AM were			
	reviewed with MDS N	Nurse #2. The care plan dicated the intervention of			
		sident #53 's hands when			
	•	s reviewed with MDS Nurse evealed she was unaware a			
		Resident #53 's hand and			
		e that it was added to her			
	•	d she believed placing a 3 ' s hand met the definition			
		t indicating that the sock			
	would not have easily	y been removed by the			
		estricted normal access to			
F 623	her body.	Before Transfer/Discharge	F 623		12/21/18
SS=B	CFR(s): 483.15(c)(3)		1 020		
	§483.15(c)(3) Notice				
	Before a facility trans	-			
	resident, the facility r (i) Notify the resident				
	(i) Noury the resident				

Facility ID: 991059

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391				
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY LETED
		345523	B. WING				。 06/2018
NAME OF P	ROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
UNIVERS	AL HEALTH CARE/RAMS	EUR			166 JORDON ROAD AMSEUR, NC 27316		
(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 623	the reasons for the m language and manne facility must send a correpresentative of the Long-Term Care Omb (ii) Record the reason discharge in the reside accordance with para and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required ur made by the facility a resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(7 (E) A resident has not days. §483.15(c)(5) Content	ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. as for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section	F	623			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/03/2019 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345523	B. WING					C 06/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/RAMS	EUR			7166 JORDON ROAD RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 623	(iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such requess to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailin telephone number of the protection and ad developmental disabi C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individual §483.15(c)(6) Change If the information in the effecting the transfer of must update the recip	nsfer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how rm and assistance in nd submitting the appeal s (mailing and email) and the Office of the State budsman; r residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with ities established under Part cal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental cabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy uals Act.	F	623				

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		ND HUMAN SERVICES			FOF	ED: 01/03/20 RM APPROVE IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
		345523	B. WING		C 12/06/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
UNIVERSA	AL HEALTH CARE/RAM	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETIO
F 623	Continued From pag	e 30	F 62	3		
	1.0	in advance of facility closure	1 02			
		closure, the individual who is				
		he facility must provide				
		ior to the impending closure				
	-	Agency, the Office of the				
		re Ombudsman, residents of				
		esident representatives, as ne transfer and adequate				
		dents, as required at §				
	483.70(I).					
		T is not met as evidenced				
	by:					
	Based on record rev	views and staff interviews, the		F 623		
		the Ombudsman in writing		Based on the root cause ana		
	of resident discharge	-		facility administrative staff and	-	
	residents (Residents	#58 and #83).		Executive Director, facility sta		
	The findings include:	4.		notify the Ombudsman when		
	The findings included	J.		are discharged from the facili Immediate	ty.	
	1 Resident #58 was	originally admitted to the		The Ombudsman was notified	dof	
		readmission date of 10/24/18		discharges for resident #58 a		
		to the Hospice House on		#83 on 12/5/2018 by the Soc		
		oses included malignant		(SW) after speaking to the Su		
		er lobe of lung, pneumonia,		2:30pm on 12/5/2018.		
		embolism (a blood clot in the		Identification		
	lung) and dependent	cy on oxygen.		A 100% audit of all unplanned	-	
	During on interviews	with the Social Worker		and discharges initiated by th conducted by the SW on 12/5	•	
	-	n, she stated she had not		determine if notification was g		
	-	on to the Ombudsman at the		Ombudsman. As of 12/5/201		
		discharge. She further		discharges were sent to the C		
		day she had not been		Systemic		
		cation to the Ombudsman for		Measures put into place to er		
	-	acilities. She explained that		plan of correction is effective		
	-	acking log for all transfers,		in compliance are: Effective 1		
	•	hs that she would begin to		the SW will print a list of disch		
	send to the Ombuds	man as ur luuay.		weekly, have the Executive D review the form and send the		
	1				mornation	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/03/20 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345523	B. WING		C 12/06/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
	AL HEALTH CARE/RAM	SEUR		7166 JORDON ROAD	
UNIVERO,		520K		RAMSEUR, NC 27316	
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
F 623	Continued From page	e 31	F 62	3	
1 020	3:05pm she stated th the Ombudsman to b	at it was her expectation for e notified in writing of all	1 02	or fax will be kept with this dischart form.	-
	discharges.			The ED educated the SW and Adn Coordinator of the requirements of	
	6/28/18 with multiple	admitted to the facility on diagnoses including discharged to the hospital on		notifying the Ombudsman of unpla discharges and facility- initiated discharges on 12/7/2018. Any new	
	10/31/18 and was rea			hired in these two roles will be edu on this process as well.	
	Review of the social conducted. There was	worker's notes was as no documentation that the		Monitoring This process will be conducted we	ekly x 4
	ombudsman was not discharge to the hosp	-		weeks, then monthly x 3 months. F will be presented in Quality Assura Performance Improvement meetin	ince
		Social Worker (SW) was 3 at 2:30 PM. The SW stated		SW for recommendations and modifications until substantial com	
		sible for notifying the g of residents who had been facility. The SW stated that		is achieved. Date of Compliance 12/21/2018	
	she had sent a list of ombudsman today (1	discharges to the 2/5/18) and acknowledged			
	that she had not notif discharges in the pas	fied the ombudsman of st.			
	On 12/5/18 at 2:45 P ombudsman but was	M, tried to interview the not available.			
	was conducted on 12 stated that she expect	Director of Nursing (DON) 2/6/18 at 2:59 PM. The DON cted the ombudsman to be esidents who had been facility.			
F 637 SS=D	-	essment After Signifcant Chg	F 63	7	12/21/18
		hin 14 days after the facility d have determined, that nificant change in the			

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If continuation sheet Page 32 of 110

		ND HUMAN SERVICES				ED: 01/03/20 RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED C
		345523	B. WING		12/06/201	
NAME OF PROVIDER OR SUPPLIER STREET/ UNIVERSAL HEALTH CARE/RAMSEUR T166 Joi RAMSE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX TAG F 637 Continued From page 32 resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interview, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after it was determined that a resident had a decline in two or more MDS areas (activities of daily living (ADL), F 607	STREET ADDRESS, CITY, STATE, ZIP COD					
		SELID		7166 JORDON ROAD		
		520K		RAMSEUR, NC 27316		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 637	Continued From page	- 2 2	F 625	7		
F 037			F 637			
		•				
	-	•				
		•				
	requires interdisciplin	nary review or revision of the				
		Γ is not met as evidenced				
	-					
				F 637		
				Based on the root cause anal		
				facility administrative staff and Director of Nursing, the MDS		
	. ,	-		did not complete a significant		
				assessment on resident #83.	change	
		for 1 of 1 sampled resident		Immediate		
		int change in status MDS		Resident #83 had a significar	nt change	
	(Resident #83).	0		assessment with an Assessm	-	
	· · · · ·			Reference Date (ARD) of 12/	14/2018	
	Findings included:			completed by the Minimum D Coordinator (MDSC).		
	Resident #83 was ad	lmitted to the facility on		Identification		
	6/28/18 with multiple	-		All current active resident Min	nimum Data	
		disorder. The quarterly		Sets (MDS) for the last 30 day		
		ted 10/1/18 indicated that		reviewed to determine if a sig		
	Resident #83 had int	-		change assessment was nee		
		cated that Resident #83		MDSC, Minimum Data Set As		
		tance with 1 person with bed		(MDSA), Director of Nursing (
		bulation, dressing, toilet use,		Assistant Director of Nursing		
	1 20	d bathing. The assessment		Unit Coordinator (UC) on 12/2		
	loss and had no falls.	Resident #83 had no weight		residents were identified requ	•	
	iuss anu nau nu ialis.			significant change assessmen opened for completion.	in and were	
	On 10/31/18 Reside	nt #83 was discharged to the		Systemic		
		nd was readmitted on 11/3/18		Measures put into place to er	sure the	
			1			

Facility ID: 991059

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TATEMENT (F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
						С
		345523	B. WING			2/06/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
(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 THE APPROPRIATE	(X5) COMPLETION DATE
F 637	Continued From page	e 33	F 63	7		
	status- post surgery.		1 00	in compliance are: The M	DSC. MDSA.	
	peer ourgery.			DON, ADON and UC will		
	The 14 days MDS as	sessment dated 11/17/18		current MDS to the previo	ous MDS to	
		assessment indicated that		determine if a significant	•	
		extensive assistance with 2		occurred by evaluating se		
		bility, transfer, dressing,		MDSC and or DON will al		
		ygiene and bathing. The cated that ambulation did		nursing 24- hour clinical r daily clinical meeting to d		
		assessment period. The		significant change has oc		
	-	ndicated that Resident #83		more areas according to t		
	had a significant weig	ght loss.		Assessment Instrument (
				The MDSC, MDSA and D		
	On 12/3/18 at 1:40 Pl			educated on 12/21/2018	•	
	interviewed. She star			significant change in statu		
	-	nsfer, ambulation, toilet use, I bathing but after the fall		by the Regional MDS Nur	rse.	
		ce from the staff to do stuff.		Monitoring Weekly audit of MDSs on	calondar will be	
	On 12/5/18 at 11:20 A	AM, MDS Nurse #1 was		conducted by the MDSC,		
	interviewed. She star			ADON. Ten (10) random		
		t change in status MDS		completed per week. If a		
	assessment for Resid	dent #83 because Resident		change has occurred, the	e resident will be	
		therapy and after 30 days		scheduled for a significan	•	
		er baseline status. The		assessment. Audits will b		
		ied that Resident #83 had a a state and had a state at a		weekly x 4 weeks, then m		
	significant weight loss			months. Results will be p Quality Assurance Perform		
	• •	DS Nurse further indicated		Improvement meeting by		
		vould not return to her		for recommendations and		
	baseline in 30 days, s	she would complete a		until substantial complian		
	significant change in	status MDS assessment.		Compliance date 12/21/2	018	
	On 12/6/18 at 2:59 Pl	M, the Director of Nursing				
		ed. The DON stated that				
	-	S Nurse to complete a				
		status MDS assessment as				
	changes in the MDS	tion, 14 days after 2 or more				

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	-	ND HUMAN SERVICES					MAPPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345523	B. WING				C /06/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAM	SEUR			66 JORDON ROAD		
				R/	AMSEUR, NC 27316		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	e 34	F 6	641			
F 641			F 6				12/21/18
SS=D	CFR(s): 483.20(g)						
	§483.20(g) Accuracy	of Assessments.					
		st accurately reflect the					
	resident's status.	L is not mot as ovidenced					
	by:	Γ is not met as evidenced					
	-	iews and staff interviews, the			F 641		
		the Minimum Data Set			Based on the root cause analysis by th	е	
	-	a of Activities of Daily Living			facility administrative staff and the facili		
	(Resident #34) and for	or discharge (Resident #71			Director of Nursing, the MDSC did not		
	and #89) for 3 of 22 s	sampled residents.			properly code the MDS per the RAI		
	The findings included	4.			guidelines. Immediate		
		1.			MDS for Resident #34 was modified to		
	1. Resident #34 was	admitted to the facility on			reflect the level of assistance required t	for	
		es that included history of			Activities of Daily Living (ADL) on		
	fractures to the right	hip, left clavicle and left side			12/21/2018 by the Minimum Data Set		
	of ribs, dementia, mu				Coordinator (MDSC).		
	torticollis (abnormal r	neck position).			MDS for Resident #71 was modified to		
	A				reflect correct discharge location on		
		recent comprehensive MDS assessment and dated			12/6/2018 by the Minimum Data Set Assistant (MDSA).		
		resident was confused with			Resident #89 was modified to reflect		
		ort-term memory. The			correct discharge location on 12/21/201	18	
		umentation that she required			by MDSA.		
	total assistance of sta	aff members for all ADL's to			Identification		
		was coded as having limited			All current active resident Minimum Dat	ta	
	-	ne upper and both lower			Sets (MDS) for the last 30 days were		
	extremities.				reviewed to determine if a modification		
	The most recent MD	C (Minimum Data Sat) and a			was needed based on Activities of Daily	y	
		S (Minimum Data Set) coded sment and dated 11/15/18,			Living (ADL) and supportive documentation needed by MDSC, Direct	ctor	
		and dated 11/15/16, It as having confusion with			Nursing (DON), Assistant Director of		
		ing-term memory. The			Nursing (ADON), Unit Coordinator (UC)	
		umentation that she required			and Infection Prevention Nurse (IPN) o	-	
	extensive assistance				12/21/2018. No other resident MDSs w		
		giene, transfers and was			identified with inaccurate coding related	d to	

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	S FOR MEDICARE &				OMB NO. 0938-	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING		C 12/06/2018	8
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, Z	P CODE	
UNIVERS	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DAT	ETION
F 641	Continued From page	35	F 64	1		
	She was coded as ha to both sides of her up A review of the reside 11/26/18 revealed that requiring assistance w 2-person assistance w 2-person assistance w and required full assist A review of the nursin period of 11/2/18 to p consistently document total assistance with a and was a hoyer lift tr On 12/5/18 at 9:10 Al requiring total assistant skin assessment to he self in bed. An interview was held 12/5/18 at 11:00 Alf coded the ADL portion on the ADL Assistanc completed by the nursi stated that she coded the lowest level of assist NA's. She stated that resident as well as re for staff documentation	2 staff members for bathing. ving limited range of motion pper and lower extremities. ent's active care plan dated at she was care planned for with ADL's, required for transfers with a hoyer lift stance with meals and fluids. ang documentation for the resent revealed the staff had ated the resident required all ADL's to include eating ransfer by 2 staff members. M resident was observed nce from staff to lift leg for eels as well as reposition d with the MDS nurse #1 on who explained that she n of the assessment based e and Support form that was sing assistants (NA). She I the assessment based on sistance documented by the she went and observed the viewed the medical record on, but that she was told to form completed by the		ADLs and discharge loc Systemic Measures put into place plan of correction is effe in compliance are: The M DON, ADON or the UC M compare the current MD coding which is entered Nursing Assistants (CNA nurse's notes and other documentation daily of s to ensure accurate codir discharge locations on th guidelines. The MDSC and MDSA w on 12/21/2018 with rega coding of MDS assessm of ADLs and correct disc the Regional MDS Nurse Monitoring Weekly audit of ADL doo discharge locations will b the MDSC, MDSA, DON (10) random audits will b week. If a modification i resident will be schedule assessment. Audits will weekly x 4 weeks, then months. Results will be Quality Assurance Perfor Improvement meeting by	to ensure the ctive and remains MDSC, MDSA, will evaluate and S to the ADL by the Certified A), review of discipline scheduled MDSs ng of ADLs and he MDS per RAI were in-serviced rd to accurate ents for accuracy charge location by e. cumentation and be conducted by l or ADON. Ten be completed per s warranted, the ed for an be completed monthly for 3 presented in rmance	
	the nurses notes during the most recent MDS showed the resident r all ADL's to include n	ne interview she reviewed ng the look back period for and confirmed that it required total assistance for neals but stated that could due to the way the NA flow		recommendations and n substantial compliance i Date of Compliance 12/2	s achieved.	

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DEPARTMENT OF HEALTH A					FORM APPROVED 1B NO. 0938-0391
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		COMPLETED
	345523	B. WING			12/06/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
UNIVERSAL HEALTH CARE/RAI	ISEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
PRÉFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 641 Continued From pa	ge 36	F 6	41		
Review of the ADL, the MDS look back 11/15/18 revealed to NA's needing total of for bed mobility, tra- toileting, personal ho Observation occum- requiring total assiss lunch. She was un the time of the lunch During an interview AM it was confirmed total assistance with and was transferred members. She furth the ADL's require 2 is unable to assist a An interview occum 9:55 AM, who state total assistance with She further stated to medications to the in- them to her to inclu- unable to hold a spec- During an interview on 12/6/18 at 3:00 ff expectation for the accurate reflection of 2. Resident # 71 wa 11/1/18 with multipli dementia. The adm (MDS) assessment	Assistance and Support log for period of 11/9/18 through he resident was marked by dependence most of the time hsfers, dressing, eating, ygiene and bathing. ed on 12/5/18 at 12:30 PM tance from staff member for able to hold spoon or cup at h meal. with NA #5 on 12/6/18 at 9:30 d that the resident required h all ADL's to include eating d by a hoyer lift with 2 staff her stated that the majority of staff members as the resident tt all. ed with LPN #5 on 12/6/18 at d that the resident required h all ADL's to include eating. hat when she provided esident she had to provide de liquids as the resident was bon or cup. with the Director of Nursing PM, who stated that it was her MDS to be coded as an				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345523	B. WING				C 106/2018	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/RAMS	EUR	7166 JORDON ROAD RAMSEUR, NC 27316					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE			
F 641	The discharge MDS a indicated that Resident the hospital. Review of Resident # 11/29/18 (late entry for Resident #71 was dis 11/27/18. An interview with MDF on 12/6/18 at 3:19 PM that Resident #71 wa 11/27/18. After she re assessment dated 11 that the discharge loo Resident #71 was dis the hospital. An interview with the was conducted on 12 stated that she expect be coded accurately. 3. Resident #89 was a 3/28/17 with diagnose (difficulty swallowing) The 6/2/18 discharge assessment indicated facility. A physician's order da Resident #89 was to Room (ER) for evaluation A Resident Transfer F	Assessment dated 11/27/18 Int #71 was discharged to 71 nurse's notes dated or 11/27/18) revealed that charged to home on S Nurse #2 was conducted A. MDS Nurse #2 verified is discharged to home on eviewed the MDS /27/18, she acknowledged ation was coded wrong, charged to home and not to Director of Nursing (DON) /6/18 at 2:59 PM. The DON ted the MDS assessment to admitted to the facility on es that included dysphagia and Alzheimer's. Minimum Data Set (MDS) I Resident #89 died in the ated 6/2/18 indicated be sent to the Emergency ation. Form dated 6/2/18 #1 indicated Resident #89	F	64				

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURV	38-039
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETE	
		345523	B. WING		C 12/06/20)18
IAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
	AL HEALTH CARE/RAM	SEUR		7166 JORDON ROAD		
				RAMSEUR, NC 27316		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM IE APPROPRIATE	(X5) IPLETION DATE
F 641	Continued From pag	e 38	F 64	1		
		6/2/18 completed by Nurse				
	#1 indicated Resider					
	U	Services (EMS) out of the				
	facility at 2:15 PM for	r transport to the ER.				
	A written statement o	lated 6/2/18 by Nurse #1				
		nately 2:48 PM EMS called				
		that Resident #89 died before				
	she ever got to the h	ospital.				
	The EMS record date	ed 6/2/18 indicated Resident				
		by EMS out of the facility.				
	-	to the hospital Resident #89				
	-	h was pronounced at 2:29				
	PM in the ambulance	9.				
	A phone interview wa	as conducted with Nurse #1				
	-	PM. She verified that				
		ive when she left the facility				
		and she died on the way to				
	the hospital.					
	An interview was cor	nducted with the Director of				
		t 2:57 PM. She indicated				
		OS to be coded accurately.				
F 644		ARR and Assessments	F 644	1	12/2	1/18
SS=D	CFR(s): 483.20(e)(1))(2)				
	§483.20(e) Coordina	tion.				
	A facility must coordi	nate assessments with the				
	•	ning and resident review				
		under Medicaid in subpart C				
		ximum extent practicable to ting and effort. Coordination				
	includes:					
	§483.20(e)(1)Incorpo	prating the recommendations				
			1			

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	-	ID HUMAN SERVICES			PRINTED: 01/03/201 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED C
		345523	B. WING		12/06/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	AL HEALTH CARE/RAMS		7	166 JORDON ROAD	
UNIVERSI	AL HEALTH CARE/RAMS	BEUR	R	AMSEUR, NC 27316	
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 644	assessment, care pla care. §483.20(e)(2) Referri all residents with new serious mental disord related condition for la a significant change i This REQUIREMENT by: Based on observation medical record review resident with newly e mental illnesses for P and Annual Resident screen for 1 of 1 resid (Resident #78). The findings included Resident #78 was ad 10/5/16 with no ment level I Pre-Admission Resident Review (PA A Psychiatric Physicia Resident #78 dated 6 diagnoses of psychot anxiety disorder, majo pseudobulbar affect (laughing or crying card disorder). This note it that Resident #78 was	report into a resident's inning, and transitions of ng all level II residents and ly evident or possible ler, intellectual disability, or a evel II resident review upon n status assessment. T is not met as evidenced in, staff interview, and v, the facility failed to refer a vident diagnoses of serious Pre-Admission Screening Review (PASARR) Level II dent reviewed for PASARR I: mitted to the facility on al health diagnoses and a Screening and Annual SARR). an 's Assistant note for 6/26/18 indicated the tic disorder due to delusions, or depressive disorder, and (inappropriate involuntary used by a nervous system indicated that staff reported s crying more and had following a decrease in	F 644	F 644 Based on the root cause analysis I facility administrative team and the Executive Director, the SW did not a resident with new onset serious illness and update the Pre-Admiss Screening And Resident Review (PASARR) as required. Immediate A PASARR was sent for review for Resident #78 on 12/21/2018 by the Worker (SW). Identification A review was conducted by the Ex Director (ED) of all active resident diagnosis to determine if any resid a newly (since admission) evident diagnosis of serious mental illness resident identified with a new diagi serious mental illness will be revie physician, in- house psychological services and if warranted sent for to PASARR by the SW or Executiv Director (ED). 3 residents were ide with onset of serious mental illness	e identify mental ion e Social e Social ecutive s ent has . Any nosis of wed by review re entified
	The annual Minimum			submitted for review to PASARR. Social Worker was educated by El requirements set forth for further	D of the

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/03/2019 ORM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		345523	B. WING				C 12/06/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 644	 #78 's cognition was assessment of Residu feeling or appearing of on 2 to 6 days, poor a 11 days, and moving/fidgety/restless on 2 to behaviors on 1 to 3 d noted to put Resident significant risk of injut administered antipsyd antidepressant medic active diagnoses includepression. The Behavioral Symp Assessment (CAA) for Resident #78 was on assist with depression stabilizer) to assist with Seroquel (antipsychol reinitiated after a failer (GDR) in which Resident #78 was on assist with depression. The quarterly MDS as indicated Resident #78 was on The quarterly MDS as indicated Resident #77 impaired. The staff as mood noted her fee down/depressed/hop appetite or overeating moving/speaking slow 2 to 6 days, and being annoyed on 2 to 6 days 	severely impaired. The staff ent #78 's mood noted her down/depressed/hopeless appetite or overeating on 7 to speaking slowly or the o 6 days. She had physical ays. These behaviors were #78 and others at ry. Resident #78 was chotic medication and ration on 7 of 7 days. Her uded psychotic disorder and tooms Care Area for the 8/16/18 MDS indicated Prozac (antidepressant) to n and Depakote (mood th depression and anxiety. tic) was noted to be ad Gradual Dose Reduction thent #78 presented with d tearful episodes that were he Psychotropic the 8/16/18 MDS indicated Seroquel for delusions.	F	644	evaluations in regard to PASARR requirements on 12/21/2018. Any ne employee in this department will be educated during new hire orientation Systemic Measures put into place to ensure pla correction is effective and remains in compliance are: Effective 12/21/2018 PASARRs will be added to daily clinic rounds daily Monday through Friday discussed by the DON, ADON, UC, S and ED the need for PASARR review based on new diagnosis of serious m illness. Monitoring This will be completed daily x 2 week then weekly x 2 weeks, monthly x 3 months. Results will be presented in Quality Assurance Performance Improvement meeting by the SW for recommendations and modifications substantial compliance is achieved. Date of compliance 12/21/2018	an of cal to be SW rental	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345523	B. WING				。 06/2018
	ROVIDER OR SUPPLIER	EUR		7'	TREET ADDRESS, CITY, STATE, ZIP CODE 166 JORDON ROAD	•	
			RAMSEUR, NC 27316				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 644	medication on 7 of 7 of included psychotic dis An observation was con on 12/3/18 at 9:35 AM wheelchair in the half and she was crying. was observed to prov of comfort to Residen An interview was con- Worker (SW) on 12/5, stated she was aware newly diagnosed with was not present on ac needed to be referred re-evaluation. She in for the completion of the confirmed that Reside PASARR. Resident # that included no ment reviewed with SW. R 11/29/18 MDS assess active diagnoses of p depression as well as medication and antide reviewed with the SW not referred Resident authority for a re-eval diagnoses as she tho diagnoses like schizo disorder. An interview was com- Nursing on 12/6/18 at	ion and antidepressant days. Her active diagnoses sorder and depression. onducted of Resident #78 A. She was seated in her way of the memory care unit Nursing Assistant (NA) #8 ide hand holding and words t #78. ducted with the Social (18 at 11:10 AM. She e that when a resident was a serious mental illness that dmission that the resident for a PASARR dicated she was responsible this referral. The SW ent #78 had a level I 478 's admission diagnoses ral health diagnoses were esident #78 's 8/16/18 and sments that indicated the sychotic disorder and the use of antipsychotic epressant medication were 2. The SW revealed she had #78 to the PASARR uation related to these new ught it only applied to phrenia and bipolar	F	544			
	•	ulations related to PASARR					

Facility ID: 991059

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		· · ·	MPLETED
						С
		345523	B. WING		12/06/2018	
NAME OF PI	ROVIDER OR SUPPLIER	-	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	EUR	-	6 JORDON ROAD MSEUR, NC 27316		
		ATEMENT OF DEFICIENCIES	I	PROVIDER'S PLAN OF COR	DECTION	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)		F 656			12/21/18
	implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re- under §483.10, includ treatment under §483 (iii) Any specialized se rehabilitative services provide as a result of recommendations. If a findings of the PASAF rationale in the resider (iv)In consultation with resident's representat (A) The resident's pre- future discharge. Faci whether the resident's community was asses local contact agencies entities, for this purpo	cility must develop and bensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ied in the comprehensive mprehensive care plan must g- tre to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 0.10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)- als for admission and eference and potential for ilities must document is desire to return to the ssed and any referrals to s and/or other appropriate				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/0 FORM APPF OMB NO. 0938	ROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		345523	B. WING		C 12/06/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
	AL HEALTH CARE/RAMS	SELIP		7166 JORDON ROAD		
				RAMSEUR, NC 27316		
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP	X5) PLETION ATE
F 656		in accordance with the	F 65	6		
	requirements set forth section. This REQUIREMENT by: Based on record revi interview, the facility of plan interventions related and swallowing precations (Residents #89, #33, aspiration precautions) The findings included 1. Resident #89 was 3/28/17 with diagnose (difficulty swallowing) aphasia (loss of abiliting speech), hemiplegia (body) affecting right of Alzheimer's disease. A physician's order date physician agreed to a recommended by Spe order indicated Residf one] supervision or difficulty in the swallow between bite [and] liquids". This 4 place throughout the s stay at the facility. Resident #89's plan of monitoring of nutrition related to a diagnosist Alzheimer's disease.	h in paragraph (c) of this is not met as evidenced iew, observation, and staff failed to implement the care ated to feeding assistance butions for 3 of 3 residents and #57) reviewed for s. admitted to the facility on es that included dysphagia following cerebral infarction, y to understand or express (paralysis of one side of the dominant side, and ated 4/17/17 indicated the a dietary order change as eech Therapist (ST) #1. The lent#89, "needs [one on ining room supervision to small bites, eat slow and s, and to alternate solids //17/17 order remained in remainder of Resident #89 '		F 656 Based on the root cause analy facility administrative staff and Director of Nursing, the facility to implement care plan interver related to feeding assistance a swallowing precautions. Immediate Resident # 89 no longer reside facility. Resident # 33 care plan was re- include approaches to reflect the during meals. Resident # 57 care plan was re- include approaches to reflect the during meals. Identification A 100% audit of Residents diag conducted by Director of Nursi Staff Development Coordinator Assistant Director of Nursing (/ Unit Manager (UM) and Director Rehabilitation (DOR) for diagno Dysphagia and Aphasia on 12/ 43 residents were identified with diagnosis of Dysphagia or Aph residents were identified with a recommendation with swallowi guidelines. A Swallowing Guid sheet, was implemented on 12 current recommendations for 2 identified with swallowing indic	the staff failed ntions nd s in the evised to ne needs evised to ne needs gnosis was ng (DON), r (SDC), ADON), or of osis of 5/18 and th a asia, 26 ng lelines /6/18 with 6 of the	

Facility ID: 991059

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		MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /	3	· · ·	MPLETED
			A. BOILDING			С
		345523	B. WING		1	2/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		2/00/2010
			7166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAM	SEUR		RAMSEUR, NC 27316		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION DATE
F 656	Continued From page	e 44	F 65	56		
	mechanical soft with			Guidelines sheets (name,	room number	
	interventions include			diet, and recommendation		
		39 with assist at meals to		and /or speech therapist)		
	ensure optimal and s	afe oral intake.		aspiration precaution bind		
	- Remind Resident #8			each dining room and eac		
	precautions.	-		kiosk. The swallowing gui	deline sheets	
				and the kiosk are reconcil	ed by the	
	The quarterly Minimu	ım Data Set (MDS)		Assistant Director of Nurs	es and changes	
	assessment dated 5/	9/18 indicated Resident		are updated when indicate	ed by the	
	-	severely impaired. She had		physician or speech thera		
		erm memory problems and		residents with diagnosis of		
		cision making. Resident #89		Aphasia care plans were	•	
	was assessed as req			Assistant Director of Nurs	•	
	assistance of 1 for ea	-		revisions required. CNAs		
	-	diet and had no swallowing		the dining room each mea		
		#89 had not received Speech		residents requiring cueing		
	Therapy during this N	nDS period.		precautions by the charge beginning each shift.	inurse at the	
		ted 6/2/18 completed by				
		esident #89 had an incident		Systemic		
	-	on" on 6/2/18 at 1:30 PM.		Measures put into place to		
		ally reported by Nursing		plan of correction is effect		
		he narrative of the incident		in compliance are: Physic		
		nt [Resident #89] out of		speech therapy recomme		
	needs some help '.	s station, stating 'I think she		reviewed daily by DON, A Data Set Coordinator (MD		
		noted in oral cavity. Another		Weekend Nurse Manager		
		loved some food particles		orders and recommendati		
		ures. There was a large		followed on the care plan		
		d food and [Nurse #2]		initiation or revision and re	•	
	-	food until no longer visible".		Swallowing Guidelines sh		
		3		kiosk. Education was pro		
	Based on the staff sc	hedule, the assignment		Executive Director to DON	•	
		erview with the Director of		MDSC, UC and NM regar		
		t 8:20 AM NA #1 was		orders and recommendation		
	responsible for super	vision of Resident #89		care plans, initiating care	plans and	
	during the lunch mea			revising care plans as wa		
				not educated by 12/21/18		
	A written statement (i	incorrectly dated 5/2/18)		allowed to work until educ	ated. Training	

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /	·		IPLETED
						С
		345523	B. WING		12	2/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			7166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAMS	BEUR		RAMSEUR, NC 27316		
(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 SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	2 45	F 65	6		
	indicated that betwee 6/2/18 she was in the out trays and feeding she set up Resident # had grilled chicken th pieces. NA #1 wrote, was helping feed and indicated that around and another NA remo #1 reported she then #89 in her wheelchain indicated that when s door with Resident #8 "making a noise like s NA #1 wrote that she the hall in her wheelc Nurse #4 to help her. she reached the nurs #2, and Nurse #4 we the nurses removed a Resident #89 ' s mou	1:30 PM lunch was over, oved Resident #89's tray. NA started pushing Resident out of the dining room. She he reached the dining room 39 she heard the resident she was trying to throw up". pushed Resident #89 down hair and started yelling for She indicated that when e's station Nurse #1, Nurse re there. She indicated that about 4 ounces of food from th.		of licensed and certified staff pro SDC and DON on cueing and as precautions and responsibilities a to the care plan initiated on 12/6/ licensed and certified nursing sta receive this training prior to work shift. This training will be include licensed and certified nursing sta orientation process. Monitoring Physician orders and therapy recommendations will be added to daily rounds Monday through Frie discussed by the DON, ADON, L MDSC to ensure physician order recommendations are being carr to the care plan as well as the CI Kardex. This will be completed of weeks, then weekly x2 weeks, the monthly x3 months. Results will	piration as related 18. All ff will ing next id in new ff to the day to be IC and s and ied over NA laily x2 en be	
	written statement rela substance ingestion of was reviewed with N/ recalled setting up Re indicated Resident #8 set-up during lunch in She stated that she lo during the meal to ma that she had not obse meal as she was help was asked if she noti eating fast, if she was holding food in her m	The incident report and her ated to the incident of on 6/2/18 for Resident #89 A #1. She stated that she esident #89's tray. She 39 ate independently after in the dining room on 6/2/18. boked over at Resident #89 ake sure she was eating, but erved her during the whole boing someone else. NA #1 ced if Resident #89 was is swallowing, if she was outh, or if she required any was safely eating. NA #1		presented in the Quality Assuran Performance Improvement (QAP meeting by the DON for recommendations and modificati substantial compliance is achieve Date of Compliance 12/21/2018	I) ons until	

Facility ID: 991059

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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:				(X3) DATE COMP	E SURVEY PLETED	
		345523	B. WING				C / 06/2018	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316			
(X4) ID PREFIX TAG			ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 656	stated, "to be honest This interview with N/ asked if Resident #89 interventions related to swallowing/aspiration that Resident #89 wa while eating but explation that Resident #89 wa while eating but explation on one observation it make sure she was e was not aware of any swallowing precaution confirmed she had no cues to Resident #89 date. A phone interview wa on 12/5/18 at 12:20 P related to Resident #89 date. A phone interview wa on 12/5/18 at 12:20 P related to Resident #89 substance ingestion w She stated that when #89 out to the nurse's could see [Resident # food". A phone interview was on 12/4/18 at 4:11 PM reviewed with Nurse a Resident #89 was bro station by NA #1 that observation alone that full of food. An interview was con Nursing (DON) on 12 plan related to nutrition indicated she was to at meals to ensure op	with you I don ' t recall". A #1 continued. NA #1 was b had any care plan to nutrition, eating, or precautions. She stated s supposed to be observed ained that this was not one was just checking on her to ating. She revealed she cueing related to hs for Resident #89 and she of provided any of these on 6/2/18 or on any prior s conducted with Nurse #1 PM. The incident report	F	650	6			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345523	B. WING				C 06/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
UNIVERS	AL HEALTH CARE/RAMS	SEUR			'166 JORDON ROAD RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	IFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE G REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 656	stated that swallowing ensuring the resident was not pocketing foc the swallowing precase provision of cueing to small bites, eat slowly solids and liquids. Shi interventions had not #89 on 6/2/18 during indicated her expecta interventions to be fol 2. Resident #33 was 1/17/14 with diagnose (difficulty in swallowing The most recent com assessment coded as 7/20/18 revealed the oriented with periods setup and supervision assessment had door coughing or choking of swallowing medicatio mechanically altered Review of a Speech T stated the resident re he was at increased r in which food, liquids, into the airways). He consume small portio adaptive spoon. The most recent MDS as a Quarterly assess assessed the resident	ewed with the DON. She g precautions included was sitting up straight and od. She additionally stated utions also included the swallow the food, take y, and to alternate between he revealed these care plan been followed for Resident the lunch meal. She tion was for the care plan lowed. admitted to the facility on es that included dysphagia g) and Diabetes Mellitus. prehensive MDS is an Annual and dated resident was alert and of confusion. He required in with meals. The umentation that he had during meals and when ins and received a diet. Therapy note dated 7/25/18 quired close supervision as isk of aspiration (A condition saliva, or vomit is breathed was not to talk while eating,	F	656			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345523	B. WING				C /06/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 656	documentation that he during meals or when and received a mechan Review of the resident 10/15/18 revealed the mechanically altered difficulties and required with supervision and of guidelines were to be Review of Resident # Checklist revealed the resident during meals thick liquids, required verbal cues to take sr alternate food and dri no straws, a small cup two to three times; lin teaspoon or less, swa bite, empty mouth be alternate bites of food several sips of liquid a remind resident to che tongue or finger and of pocketing; remind res eating, eliminate distr eating and sit up right eating. The Swallow F a binder in the dining resident's medical red Review of a FMP (Fur Program) note dated resident was started of difficulties and was to follow aspiration pred	 Is. The assessment had e had coughing or choking a swallowing medications anically altered diet. It's active care plan dated e resident received a diet, had swallowing ed setup of the meal tray cues. The safe swallow utilized during meal time. 33's Swallow Precautions e following needs for the s: Pureed diet with nectar constant supervision with nall bites, eat slow and nk, sit upright during meals; p with one sip then swallow mit bite size to half a allow 2 to 3 times with each fore additional bites, I with sips of liquid, drink at the end of the meal, eck for pocketed food with check mouth after meals for ident to slow down while actions, no talking while t for 20 to 30 minutes after Precautions Checklist was in room, as well as the cord 	F	656			

Facility ID: 991059

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345523	B. WING				C 106/2018
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	SEUR			166 JORDON ROAD RAMSEUR, NC 27316		
(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 656	During an observation resident #33 was eati He had the appropria consistency. No straw and he was using a m The resident was obs amounts of food pres coughed three times of staff were observed p supervision, cues or m the Swallow Precaution the dining room were and assisting other re- the opposite side of th An interview with the Coordinator/FMP num 1:25 PM, who stated the resident's progress to see if he is following precautions. She furth required cues during the dining room were supervision and cuess An interview was con 12/4/18 at 2:15 PM. S fast during meals and She was able to state as well as no straws a spoon with all meals. the dining room super to slow down while th and assisting other re-	e nursing assistants (NA). In on 12/4/18 at 12:45 PM, ng lunch in the dining room. te diet and liquid ws were present in his fluids haroon spoon to eat with. Herved eating fast, with small ent on the spoon and during the lunch meal. No providing any type of reminders to the resident per ons Checklist. The staff in observed passing out trays esidents with their meals on the dining room. Staff Development se occurred on 12/4/18 at that the FMP NA monitors ss with meals once a week ig the swallowing her stated that Resident #33 meals and that the NA's in responsible for providing during his meals. ducted with FMP Aide on She stated Resident #33 ate I required cues to eat slow. his correct diet consistency and the need for the maroon She added that the NA's in rvise him and provided cues ey were passing out trays isidents with their meals. n 12/4/18 at 4:50 PM with	F	656			
	During an interview o NA #6, she explained						

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345523	B. WING				。 06/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				7	7166 JORDON ROAD		
UNIVERS	AL HEALTH CARE/RAMS	EUR		F	RAMSEUR, NC 27316		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	supervision and cues are passing out other monitors the resident tables. She was able required supervision a have his maroon spoo not to have any straw the dining room was a Precautions Checklist special needs during a During an observation resident was in the dir Correct diet and fluid Staff were observed p assisting other reside or prompts we	to Resident #33 while they resident's trays and from the assisted dining to state the resident and cues to eat slow, must on with all meals and was s. She further stated that in a binder with the Swallow t for any resident that had a meal. n on 12/5/18 at 8:10 AM the ning room eating breakfast. consistency was present. bassing out trays and nts with their meal. No cues erved from staff during the with NA #2 on 12/5/18 at not confirm how supervision dents that require cues brecautions other than to say reghing she would ask if they hat no one sat at the table AM an interview occurred ad that Resident #33 slow. She stated that he was nts to receive their tray and p they reminded him to eat his liquids were thickened, on spoon. She stated that ervised while the other trays at. She further stated that a the dining room with the Checklist for any resident	F	656			

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RS FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391			
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) [DATE SURVEY
	345523	B. WING _			C 12/06/2018
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
	EUD		7166 JORDON ROAD		
AL HEALTH CARE/RAMS	BEOR		RAMSEUR, NC 27316		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	CTION SHOULD BE	(X5) COMPLETION DATE
Continued From page	9 51	F 6	56		
AM, she stated that R while staff were passi assisted dining tables down when this was of that he required supe Swallow Precautions During an interview of Director of Nursing sta expectation for the ca 3. Resident #57 adm 7/27/18 with diagnose Disease, Protein Calc difficulty swallowing. comprehensive asses revealed he was mod and required supervise	Resident #33 was supervised ng out trays and from the swith reminders to slow observed. She confirmed rvision and cues per the Checklist. In 12/6/18 at 3:00 pm the ated that it was her are plan to be followed. Witted to the facility on es of Dementia, Parkinson's orie Malnutrition, and His most recent assment dated 11/29/18 erately cognitively impaired sion of staff for meals. He				
revealed an order for and Honey Thick Liqu A Swallow Precaution stated Resident #57 r supervision, sitting up eating, taking small cu swallow, cough and c then swallow, alternat liquid at end of meal, less, and check mout A review of Resident	Regular Mechanical Soft iids Diet dated 11/15/18. As Checklist dated 11/16/18 equired constant oright 90 degrees when up sips, taking one sip then lear throat after each sip te bites of food with sips of bite size to half teaspoon or h after meals for pocketing.				
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I During an interview w AM, she stated that R while staff were passi assisted dining tables down when this was of that he required supe Swallow Precautions During an interview o Director of Nursing st expectation for the ca 3. Resident #57 adm 7/27/18 with diagnose Disease, Protein Calo difficulty swallowing. comprehensive asses revealed he was mod and required supervis was also coded as ha during meals. Review of Resident # revealed an order for and Honey Thick Liqu A Swallow Precaution stated Resident #57 r supervision, sitting up eating, taking small c swallow, cough and of then swallow, alternat liquid at end of meal, less, and check mout A review of Resident updated on 11/30/18	F CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345523 ROVIDER OR SUPPLIER AL HEALTH CARE/RAMSEUR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 51 During an interview with NA #5 on 12/6/18 at 9:30 AM, she stated that Resident #33 was supervised while staff were passing out trays and from the assisted dining tables with reminders to slow down when this was observed. She confirmed that he required supervision and cues per the Swallow Precautions Checklist. During an interview on 12/6/18 at 3:00 pm the Director of Nursing stated that it was her expectation for the care plan to be followed. 3. Resident #57 admitted to the facility on 7/27/18 with diagnoses of Dementia, Parkinson's Disease, Protein Calorie Malnutrition, and difficulty swallowing. His most recent comprehensive assessment dated 11/29/18 revealed he was moderately cognitively impaired and required supervision of staff for meals. He was also coded as having coughing and choking	F CORRECTION IDENTIFICATION NUMBER: A. BUILDIN IDENTIFICATION NUMBER: A BUILDIN IDENTIFICATION NUMBER: A BUILDIN A BUILDIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 51 F 6 During an interview with NA #5 on 12/6/18 at 9:30 AM, she stated that Resident #33 was supervised while staff were passing out trays and from the assisted dining tables with reminders to slow down when this was observed. She confirmed that he required supervision and cues per the Swallow Precautions Checklist. During an interview on 12/6/18 at 3:00 pm the Director of Nursing stated that it was her expectation for the care plan to be followed. 3. Resident #57 admitted to the facility on 7/27/18 with diagnoses of Dementia, Parkinson's Disease, Protein Calorie Malnutrition, and difficulty swallowing. His most recent comprehensive assessment dated 11/29/18 revealed he was moderately cognitively impaired and required supervision of staff for meals. He was also coded as having coughing and choking during meals. Review of Resident #57's Physician's Orders revealed an order for Regular Mechanical Soft and Honey Thick Liquids Diet dated 11/16/18 stated Resident #57 required constant supervision, sitting upright 90 degrees when eating, taking small cup sips, taking one sip then swallow, cough and clear throat after each si	F CORRECTION IDENTIFICATION NUMBER: A BUILDING 345523 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 21 AL HEALTH CARE/RAMSEUR STREET ADDRESS, CITY, STATE, 21 IDENTIFICATION NUMBER: B. WING (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX Continued From page 51 F 656 During an interview with NA #5 on 12/6/18 at 9:30 AM, she stated that Resident #33 was supervised while staff were passing out trays and from the assisted dining tables with reminders to slow down when this was observed. She confirmed that it was her expectation for the care plan to be followed. 3. 3. Resident #57 admitted to the facility on 7/27/18 with diagnoses of Dementia, Parkinson's Disease, Protein Caloric Malnutrition, and difficulty swallowing. His most recent comprehensive assessment dated 11/29/18 revealed he was moderately cognitively impaired and required supervision of staff for meals. He was also coded as having coughing and choking during meals. Review of Resident #57's Physician's Orders revealed he was moderately cognitively impaired and required supervision of staff tor meals. Stip <td>F CORRECTION IDENTIFICATION NUMBER: A. BUILDING </td>	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING

Facility ID: 991059

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345523	B. WING				C / 06/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	swallowing difficulty. revealed Resident #5 meals, use an inner li utensils. Interview with Nurse A pm revealed Residen dining room. She sta when he eats and he constant staff supervi not aware of Residen precautions for eating. During an interview w 12/5/18 at 8:35 am sh requires constant sup stated there is a Swa his Medical Record th Speech Therapist #2 required constant sup degrees when eating, taking one sip then sy throat after each sip t of food with sips of lic to half teaspoon or le meals for pocketing. During an interview w 12/5/18 at 12:41 pm s at the dining table wit staff follow-up, but the he eats. She stated s another table while sh so he does not receiv at meals. An interview on 12/6/ Director of Nursing re	The care plan further 7 should be supervised at p plate, and large grip Aide #5 on 12/04/18 at 3:10 t #57 usually eats in the ted she does not sit with him eats his meals without sion. She stated she was t #57 having any g. with Speech Therapist #2 on he stated Resident #57 pervision during meals. She llowing Precautions Sheet in hat the staff should follow. stated Resident #47 pervision, sitting upright 90 , taking small cup sips, wallow, cough and clear hen swallow, alternate bites juid at end of meal, bite size ss, and check mouth after	F	656			

Facility ID: 991059

If continuation sheet Page 53 of 110

D SERVICES IDER/SUPPLIER/CLIA IFICATION NUMBER: 345523 F DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)	PREFIX (EACH CORRECT) TAG CROSS-REFERENC	PLAN OF CORRECTION (X5)
F DEFICIENCIES PRECEDED BY FULL	ID PREVIDERS'S CITY, STAT T166 JORDON ROAD RAMSEUR, NC 27316 ID PROVIDER'S PI PREFIX (EACH CORRECT) TAG CROSS-REFERENC	12/06/2018 TE, ZIP CODE PLAN OF CORRECTION
PRECEDED BY FULL	7166 JORDON ROAD RAMSEUR, NC 27316 ID PROVIDER'S P PREFIX (EACH CORRECT) TAG CROSS-REFERENC	PLAN OF CORRECTION (X5)
PRECEDED BY FULL	ID PROVIDER'S PI PREFIX (EACH CORRECT TAG CROSS-REFERENC	
PRECEDED BY FULL	ID PROVIDER'S P PREFIX (EACH CORRECT TAG CROSS-REFERENC	
	DEI	TVE ACTION SHOULD BE COMPLETION SED TO THE APPROPRIATE DATE FICIENCY)
w the residents'	F 656	
1	F 657	12/21/18
are Plans e care plan must er completion of nt. nary team, that ponsibility for the bility for the ition services staff. he participation of representative(s). ed in a resident's ion of the resident ve is determined ment of the rofessionals in he resident's needs t. le interdisciplinary ncluding both the eview het as evidenced taff interview, the ise the care plan for	F 657 Based on the root ca	
	ve is determined ment of the rofessionals in ne resident's needs t. ne interdisciplinary ncluding both the eview	ve is determined ment of the rofessionals in he resident's needs t. he interdisciplinary including both the review let as evidenced taff interview, the ise the care plan for ion (Residents #72)

Facility ID: 991059

If continuation sheet Page 54 of 110

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 01/03/20 ⁷ RM APPROVE O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY IPLETED
		345523	B. WING		12	2/06/2018
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COE		
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		166 JORDON ROAD RAMSEUR, NC 27316		
(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 657	Continued From page	e 54	F 657			
	sampled residents re			care plans for falls, hydration nutrition.	and	
	Findings included:			Immediate Resident #83 care plan revise	ed to include	
		admitted to the facility on dmitted on 11/3/18 with		falls and interventions by AD 12/13/18.		
		cluding right femur fracture.		Resident #72 care plan revise fluid restrictions by the Regis		
	assessment dated 10			Dietician on 12/17/2018.		
	Resident #83 had inta falls.	act cognition and had no		Resident #89 no longer resid facility.	es in the	
	reviewed. One of the Resident #83 was at decrease mobility, we to admission. The go experience no injurio The approaches inclu- clean and clutter free rearrange furniture of accommodate her pro- used belongings with with activities of daily call light within reach its use, monitor for sa to ask for assistance at low position with b toileting per protocol to lock brakes during and administer medic monitor for side effect	aff to make her bed were ches. There were no		Identification A 100% audit of Residents w last 30 days was conducted to Nursing (DON), Assistant Dir Nursing (ADON) and Unit Ma on 12/21/2018 and there wer plans requiring revision for fa residents on fluid restrictions reviewed by DON, ADON and 12/18/2018 and no care plan revision. 100% audit of all re nutrition care plans were revi Registered Dietician on 12/13 no revisions required. Corrective actions will be acc for those residents having the be effected by the same define All have the potential to be at time care plan is due. Systematic Measures put into place to er plan of correction is effective in compliance are: Effective	by Director of ector of inager (UM) e no care lls. 100% of were d UM on s required sident ewed by 3/2018 and complished e potential to cient practice. fected at the	
	The nurse's notes an reviewed. The note/re	d incident reports were eport dated 10/20/18		Falls, fluid restriction and nut will be added to daily clinical	rition status	

Facility ID: 991059

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STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	LE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
	GUILETION	BENTHICKNON NUMBER.	A. BUILDING			C
		345523	B. WING			2/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
UNIVERS	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
(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)	SHOULD BE	(X5) COMPLETION DATE
F 657	noted to have a bruis tear to left shin. On 1 revealed that Resider sustained a right fem On 12/5/18 at 11:20 / interviewed. The MD Resident #83 had a fi sustained right femor that Resident #83 wa after the fall and was MDS Nurse had verif declined in her ADLs indicated that the Ass (ADON) was respons plan after every falls. On 12/5/18 at 11:22 / interviewed. She sta had met and discusse The ADON verified th with major injury and on 10/31/18. She ind (11/3/18), the care pla but it was not. On 12/6/18 at 2:59 P (DON) was interviewed she expected the MD for revising the care pla	AM, the ADON was ted that the falls committee ed residents who had falls. tat Resident #83 had a fall and oral fracture. AM, MDS Nurse #1 was S Nurse verified that all on 10/31/18 and al fracture. She indicated is discharged to the hospital readmitted on 11/3/18. The ied that Resident #83 had after the fall. She also sistant Director of Nursing sible for revising the care AM, the ADON was ted that the falls committee ed residents who had falls. tat Resident #83 had a fall was admitted to the hospital licated that after readmission an should have been revised AM, the Director of Nursing ed. The DON stated that by Nurse to be responsible olan every after falls. She	F 65		C to ensure dingly. e Executive ON, MDSC ewing and 2 weeks, nonthly x 3 ented by the and compliance	
	2. Resident #72 was 10/10/18 with multiple	admitted to the facility on e diagnoses including ire (CHF). The admission				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMF	
		345523	B. WING				06/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	EUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 657	10/17/18 indicated that cognitive impairment. Resident #72's care p reviewed. One of the resident has the poter related to use of diure would not show signs dehydration daily. The monitor fluid intake are in glass so resident car offer fluids when enter each medication pass bedside and remind/e fluids throughout the of On 11/20/18, Resider for 1500 milliliter (ml) provide 720 ml. On 12/6/18 at 3:19 PI interviewed. She stat Resident #72 should order for the fluid rest not. On 12/6/18 at 2:59 PI (DON) was interviewed she expected the MD	IDS) assessment dated at Resident #72 had severe blan dated 10/19/18 was care plan problems was ntial for fluid volume deficit etic. The goal was resident and symptoms of the approaches included nd output daily, place straw an drink fluid independently, r resident's room and with a and maintain fluids at encourage resident to drink	F	65			
	when the fluid restrict 3. Resident #89 was 3/28/17 with diagnose (difficulty swallowing) aphasia (loss of ability	n of Resident #72 revised ion was ordered. admitted to the facility on es that included dysphagia following cerebral infarction, y to understand or express paralysis of one side of the					

Facility ID: 991059

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345523	B. WING				C / 06/2018
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	area of the need for n status and weight sta dysphagia and Alzhei initiated on 2/19/18 ar reviewed/revised on 8 Manager (DM). The in Resident #89 was red dysphagia. The quarterly Minimu assessment dated 5/8 #89's cognition was s short-term and long-to severely impaired ded had not received Spe this MDS period. A review of the ST do Resident #89 was dis on 5/12/17 and ST ha An interview was con 12/5/18 at 2:20 PM. nutritional status (initi reviewed/revised 5/8/ indicated she was red reviewed with the DM was responsible for th #89 and revealed tha as ST had not been a 2018.	dominant side, and of care indicated the problem nonitoring of nutritional tus related to a diagnosis of mer's. This care plan was nd most recently 5/8/18 by the Dietary interventions indicated ceiving speech therapy for m Data Set (MDS) 9/18 indicated Resident everely impaired. She had erm memory problems and cision making. Resident #89 ech Therapy (ST) during cumentation indicated charged from their services ad not been reinitiated. ducted with the DM on The care plan related to	F	657			
	Nursing on 12/4/18 at	t 2:00 PM. She verified that t received ST since 2017.					

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					OMB NO. O		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SU COMPLE		
		345523	B. WING		C 12/06	/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316			
(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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E ((X5) COMPLETION DATE	
F 657	She stated she experience	e 58 cted the care plans to I to reflect the resident's	F 657				
F 689 SS=J		ards/Supervision/Devices (2)	F 689)	12	2/21/18	
	as free of accident has §483.25(d)(2)Each re- supervision and assis accidents. This REQUIREMENT by: Based on record rev- interviews with Speed Dietician, physician, a supervise residents v- during meals for 3 of #33, and #57) review precautions. Resider nursing staff with a m- vomiting noise after r- transferred to the Em- Emergency Medical S ambulance on the war Immediate Jeopardy approximately 1:30 P #1 observed Resider sound following the lu- eaten in the dining ro nursing staff to have ground/chewed food,	ure that - sident environment remains azards as is possible; and esident receives adequate stance devices to prevent T is not met as evidenced iew, observation, and ch Therapist, Registered and staff, the facility failed to vith aspiration precautions 3 residents (Residents #89, red for aspiration nt #89 was observed by nouth full of food making a neal time. She was rergency Room by Services and died in the ay to the hospital. began on 6/2/18 at 2M when Nursing Assistant at #89 making a vomiting unch meal that she had om. She was assessed by		F 689 Based on the root cause analysis by the facility administrative staff and the facility administrative staff and the facility administrative staff and the facility control of Nursing, facility staff did not provide direct supervision for resident during meal. Immediate On 6/2/2018 at approximately 1:30pm Resident was escorted from the dining room and was noted making a vomitin noise. The Certified Nursing Assistant immediately took the resident to the nurse's station where the nurse assess resident having difficulty swallowing at showing signs of aspiration with audib wheezing. The nurse attempted to remove food particles from resident's mouth but was unsuccessful in remov- all food particles and therefore denture	lity t #89 n, g t sed nd le		

Event ID: BQIO11

Facility ID: 991059

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· /	E SURVEY PLETED
							С
		345523	B. WING			12	2/06/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316			
(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)		(X5) COMPLETIO DATE
F 689	Continued From page	e 59	F 68	89			
		chief complaint of "choking".	1.00		During this process the resident contin	hau	
		route to the hospital with			to try to chew and swallow. At this time		
		into cardiac arrest and			resident's lips became cyanotic and	-	
		d was pronounced dead on			showing signs of difficulty breathing so		
	6/2/18 at 2:29 PM.				Heimlich maneuver was initiated by the	е	
					nurse without success. Resident		
		was removed on 12/6/18			remained conscious and was moving a		
		ided and implemented an			The resident was taken from the nurse	-	
		Illegation of Immediate			station to her room in wheelchair by th Nurse supervisor, Nurse and Certified	e	
		r scope and severity of "D"			Nursing Assistant. Nurse supervisor		
	(isolated and no harm			suctioned resident to attempt to remov	'e		
	than minimal harm th			remaining food particles unsuccessfull			
	jeopardy) to ensure n	nonitoring systems put in			Resident's oxygen saturation was 79		
	place are effective.				percent, oxygen at 5 liters was applied	via	
					non-rebreather face mask. Physician		
					Assistant and Responsible Party were		
	The findings included				notified at 1:40pm. The Physician		
	1 Decident #90 wee	admitted to the facility on			Assistant stated to call Emergency Management Services. Emergency		
		es that included dysphagia			Services was called at 1:45pm and		
		following cerebral infarction,			arrived at 2:00pm. First Responders to	ok	
		y to understand or express			over care of the resident. Facility Nurs		
		(paralysis of one side of the			staff remained in room for support. Fir		
	body) affecting right of				Responders applied oxygen with their		
	Alzheimer's disease.				regulator at fifteen liters per minute. A	t	
					2:10pm the Emergency Management		
		ated 4/17/17 indicated the			Technicians (EMT) arrived. They		
		a dietary order change as			discussed with first responders and fac		
		eech Therapist (ST) #1. The nge] diet to [mechanical			staff resident's condition and decision suction resident in ambulance. First	10	
		esident #89] needs [one on			Responders and Emergency		
		ining room supervision to			Management Technicians assisted the		
		small bites, eat slow and			resident to the hall in her wheelchair,		
		es, and to alternate solids			placed her on the gurney and proceed	ed	
		1/17/17 order remained in			to the ambulance. The EMTs remaine	d in	
		remainder of Resident #89's			the ambulance for a few minutes and I	eft	
	stay at the facility.				the facility at 2:15pm. At 2:48pm the		
					EMTs called to get next of kin contact		

Facility ID: 991059

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/03/20 MAPPROVE 0. 0938-039	
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		E SURVEY PLETED	
		345523	B. WING		C 12/06/2018		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
				7166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAM	SEUR		RAMSEUR, NC 27316			
(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	(X5) COMPLETIO DATE	
F 689	Continued From page	<u>e 60</u>	F 689				
1 000			F 008	information and informed the	otoff that the		
		ation Risk Assessment dated ident #89 had severely		resident had died prior to read			
		aking, she was rarely/never		hospital. On 6/2/18 an invest	-		
		had impairment on one side		initiated immediately by the D			
		ies. She was assessed as		Nursing and the Administrator			
	dependent on staff for	r assistance with eating.		statements received from staf	f present in		
	Resident #89 was no	ted to have no swallowing		the dining room, at the nurse'	s station. At		
	disorders and she wa	as on mechanically altered		the conclusion of the investigation			
	diet.			determined that the Certified	-		
				Assistant was at the table pro	-		
		of care indicated she needed		assistance to another residen			
	related to a diagnosis	nal status and weight status		According to the Certified nur assistant's statement she follo	-		
		This care plan, initiated on		aspiration precautions by sett			
		cently reviewed/revised on		tray, the chicken was in small			
	5/8/18, indicated Res	-		saw her eating while helping a			
	mechanical soft with			resident. During the facility in			
	interventions include	d, in part:		the C.N.A. did not state or do	cument in		
	- Provide Resident #8	39 with assist at meals to		her statement that she did not	t provide		
	ensure optimal and s			supervision.			
	- Remind Resident #	89 of swallowing					
	precautions.			Identification			
	The quarterly Minimu	Im Data Set (MDS)		A 100% audit of Residents dia conducted by Director of Nurs			
		9/18 indicated Resident		Staff Development Coordinate	• • •		
		severely impaired. She had		Assistant Director of Nursing			
	-	erm memory problems and		Unit Manager (UM) and Direc			
	-	cision making. Resident #89		Rehabilitation (DOR) for diagr			
	was assessed as req	•		Dysphagia and Aphasia on 12			
	assistance of 1 for ea	•		43 were identified with diagno			
	•	diet and had no swallowing		Dysphagia or Aphasia, 26 we			
		#89 had not received Speech		with recommendations with sy	•		
	Therapy during this N	IDS period.		guidelines. An information sh			
		dy Appropriate data d 5/0/40		Swallowing Guidelines sheet,			
		ly Assessment dated 5/9/18		implemented on 12/6/18 with			
		gistered Dietician (RD)		recommendations for those 2			
		39's diet was, "[mechanical] d she was noted with no		with swallowing guidelines red supervision. The Swallowing			
		ler diagnoses included		sheets (name, room number,			

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/03/20 RM APPROVE IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED	
		345523	B. WING			C 12/06/2018		
NAME OF PI	ROVIDER OR SUPPLIER	-		TREET ADDRESS, CITY, STATE, ZIP CODE				
			7166 JORDON ROAD		166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAM	SEUR		R	AMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 689	Continued From page	e 61	E 4	689				
1 000				009	recommendation from physician and			
	dysphagia and Alzhe	1111EL 2 UISEASE.			recommendation from physician and speech therapist) are located in an			
	Resident #80's Nursi	ng Assistant (NA) Kardex			aspiration precaution binder located in an	n		
		d, indicated Resident #89's			each dining room and each resident			
		soft with finger food and she			kiosk. The swallowing guideline shee			
		1:1) supervision or dining			and the kiosk are reconciled by the			
	room supervision.				Assistant Director of Nurses and cha	nges		
					are updated when indicated by the			
		ocumentation of Resident			physician or speech therapist All 43			
	-	ce for May 2018 indicated:			residents with diagnosis of Dysphagia			
		mented as independent with			Aphasia care plans were reviewed by	/ the		
	no set up				Assistant Director of Nursing with no	ava a d		
	set up only	mented as supervision with			revisions required. CNAs will be assign to residents identified requiring cuein	•		
	- 10 meals were docu	imented as limited			aspiration precautions by the charge	y anu		
	assistance of 1				nurse at the beginning each shift.			
	- 1 meal was docume	ented as extensive			Training of licensed and certified staf	f		
	assistance of 1				provided by SDC and DON on cueing			
	- 28 meals were docu	umented as dependent of 1			aspiration precautions and responsib	-		
					initiated on 12/6/18. All licensed and			
		ocumentation of Resident			certified nursing staff will receive this			
	-	ce for 6/1/18 through 6/2/18			training prior to working next shift. The			
	indicated:				training will be included in new licens	ed		
		re documented with 1 noted			and certified nursing staff orientation			
	as limited assistance dependent of 1				process.			
		documented, and it was			Systemic			
	noted as limited assis				Measures put into place to ensure the	е		
					plan of correction is effective and rem			
					in compliance are: On 12/5/18 an			
	An incident report da	ted 6/2/18 completed by			implementation of a dining room staff	:		
Nurse #1 indicated Resident #89 had an incident of "substance ingestion" on 6/2/18 at 1:30 PM.				sign-in sheet to include sign in times/	•			
				out times as well as aspiration preca				
	The incident was initially reported by NA #1. The				and supervision to be provided. This			
		ent read, "[NA #1] brought			information is located in a binder in e	ach		
		dining room to nurses			dining room and resident care kiosk.			
	-	nk she needs some help '.			Management, Licensed Nursing or			
		ompleted with food noted in			Department Head will monitor meal	ion		
	oral cavity. Another I	nurse [Nurse #2] removed			supervision, utilizing Dining Supervision			

Facility ID: 991059

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/03/2019 / APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345523	B. WING	B. WING			C 06/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				71	166 JORDON ROAD		
UNIVERS	AL HEALTH CARE/RAMS	SEUR		R	AMSEUR, NC 27316		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	some food particles fi There was a large an and [Nurse #2] contin longer visible. As [Re wheeze, Heimlich ma resident. Mouth chec noted." Resident #89 noted as temperature 28, blood pressure (E 0. The physician was immediate actions tal sweep, Heimlich, VS, and Emergency Medi transported Resident post-incident actions sent to the Emergency A nursing note dated #1 indicated the follow "1:30 PM - [Resident hallway by [NA #1] ou stated resident was co [Resident #89] had a trying to chew and sw resident to spit out for do so and clamped te to swallow the food. the Heimlich maneuv remove dentures and of food in mouth and well as food stuck to #89] began to have a oxygen saturation wa rate 75, respirations 2 [(bluish discoloration circulation)]. [Reside oxygen applied at 5 [1 1:40 PM - Notified [PI	rom mouth and dentures. hount of well ground food hued to remove food until no esident #89] began to aneuver was performed on ck repeatedly with no food 0's vital signs (VS) were e 95.7, pulse 75, respirations 8/P) 100/70, and pain scale s notified at 1:40 PM. The ken were noted as a mouth , oxygen (O2), 911 called, ical Services (EMS) #89. The immediate indicated Resident #89 was cy Room (ER). 6/2/18 completed by Nurse	F	689	Manager Observation sheet. Supervision is being provided to ensure aspiration safety precautions are being followed during meals in the dining rooms and residents that eat in their rooms. The Director of Nursing will assign manage to the dining rooms to include residen rooms. Effective 12/5/18, on-site licen staff, certified staff and department he were trained by SDC on the information provided on aspiration precautions and residents requiring supervision to ensi- that safety precautions are being follo. This information is located in a binder each dining room and resident care ki- training on the Heimlich maneuver wi- return demonstration and proper use suction machine was conducted as wi- This education was provided by the Registered Nurse, Staff Development Coordinator (SDC) to Licensed staff a other licensed staff will be trained prior next shift worked. Emergency equipm (suction machine) was placed 12/5/18 the dining rooms, set-up was complet and instructions were given to License Staff by the SDC. On 12/5/18 education was also provided by the SDC for nur staff to ensure supervision is being provided during meals and ensure aspiration precautions and safety is be provided. Licensed and Certified Nurse staff were also educated on the signs symptoms of aspiration. This education was provided by RN Staff Developme Coordinator. Staff not educated by 12/6/18 will not be allowed to work un educated. Effective 12/6/18, education providing supervision during meals to	and for ers t sed ads on d ure wed. in osk. ith of ell. nd of ell. nd of ell. nd of ell. sin g and on nt til	

Facility ID: 991059

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	D. 0938-039 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED	
						С	
		345523	B. WING		12/06/2018		
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE			
				7166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAM	SEUR		RAMSEUR, NC 27316			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	ΓΙΟΝ	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION	
F 689	Continued From page	e 63	F 689	9			
	to send to ER. 1:45 I	PM - Called EMS for		ensure aspiration precautions and	safety		
		:00 PM - EMS arrived - VS		is added to all new employee orier	-		
		79%, [heart rate] 104,		This education will also be conduc			
		100/70. 2:15 pm EMS		annually by SDC for all staff. CNAs	s will be		
	transported [Residen	t #89] to ER at this time".		assigned to residents identified rec	quiring		
				cueing and aspiration precautions			
		ated 6/2/18 for Resident #89		charge nurse at the beginning eac			
		R for evaluation per family		Training of licensed and certified s			
	request and [physicia	an]".		provided by SDC and DON on cue	-		
				aspiration precautions and response			
	A Resident Transfer I			initiated on 12/6/18. All licensed ar			
		#1 indicated Resident #89		certified nursing staff will receive th			
		local hospital. The reason		training prior to working next shift.			
		oted to be "choking while		training will be included in new lice			
	eating chicken".			and certified nursing staff orientation process.	חכ		
	The EMS record date	ed 6/2/18 was reviewed. The					
	record indicated the f			Monitoring			
	The chief complaint f			Effective 12/6/18, The Director of N	lursina.		
		IS were en-route to the		Assistant Director of Nursing, Staff			
	-	nders on scene advised		Development Coordinator, Nurse			
		as "condition red" (critical)		Management, Licensed Nursing or			
		on. Upon EMS arrival on		Department Head will monitor mea			
	scene Resident #89	was seated upright in a		supervision, utilizing Dining Superv	/ision		
	wheelchair with first r	esponders administering		Manager Observation sheet. Supe	rvision		
	high flow O2 via mas	 K. The first responders 		is being provided to ensure aspirat			
	advised EMS that Re			safety precautions are being follow			
		ed a large amount of		during meals in the dining rooms a			
		and began choking on it.		residents that eat in their rooms.			
	-	all they could from Resident		mentioned above will be assigned	to each		
		at. Resident #89 was		meal for supervision utilizing the	of		
		air to EMS stretcher and		Assignment calendar. The Director			
		lity onto the transport. to the ER Resident #89 was		Nursing will assign managers to th rooms to include resident rooms. T	•		
		bund to have chicken in her		monitoring process will be continue			
		n was removed. Resident		the Charge nurses on Saturday an			
		with decreased respiratory		Sunday. This monitoring will be	u		
		ite was decreasing into an		conducted daily for four weeks, the	'n		
	extremely bradycardi			weekly x4, then monthly thereafter		1	

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		MEDICAID SERVICES				O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>′</i>	LE CONSTRUCTION		E SURVEY	
						С	
		345523	B. WING		12/06/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
UNIVERS	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316			
(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)	SHOULD BE	(X5) COMPLETION DATE	
F 689	Approximately 2 minu Resident #89 was no respiratory failure. A (DNR) was present w resuscitative efforts w death was pronounce Upon arrival at the Eff since Resident #89 e was to be transferred #89's physician was of that since it was an "t to be a Medical Exam #89 was transported examined by the ME. A death certificate, si Examiner on 6/5/18, i choked on a bolus (a saliva) of chicken at t accidental death on 6 cause identified as "a airway by bolus of for A phone interview wa 12/5/18 at 3:30 PM. longer worked at the to recall any specifics reviewing the speech speech therapy plan	utes prior to arrival at the ER ted with cardiac arrest and A valid Do Not Resuscitate vith the resident and no vere made. Resident #89's ed on 6/2/18 at 2:29 PM. R the physician advised that xpired prior arrival that she I to the morgue. Resident contacted, and he advised un-natural death" it needed hiner's (ME) case. Resident to the morgue and was to be gned by the Medical indicated Resident #89 ball-like mixture of food and the facility resulting in an S/2/18 with the immediate asphyxia - occlusion of	F 68		y Assurance nt mendations		
	therapy plan of care of ST #1 indicated spee for Resident #89 due The physician's order dietary order change "[change] diet to [med [Resident #89] needs	vith ST #1. The speech dated 3/28/17 completed by ech therapy was necessary to dysphagia and aphasia. r dated 4/17/17 indicated a as recommended by ST #1, chanical soft] finger foods. s [one on one] supervision or ion to cue [resident] to take					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/03/2019 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345523	B. WING					C 06/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	EUR			166 JORDON ROAD RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 689	and to alternate solids #89's speech therapy dated 5/12/17 complete aspiration precautions the provision of complete swallowing as well as communication. ST # Resident #89's diet of soft and finger foods. #89 was able to have mechanical soft foods bite size pieces was a based on the diet ord her expectations relate Resident #89. She st in her room that 1:1 s provided. She indicate dining room she expet the vicinity of her and provide compensatory precaution cues to the meal. She explained reminders to take sittif wheelchair, taking sm alternating between s swallow her food. Based on the staff scl schedule, and an inter Nursing on 12/5/18 at supposed to be in the on 6/2/18 were NA #1 DON reported that NA Resident #89 at the ti DON revealed it was	and swallow between bites, a [and] liquids". Resident discharge instructions eted by ST #1 indicated a were to be continued with ensatory strategies for strategies to maximize at was asked about rder that stated mechanical She reported that Resident finger foods and/or a. She stated that chicken in appropriate for Resident #89 er. ST #1 was asked about red to meal supervision for rated that if Resident #89 ate upervision was to be ted if Resident #89 ate in the otted a staff member to be in for the staff member to be in for the staff member to y strategy cues/aspiration e resident throughout the that these cues included ng up straight in her all sips, taking small bites, olids and liquids, and to hedule, the assignment rview with the Director of a 8:20 AM the NAs that were dining room during lunch , NA #2, and NA #3. The A #1 was supervising me of the incident. The unknown how many lunch in the dining room at	F	689				

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 01/03/2019 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345523	B. WING				C 06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
			7	166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAMS	EUR	F	RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 689	completed by NA #1 w indicated that betwee 6/2/18 she was in the out trays and feeding she set up Resident # had grilled chicken the pieces. NA #1 wrote, was helping feed and indicated that around and another NA remo #1 reported she then #89 in her wheelchair indicated that when sl door with Resident #8 "making a noise like s NA #1 wrote that she the hall in her wheelch Nurse #4 to help her. she reached the nurse #2, and Nurse #4 wer the nurses removed a Resident #89's mouth A phone interview wa 12/5/18 at 5:08 PM. written statement rela substance ingestion of was reviewed with NA describe the seating a room for herself and F during the lunch meal Resident #89 was sea rectangular table that She indicated that 2 s the table and one sea She was unable to real	hoorrectly dated 5/2/18) was reviewed. NA #1 in 12:15 PM and 1:30 PM on dining room helping pass residents. She noted that #89's tray reporting that she at was cut up into small "I saw her eating while I ther resident". She 1:30 PM lunch was over, ved Resident #89's tray. NA started pushing Resident out of the dining room. She he reached the dining room 49 she heard the resident the was trying to throw up". pushed Resident #89 down hair and started yelling for She indicated that when e's station Nurse #1, Nurse e there. She indicated that about 4 ounces of food from h. s conducted with NA #1 on The incident report and her ted to the incident of on 6/2/18 for Resident #89 A#1. NA #1 was asked to arrangements in the dining Resident #89 on 6/2/18 . She reported that ated at one end of a had seating for 6 residents. eats were on each side of t on each end of the table. call if all 6 of the seats were a on 6/2/18 during the lunch	F 689				

Facility ID: 991059

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(V2) DAT	E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	IPLETED	
			A. BUILDING	<u> </u>		С	
		345523	B. WING		12/06/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		2/00/2010	
				7166 JORDON ROAD	DL		
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		RAMSEUR, NC 27316			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 689	Continued From page	- 6 7	Ге	20			
1 009			F 68	39			
		eating on this date (6/2/18)					
	-	believed the resident she					
		ated next to Resident #89. recall with certainty if she					
		Resident #89 and the					
		isting or if she was seated					
		of the resident she was					
		that she recalled setting up					
		She reported that Resident					
		en that had been cut up into					
	-	as some vegetables. She					
		39 ate independently after					
		the dining room on 6/2/18.					
		boked over at Resident #89					
		ake sure she was eating, but					
	-	erved her during the whole					
		bing someone else. NA #1					
		ced if Resident #89 was					
		s swallowing, if she was					
		outh, or if she required any					
	•	as safely eating. NA #1					
		with you I don't recall". She					
		nows that Resident #89 was					
		g any unusual sounds during					
		't think there was anything					
	she needed". She re	eported that after Resident					
	#89's tray had been of	cleared she was going to					
		room to lay down. She					
	•	n to push Resident #89 by					
		dining room when the					
	resident started coug						
		aking a noise like she was					
		She reported she called out					
		to help and that it was					
		alized Resident #89 had					
		A #1 was asked if she had					
I	observed Resident #8	VO's mouth prior to	1			1	
		of the dining room and she					

Facility ID: 991059

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/03/2019 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·				(X3) DATE COMP	SURVEY LETED
		345523	B. WING			_		C 06/2018
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	EUR			166 JORDON ROAD AMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	and then from behind wheelchair. She rever Resident #89 from the room. She additional noticed during the lun was not swallowing he This interview with NA asked if Resident #89 eating. She stated th #89 ate independently no assistance. She w had any specific dieta aspiration precautions #89 was supposed to but explained that this was just checking on eating. She was aske any specific cueing an cueing Resident #89 encouragement to ea there rather than feed order dated 4/17/17 a 6/2/18 that indicated I to take small bites, ea bites, and to alternate with NA #1. NA #1 re of this order and she these cues to Residen prior date. A written statement da NA #2 was reviewed. walked into the dining (6/2/18) and saw Res fingers. The resident pieces of chicken in h	Resident #89 from the side , so she could push her aled she had not observed e front before exit the dining ly revealed she had not ch meal that Resident #89 er food. A #1 continued. NA #1 was required assistance with at most of the time Resident y after set-up and required vas asked if Resident #89 rry orders related to s. She stated that Resident be observed while eating s was not 1:1 observation it her to make sure she was ed if Resident #89 required nd she stated that the only	F	689				

Facility ID: 991059

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/03/2019 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
		345523	B. WING		_	C 12/0	;)6/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				7166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAMS	EUR		RAMSEUR, NC 27316			
(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	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 689	Continued From page room. NA #2 then left An interview was cond 12/5/18 at 10:37 AM. written statement rela ingestion on 6/2/18 for reviewed with NA #2. and out of the dining room on 6/2/18 and that she #89 with eating. She #89 in the dining room independently. This interview with NA asked if Resident #89 eating. She stated that ate independently after assistance, but other and not eat so she ne encouragement. She had any specific dieta aspiration precautions NAs were just suppose ensure she was eating was not 1:1 observation her throughout the material	e 69 t the dining room. ducted with NA #2 on The incident report and her ted to incident of substance r Resident #89 was She stated that she was in room during the lunch meal e had not assisted Resident reported she saw Resident n and that she was eating A #2 continued. NA #2 was required assistance with at some days Resident #89 er set-up and required no days she would just sit there ieded some verbal was asked if Resident #89	F 68	C		TE	DATE
	she stated that the on required was encoura days. The physician's was an active order o	ly cueing Resident #89 gement to eat on some s order dated 4/17/17 and n 6/2/18 that indicated cueing to take small bites,					
	eat slow, swallow bet solids liquids was revi revealed she was not	ween bites, and to alternate weed with NA #2. NA #2 aware of this order and she of these cues to Resident					
	An interview was con	ducted with NA #3 on					

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		ID HUMAN SERVICES MEDICAID SERVICES					NTED: 01/03/2019 FORM APPROVED B NO. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION		DATE SURVEY COMPLETED	
		345523	B. WING			C 12/06/2018		
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
				7166	JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAMS	SEUR		RAM	MSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	12/4/18 at 2:45 PM. S being in the dining ro She reported that she resident eat and that Resident #89. NA #3 required assistance w that sometimes she for she needed assistance encouragement. She had and specific dieta interventions, or cues precautions. NA #3 r Resident #89 was on she needed "checked eating just to make su because sometimes so food in front of her an A written statement d Nurse #1 was review approximately 1:30 P #89 out of the dining needs some help". S was assessed with a trying to chew and sw mouth". Nurse #1 wr Resident #89 to spit of had not done so. Nur Resident #89 to spit of had relamped her mo chewing the food in h removed the dentures and performed a mou "large amount" estima ground food" remove mouth. Nurse #2 cor #89's mouth until no mouth. Resident #89	She stated that she recalled om during lunch on 6/2/18. was helping another she had not observed was asked if Resident #89 with eating. She indicated ed herself and sometimes ce in the form of was asked if Resident #89 ary orders, care plan related to aspiration eported she recalled that a finger food diet and that d up on" while she was ure she was feeding herself she just sat there with her ad had not fed herself. ated 6/2/18 completed by ed. Nurse #1 indicated at M NA #1 brought Resident room stating that "I think she wallow the food in her ote that she encouraged but the food, but the resident se #2 was noted to also tell but the food, but the resident woth shut and was still	F	689				

Facility ID: 991059

If continuation sheet Page 71 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/03/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345523	B. WING				C 06/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
			7	166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAMS	EUR	F	RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 689	on Resident #89 with her mouth. Resident sat) was noted as 79 were blue". NA #1 ar #89 to her room as N Physician 's Assistan Party (RP) at approxin gave the order for trans A phone interview wa on 12/5/18 at 12:20 P nursing note, and her Resident #89's 6/2/18 ingestion were review verified that she had of documents and confir written. Nurse #1 sta Resident #89 as brout that she "visibly could mouth full of food" an food out. Nurse #1 w required any assistan revealed she believed to be supervised while "needed to be remind A written statement, u Nurse #2 indicated th medication cart on 6/2 PM when NA #1 brout nurse's station and st wrong and that she the choking. Nurse #2 in large amount of food was still chewing on the asked Resident #89 to had not done so. She	he performed the Heimlich no more food expelled from #89's oxygen saturation (O2 % on room air and her "lips ad Nurse #3 took Resident urse #1 contacted the t (PA) and the Responsible mately 1:40 PM. The PA nsfer to the ER. s conducted with Nurse #1 M. The incident report, written statement related to 8 incident of substance ved with Nurse #1. She completed all of these med the information as ted that when NA #1 brought ght out to the nurse's station I see [Resident #89] had a d that she wouldn't spit the as asked if Resident #89 ce with eating. She d Resident #89 had an order	F 689				

Facility ID: 991059

If continuation sheet Page 72 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES				RINTED: 01/03/2019 FORM APPROVED MB NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345523	B. WING			C 12/06/2018	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZI	P CODE		
			7	166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAMS	EUR	F	RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	remove food until novindicated that Resider and had a "noted char reported that Nurse # Resident #89. The re- room air and she was Nurse #3 and Nurse # with Nurse #1 to prep Resident #89 to the E A phone interview wa on 12/4/18 at 4:11 PM her handwritten stated Nurse #2. She verifie was brought out to the that it was apparent of that the resident had stated that Resident # out and that she comp resulting in a large an food being removed to A written statement da Nurse #3 was reviewed around 1:30 PM on 6/ toward the nurse's state Nurse #2 called her o Resident #89 who wa and were removing cl Nurse #3 wrote that N her that Resident #89 mouth to allow her to audible wheezing and discolored. Nurse #3 #4 took Resident #89 with a mask at 5 lpm audibly moving air. A	d food and continued to visible food was seen. She nt #89 then began wheezing nge in color". Nurse #2 1 performed the Heimlich on esident's O2 sat was 79% on then taken to her room by #4. She indicated she went are the paperwork to send FR. s conducted with Nurse #2 A. The incident report and ment were reviewed with ed that when Resident #89 e nurse's station by NA #1 in visual observation alone a mouth full of food. She #89 would not spit the food pleted a mouth sweep nount of ground/chewed he resident's mouth. ated 6/5/18 completed by ed. Nurse #3 indicated that /2/18 she was walking ation when Nurse #1 and ver. They were surrounding is seated in her wheelchair newed food from her mouth. Jurse #1 and Nurse #2 told ' "had too much food in her swallow". Resident #89 had I her lips and fingertips were wrote that she and Nurse to her room and applied O2 and she was noted to	F 689				

Facility ID: 991059

If continuation sheet Page 73 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345523	B. WING				C /06/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(X5) COMPLETION DATE		
F 689	PM and they transpor wheelchair to the EM facility. A phone interview wa on 12/5/18 at 4:32 PM her written statement 6/2/18 incident of sub reviewed with Nurse a information document Nurse #3 stated that I consciousness at any She reported Resider wheezing throughout waiting for first respor A written statement da Nurse #4 was reviewe #1 brought Resident choking". Nurse #4 w mouth and cheeks we still chewing on the fo asked to spit out the f kept chewing and wo indicated Nurse #1 ar visible food from Resi A phone interview wa on 12/5/18 at 1:45 PM unable to recall any s	arrived at approximately 2:00 ted Resident #89 from her S stretcher and left the s conducted with Nurse #3 A. The incident report and related to Resident #89's stance ingestion were #3. Nurse #3 confirmed the ted in her written statement. Resident #89 had no loss of point while at the facility. nt #89 continued with audible the time period they were	F	68	DEFICIENCY)		
	12/5/18 at 11:55 AM.	ducted with the RD on The Nutrition Quarterly 9/18 completed by the RD					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391			
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED			
		345523	B. WING				C 2/ 06/2018			
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE					
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316					
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE			
F 689	mechanical soft, finge RD indicated that if a "mechanical soft, finge was able to receive ei- revealed that sometim June 2018 the facility that contained more ti- due to a directive from explained that dietary for Resident #89 that finger foods", appeare as mechanical soft was finger foods. She furt mechanical soft was of finger foods were cut pieces. She stated th note the facility was so that contained more to texture/consistency. change with diet orde incident of substance She stated that she w	indicated her diet was er foods was reviewed. The resident had an order for er foods" that the resident ither type of food. She ne in the latter portion of ceased utilizing diet orders han one texture/consistency in the corporate office. She orders, such as the order stated, "mechanical soft, ed to be contradictory orders as a different texture than ther explained that normally ground food and up into small/bite size hat at the time of her 5/9/18 till regularly utilizing orders	F	689						
	#89's physician on 12 physician reported that recommendations of 3 be followed. He indic were expected to be in resident noted to be a	ST as well as his orders to ated aspiration precautions mplemented for any an aspiration risk.								
	Nursing (DON) on 12 revealed that when sh	ducted with the Director of /4/18 at 4:20 PM. The DON ne investigated the 6/2/18 ingestion for Resident #89								

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	-	ID HUMAN SERVICES				FORM	MAPPROVED	
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MU	тірі	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED	
			A. DOILD				с	
		345523	B. WING				06/2018	
NAME OF PI	ROVIDER OR SUPPLIER	I	1		STREET ADDRESS, CITY, STATE, ZIP CODE	/	00/2010	
					7166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAMS	SEUR			RAMSEUR, NC 27316			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·		PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)			
F 689	Continued From page	275	F	689	0			
		esident likely aspirated. She		000	3			
		tations were for staff to						
		nd cueing as recommended						
		by the physician. She						
		at she expected aspiration						
	-	plemented for all residents						
	identified as at risk fo							
		d DON were notified of the						
	Immediate Jeopardy	on 12/5/18 at 3:03 PM.						
	On 12/6/18 at 7:06 DI	M the facility provided the						
	following credible alle							
	Jeopardy removal:							
	Address how corrective	ve action will be						
	accomplished for the	resident found to have been						
	affected by the deficie	ent practice:						
		oximately 1:30pm, Resident						
		e dining room and was						
		ting noise. The Certified						
	-	nediately took the resident where the nurse assessed						
		ulty swallowing and showing						
		th audible wheezing. The						
		move food particles from						
	resident's mouth but							
		ticles and therefore dentures						
		form a mouth sweep. During						
		ent continued to try to chew						
		ime resident's lips became						
		signs of difficulty breathing						
		euver was initiated by the						
	nurse without succes	-						
	conscious and was m	noving air. The resident was						

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D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/03/2 FORM APPRO OMB NO. 0938-0		
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
345523	B. WING		C 12/06/2018		
		STREET ADDRESS, CITY, STATE, ZIP CC			
		7166 JORDON ROAD			
EUR		RAMSEUR, NC 27316			
TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLET HE APPROPRIATE DATE		
 76 a station to her room in se supervisor, Nurse and stant. Nurse supervisor attempt to remove es unsuccessfully. turation was 79 percent, applied via non-rebreather Assistant and Responsible 1:40pm. The Physician Il Emergency Management 'Services was called at 2:00pm. First Responders resident. Facility Nurse staff support. First Responders resident. Facility Nurse staff support. First Responders not the Emergency ians (EMT) arrived. They sponders and facility staff ad decision to suction e. First Responders and nent Technicians assisted I in her wheelchair, placed I proceeded to the Ts remained in the ninutes and left the facility to the EMTs called to get formation and informed the had died prior to reaching 8 an investigation was by the Director of Nursing and statements received he dining room, at the conclusion of the etermined that the Certified a at the table providing resident. 	F 68				
	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345523 EUR TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) 76 76 8 station to her room in 18 se supervisor, Nurse and 19 stant. Nurse supervisor 19 attempt to remove 19 susuccessfully. 10 turation was 79 percent, 10 applied via non-rebreather Assistant and Responsible 1:40pm. The Physician 11 Emergency Management 1:40pm. First Responders resident. Facility Nurse staff support. First Responders resident. Facility Nurse staff support. First Responders 1:40pm. The Physician 10 Emergency 1:40pm. The Physician 11 Emergency Management 1:40pm. The Physician 10 Emergency Management 1:40pm. The Physician 10 Emergency Management 1:40pm. The Sponders resident. Facility Nurse staff support. First Responders resident. Facility Nurse staff support. First Responders 1:40 decision to suction 2. First Responders and tent Technicians assisted 1 in her wheelchair, placed 1 in her wheelchair, placed 2 proceeded to the 1 s remained in the ninutes and left the facility 1 the EMTs called to get 1 ormation and informed the had died prior to reaching 8 an investigation was by the Director of Nursing and statements received 1 the table providing 1 resident.	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING 345523 B. WING	MEDICAID SERVICES (X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345523 B. WING STREET ADDRESS, CITY, STATE, ZIP CO 7166 JORDON ROAD RAMSEUR, NC 27316 EUR STREET ADDRESS, CITY, STATE, ZIP CO 7166 JORDON ROAD RAMSEUR, NC 27316 TREET ADDRESS, CITY, STATE, ZIP CO 7166 JORDON ROAD RAMSEUR, NC 27316 STREET ADDRESS, CITY, STATE, ZIP CO 7166 JORDON ROAD RAMSEUR, NC 27316 TAG CONSTRUCTION INFORMATION) TAG TAG CONSTRUCTION INFORMATION) TAG TAG TAG CONSTRUCTION TAG CONSTRUCTION INFORMATION) TAG TAG		

Facility ID: 991059

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		10. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	ECONSTRUCTION	· · · ·	MPLETED	
					С		
		345523	B. WING		1	2/06/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/00/2010	
				7166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAM	SEUR	1	RAMSEUR, NC 27316			
(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	(X5) COMPLETIO DATE	
F 689	Continued From pag	e 77	F 689				
		eating while helping another	F 008				
		view with C.N.A. on 6/2/18 by					
		and Administrator, she would					
		iding supervision and cueing.					
		-					
	Address how the fac						
		potential to be affected by					
	the same deficient p	ractice:					
	A 100% audit of Res	idents diagnosis was					
		or of Nursing (DON), Staff					
	-	nator (SDC), Assistant					
		ADON), Unit Manager (UM)					
		abilitation (DOR) for diagnosis					
		bhasia on 12/5/18 and 43					
	Aphasia, 26 were ide	diagnosis of Dysphagia or					
		ith swallowing guidelines. An					
		wallowing Guidelines sheet,					
	was implemented on	12/6/18 with current					
	recommendations fo	r those 26 identified with					
		s requiring supervision. The					
	-	es sheets (name, room					
	number, diet, and re-	h therapist) are located in an					
		binder located in each					
		h resident care kiosk. The					
	-	sheets and the kiosk are					
		sistant Director of Nurses					
	•	dated when indicated by the					
		therapist All 43 residents with					
		gia and Aphasia care plans e Assistant Director of					
		sions required. CNAs will be					
		s identified requiring cueing					
	-	utions by the charge nurse at					
	the beginning each s	shift. Training of licensed and					
	a antificad at off many lide		1	1			
	cueing and aspiration	ed by SDC and DON on					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/03/2019 1 APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		345523	B. WING				C 06/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAMS	EUR		RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page responsibilities initiate and certified nursing s prior to working next s included in new licens staff orientation proce Address what measur systemic changes ma deficient practice will On 12/5/18 an implem staff sign-in sheet to i times as well as aspir supervision to be prov located in a binder in resident care kiosk. M Nursing or Departmer supervision, utilizing D Observation sheet. So to ensure aspiration a being followed during and for residents that Director of Nursing wi dining rooms to includ 12/5/18, on-site licens department heads we information provided of and residents requirin safety precautions are information is located room and resident can Heimlich maneuver w and proper use of suc conducted as well. Th by the Registered Nur	e 78 ed on 12/6/18. All licensed staff will receive this training shift. This training will be sed and certified nursing ss. re will be put into place or de to ensure that the not recur: nentation of a dining room nclude sign in times/sign out ation precaution and vided. This information is each dining room and Anagement, Licensed at Head will monitor meal Dining Supervision Manager upervision is being provided and safety precautions are meals in the dining rooms eat in their rooms. The Il assign managers to the le resident rooms. Effective sed staff, certified staff and are trained by SDC on the on aspiration precautions g supervision to ensure that e being followed. This in a binder in each dining re kiosk. Training on the ith return demonstration	F 689	DE			
		rained prior to next shift					

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DEPART CENTER	FORM): 01/03/2019 (I APPROVED): 0938-0391					
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING				C 06/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	EUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 689	machine) was placed set-up was completed given to Licensed Sta education was also pr nursing staff to ensure provided during meals precautions and safet Licensed and Certifier educated on the signs aspiration. This educ Staff Development Co educated by 12/6/18 v until educated. Effect providing supervision aspiration precautions new employee orients also be conducted an CNAs will be assigner requiring cueing and a charge nurse at the b Training of licensed a SDC and DON on cue precautions and respon 12/6/18. All licensed a receive this training p This training will be in certified nursing staff Indicate how the facilit performance to make sustained: and includa action will be complet Effective 12/6/18, The Assistant Director of N Coordinator, Nurse M Nursing or Department supervision, utilizing I	12/5/18 in the dining rooms, d and instructions were ff by the SDC. On 12/5/18 rovided by the SDC for e supervision is being s and ensure aspiration by is being provided. d Nursing staff were also s and symptoms of ation was provided by RN bordinator. Staff not will not be allowed to work tive 12/6/18, education on during meals to ensure s and safety is added to all ation. This education will nually by SDC for all staff. d to residents identified aspiration precautions by the eginning each shift. nd certified staff provided by eing and aspiration onsibilities initiated on and certified nursing staff will rior to working next shift. cluded in new licensed and orientation process. ty plans to monitor its sure that solutions are e dates when corrective ed:	F	689			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG.		COMP	LETED
		345523	B. WING				C 06/2018
NAME OF PI	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	,	00,2010
	AL HEALTH CARE/RAMS				7166 JORDON ROAD		
UNIVERSI	AL HEALTH CARE/RAMS	BEUR			RAMSEUR, NC 27316		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIEVING INFORMATION)	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	OULD BE CON	
IAG					DEFICIENCY)		
TAG F 689	Continued From page to ensure aspiration a being followed during and for residents that mentioned above will for supervision utilizin The Director of Nursir the dining rooms to in monitoring process w Charge nurses on Sa monitoring will be con then weekly x4, then will be reported by the monthly Quality Assur Improvement committ recommendations or of compliance is achie Effective 12/6/18 the and the Director of Nur responsible for the im correction to ensure to maintains substantial Compliance Date 12/0 The credible allegatio removal was validated Record review indicat and there were 43 res dysphagia or aphasia	and safety precautions are meals in the dining rooms eat in their rooms. Staff be assigned to each meal g the Assignment calendar. ng will assign managers to clude resident rooms. This ill be continued by the turday and Sunday. This iducted daily for four weeks, monthly thereafter. Findings e Director of Nursing in the rance and Performance tee meeting for modifications until a pattern eved. facility Executive Director ursing will be ultimately plementation of this plan or he facility attains and compliance.	F	689			DATE
	for swallowing guideli Guidelines sheet impl						
	dinner meal on 12/6/1 room sign in sheet, as	ntified. Observation of the 8 confirmed the dining spiration precaution binder,					
	was present to provid	were all in place, a manager e monitoring during the					
	meal, and residents re aspiration precautions	equiring cueing and swere assigned an NA. A					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345523	B. WING				C 106/2018	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/RAMS	EUR			7166 JORDON ROAD RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 689	interviews verified edi 12/5/18 on aspiration symptoms of aspiration requiring supervision were in place. Licens education on the Heir use of the suctioning inserviced by 12/6/18 inserviced prior to wo 2. Resident #33 was 1/17/14 with diagnose (difficulty in swallowin The most recent com assessment coded as 7/20/18 revealed the oriented with periods setup and supervision assessment had door coughing or choking of swallowing medicatio mechanically altered Review of a Speech T stated the resident re he was at increased r in which food, liquids, into the airways). He consume small portio adaptive spoon. Review of Resident # Checklist dated 9/20/ needs for the residen with nectar thick liquids supervision with verbal	gn in sheets as well as staff ucation was initiated on precautions, the signs and on, cueing, and residents to ensure safety precautions sed staff were provided with mlich Maneuver and proper machine. Any staff not were required to be rking on the floor. admitted to the facility on es that included dysphagia (g) and Diabetes Mellitus. prehensive MDS is an Annual and dated resident was alert and of confusion. He required in with meals. The umentation that he had during meals and when ins and received a diet. Therapy note dated 7/25/18 quired close supervision as isk of aspiration (A condition saliva, or vomit is breathed was not to talk while eating, ins, eat slow and use 33's Swallow Precautions 18 revealed the following t during meals: Pureed diet	F	689	9			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345523	B. WING				C 106/2018	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-		
UNIVERS	AL HEALTH CARE/RAMS	EUR			7166 JORDON ROAD RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 689	during meals; no strat then swallow two to the half a teaspoon or less each bite, empty mou- alternate bites of food several sips of liquid a remind resident to che- tongue or finger and of pocketing; remind ress eating, eliminate distre eating and sit up right eating. The most recent MDS as a Quarterly assess assessed the residen periods of confusion. supervision with meal documentation that he during meals or when and received a mecha- Review of the resider 10/15/18 revealed the mechanically altered difficulties and requires supervision and cuess guidelines were to be Review of a FMP (Fu Program) note dated resident was started of follow aspiration prec precautions checklist with supervision of the Review of a physician	ws, a small cup with one sip pree times; limit bite size to s, swallow 2 to 3 times with th before additional bites, I with sips of liquid, drink at the end of the meal, eck for pocketed food with check mouth after meals for ident to slow down while actions, no talking while t for 20 to 30 minutes after 6 (Minimum Data Set) coded sment and dated 10/8/18, t as alert and oriented with He required setup and s. The assessment had e had coughing or choking swallowing medications anically altered diet. At's active care plan dated e resident received a diet, had swallowing ed setup of meal tray with . The safe swallow utilized during meal time.	F	68	9			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING _				C 06/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
UNIVERS	AL HEALTH CARE/RAMS	SEUR			166 JORDON ROAD AMSEUR, NC 27316		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	nectar thick liquids, m small maroon spoon of difficulty swallowing. During an interview w at 10:10 AM, he indic spoon and wasn't sup He was unable to stat were needed during r During an observation resident #33 was eati He had the appropria consistency. No stray and he was using a m The resident was obs amounts of food pres coughed three times of staff were observed p supervision, cues or m the Swallow Precaution the dining room were and assisting other ree the opposite side of th During an interview w Coordinator/FMP num she stated that the FM resident's progress w see if he was followin precautions. She furth required cues during the dining room were supervision and cues An interview was con 12/4/18 at 2:15 PM, w fast during meals and	o straws and to use the with all meals due to with Resident #33 on 12/4/18 ated that he used a pink oposed to talk with meals. te any other precautions that meals. In on 12/4/18 at 12:45 PM, ing lunch in the dining room. te diet and liquid ws were present in his fluids haroon spoon to eat with. terved eating fast, with small ent on the spoon and during the lunch meal. No providing any type of reminders to the resident per ons Checklist. The staff in observed passing out trays esidents with their meals on the dining room. with the Staff Development se on 12/4/18 at 1:25 PM MP NA monitored the ith meals once a week to g the swallowing her stated that Resident #33 meals and that the NA's in responsible for providing	F	589			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391			
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	COM	E SURVEY PLETED C		
		345523	B. WING				06/2018		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
UNIVERS	AL HEALTH CARE/RAMS	EUR			/166 JORDON ROAD RAMSEUR, NC 27316				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 689	as well as no straws a spoon with all meals. the dining room super cues to slow down wh trays and assisting of meals. On 12/4/18 at 2:30 PP of the Swallow Precar were kept in a binder sheet was present at staff to sign in and ou present for in the dinin During an interview of explained the staff pro- to Resident #33 while resident's trays and m the assisted dining tai the resident required slow, must have his m and was not to have a stated that in the dinin the Swallow Precaution resident that had spect During an observation resident was in the di Correct diet and fluid Staff were observed p assisting other reside or prompts were obset breakfast meal. During an interview w 10:45 AM, she could was provided for reside related to aspiration p	and the need for the maroon She added that the NA's in rvised him and provided hile they were passing out her residents with their M an observation was made utions Checklists which in the dining room. A sign in the front of the binder for t for each meal they were ng room. n 12/4/18 at 4:50 PM, NA #6 by ded supervision and cues they were passing out other nonitored the resident from bles. She was able to state supervision and cues to eat naroon spoon with all meals any straws. She further ng room was a binder with ons Checklist for any cial needs during a meal. n on 12/5/18 at 8:10 AM the ning room eating breakfast. consistency was present.	F	689					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/03/2019 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION			SURVEY LETED
		345523	B. WING		_		。 06/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/RAMS	EUR		7166 JORDON ROAD RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	table with Resident #3 During an interview w 11:15 AM, who stated cues to eat slow. She the first residents to re the staff set it up they made sure that his liq had his maroon spoor resident was supervision were being passed ou binder was present in Swallow Precautions with special needs du During an interview of stated that Resident # staff were passing our dining tables with rem this was observed. Sh required supervision a Precautions Checklist An interview was com Therapist #2 on 12/6/ that Resident #33 had Therapy multiple time swallowing difficulties and reminders to eat eating. She stated that cues when the tray wa thru out the meal. She completed the Swallo all residents with swa the evaluation and up	hat staff did not sit at the 33. ith NA #7 on 12/5/18 at that Resident #33 required stated that he was one of eccive their tray and when reminded him to eat slow, uids were thickened, and he n. She stated that the ed while the other trays at. She further stated that a the dining room with the Checklist for any resident ring meals. n 12/6/18 at 9:30 AM, NA #5 433 was supervised while t trays and from the assisted inders to slow down when he confirmed that he and cues per the Swallow the ducted with Speech 18 at 11:00 AM. She stated d been seen by Speech s in the past due to and that he required cues slow and not talk while at he did better with verbal as setup and occasionally	F 689				
	noted on Resident #3	3 Swallow Precaution's resident should be within					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345523	B. WING				C 06/2018
NAME OF PI	ROVIDER OR SUPPLIER		- I		STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(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 689	Director of Nursing streexpectation for all residifficulties to be appro- meals times. 3. Resident #57 adm 7/27/18 with diagnose Disease, Protein Calc difficulty swallowing. Review of Resident # revealed an order for and Honey Thick Liqu A Swallow Precaution stated Resident #57 r supervision, sitting up eating, taking small of swallow, cough and of then swallow, alternat liquid at end of meal, less, and check mout Resident #57's most n Minimum Data Set As	n 12/6/18 at 3:00 pm the ated that it was her idents with swallowing opriately supervised during itted to the facility on es of Dementia, Parkinson's orie Malnutrition, and 57's Physician's Orders Regular Mechanical Soft adds Diet dated 11/15/18. As Checklist dated 11/16/18 required constant oright 90 degrees when up sips, taking one sip then lear throat after each sip te bites of food with sips of bite size to half teaspoon or h after meals for pocketing.	F	68			
	and required supervis was also coded as had during meals. A review of Resident a updated on 11/30/18 the resident would no swallowing difficulty.	The care plan further					
		7 should be supervised at p plate, and large grip					

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	-	D HUMAN SERVICES				FORM	MAPPROVED
STATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED
		345523	B. WING				C 106/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		00,2010
UNIVERSA	AL HEALTH CARE/RAMS	EUR			166 JORDON ROAD RAMSEUR, NC 27316		
(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 689	Continued From page	87	F	689			
	pm revealed she was required any precaution he usually eats in the	Aide #5 on 12/04/18 at 3:10 not aware Resident #57 ons for eating. She stated dining room and sometimes t. She stated she does not eats.					
	12/5/18 at 8:35 am sh requires constant sup stated there is a Swal	ith Speech Therapist #2 on he stated Resident #57 ervision during meals. She lowing Precautions Sheet in hat the staff should follow.					
	at the dining table with staff follow-up, but the he eats. She stated s	she stated Resident #57 sits h other residents and the ey do not sit with him while					
F 756 SS=E	Director of Nursing re staff would supervise difficulties as ordered care plan. Drug Regimen Review	18 at 3:00 pm with the vealed her expectation is residents with swallowing and follow the residents' w, Report Irregular, Act On 2)(4)(5)	F	756			12/21/18
	•	men Review. Ig regimen of each resident east once a month by a					
	§483.45(c)(2) This re- of the resident's medi	view must include a review cal chart.					
	§483.45(c)(4) The ph	armacist must report any					

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	-				PRINTED: 01/03/20 FORM APPROV OMB NO. 0938-03
-		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING JA4523 B. WING NAME OF PROVIDER OR SUPPLIER Tries JORDON ROAD UNIVERSAL HEALTH CARE/RAMSEUR STREET ADDRESS, CITY, ST PREFX SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL) D PREFX REGULATORY OR LSC. IDENTIFYING INFORMATION) TAG F 756 Continued From page 88 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. F 756 (i) Ingularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. F 756 (ii) The attending physician must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's medical director and director of nursing and lists, at a minimum, the resident's medical for the monthly and the irregularity the pharmacist identified. F 756 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Physician's Assistant, and staff, the Pharmacy Consultant failed t		12/06/2018			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	AL HEALTH CARE/RAMS	SEUR			
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 756	irregularities to the at facility's medical direct and these reports mu (i) Irregularities included drug that meets the c (d) of this section for (ii) Any irregularities re- during this review mu separate, written repor- attending physician a director and director of minimum, the residen and the irregularity th (iii) The attending phy resident's medical reo irregularity has been action has been taken be no change in the r physician should door the resident's medical \$483.45(c)(5) The fac maintain policies and drug regimen review limited to, time frames the process and steps when he or she identified requires urgent action This REQUIREMENT by: Based on record revi Pharmacy Consultant Physician's Assistant. Consultant failed to ic of an antibiotic presor and without an adequ (Residents #10 and # identify and address a	tending physician and the ctor and director of nursing, ist be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. noted by the pharmacist ist be documented on a bort that is sent to the nd the facility's medical of nursing and lists, at a tit's name, the relevant drug, e pharmacist identified. visician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in I record. clility must develop and procedures for the monthly that include, but are not is for the different steps in is the pharmacist must take ifies an irregularity that in to protect the resident. is not met as evidenced iew and interviews with the t, the Physician, the , and staff, the Pharmacy dentify and address the use ribed on an indefinite basis uate clinical indication for use 465) and also failed to	F 75		DON, ibiotics d a ion. iewed by

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	-	ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 01/03/20 FORM APPROVE /IB NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		DNSTRUCTION	(X:	B) DATE SURVEY COMPLETED
		345523	B. WING				C 12/06/2018
NAME OF PI	ROVIDER OR SUPPLIER		- ' T	STRE	EET ADDRESS, CITY, STATE, ZIP COD)E	
UNIVERS	AL HEALTH CARE/RAMS	SEUR			JORDON ROAD ISEUR, NC 27316		
(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 756	Continued From page	e 89	F 7	56			
	greater than 14 days rationale (Resident # reviewed for unneces The findings included 1. Resident #10 was 11/12/18 with diagnos s and a personal hist Infections (UTIs). A review of Resident 9/11/18 revealed the UTIs. This care plan on a prophylactic ant an acute UTI. A review of Resident orders was conducted had an active order d Trimethoprim (antibic once daily for UTI pro- A review of Resident Administration Recor 12/5/18 revealed she 100 mg once daily. An interview was con 12/5/18 at 4:00 PM. #10 was on Trimetho related to a history of Resident #10 had be her admission to the	 with no documented 57) for 3 of 6 residents saary medications. d: admitted to the facility on ses that included Alzheimer ' ory of Urinary Tract #10's care plan dated problem area of the risk for indicated Resident #10 was ibiotic with no symptoms of #10's active physician's d on 12/5/18. Resident #10 lated 11/26/15 for otic) 100 milligrams (mg) ophylaxis. #10's Medication ds from 1/1/2018 through had received Trimethoprim 		COCCEPTION FILE CONTRACT OF CONTRACT.	determine adequate clinical radiuration for medication. Resident #65 antibiotic was rephysician and it was determinedication would be discontined for signs and sympleting the sympletic signs and sympleting that the resident work of the sympletic signs and sympletic sympletic signs and sympletic sympletic sympletic signs and sympletic symplets and symplets sympletic symplets and symplets and symplets symplets and	eviewed by ned that the nued on uld be otoms of redication d (prn)was determined continued psychotropic y the DON, ne clinical use of antibiotics or re identified rs for nacist was in drug review herapy. herapy. hsure the and remains orders will DON, UC or M) to ensure chotropic nd duration. ysician will	
	acute UTI. A review of Resident Regimen Reviews (D	#10's monthly Drug IRRs) from November 2017			Education was provided by th Director to Physician Assistar ADON, UC and NM regarding orders for psychotropic medic	nt (PA), DON g reviewing	I,

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		245502			С		
	ROVIDER OR SUPPLIER	345523	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	12/06/2018		
NAME OF F	ROVIDER OR SUFFLIER			7166 JORDON ROAD			
UNIVERS	AL HEALTH CARE/RAMS	SEUR		RAMSEUR, NC 27316			
(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 COMPLETI		
F 756	Continued From page	e 90	F 756				
	prophylactic Trimetho The monthly DRR for 11/12/18 completed b identified that Trimeth UTI prophylaxis. The not addressed the us Trimethoprim. An interview with the on 12/6/18 at 8:00 an antibiotics to have a d She stated she did no prophylactic antibiotic A phone interview wa Pharmacy Consultan The Pharmacy Consultan T	Resident #10 dated by the Pharmacy Consultant noprim was prescribed for e Pharmacy Consultant had e of the prophylactic Director of Nursing (DON) n revealed she expected all clinical indication for use. bt think there were any cs in the building. As conducted with the t on 12/6/18 at 2:15 PM. ultant was asked if she sed the use of prophylactic prescribed indefinitely during She stated that she generally f a resident was on a c, but that she would not mmendations to the he order unless there were		antibiotics for rationale and duratie Licensed nursing staff were re-ed on unnecessary medications, 14 o use and stop dates on antibiotics supporting documentation is in pla DON, ADON, UC and IPN. Staff m educated by 12/21/18 will not be a to work until educated. This educ be added to new hire orientation f licensed nursing staff. Monitoring Physician orders for antibiotics an psychotropic medications will be r daily in clinical rounds Monday the Friday and discussed by the DON and UC to ensure physician order rationale and duration of use. Thi completed daily x 2 weeks, then w 2 weeks, then monthly x 3 months Results will be presented in QAPI by DON for recommendations and modifications until substantial corr is achieved. Date of Compliance 12/21/2018	ucated days prn unless ace by oot allowed ation will or d eviewed rough , ADON s have s will be weekly x s. meeting		
	failure. The order for prophylactic Trimetho since 11/26/15 was re Consultant. She con recommendations rel prophylactic Trimetho A phone interview wa Physician's Assistant revealed he was not	oprim that had been in place eviewed with the Pharmacy firmed she had made no ated to Resident #10's oprim.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345523	B. WING				C /06/2018
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 756	 adequate clinical indigresidents from becom A phone interview wa #10' physician/facility 12/6/18 at 2:36 PM. Involved with the more the facility. He indicate all antibiotics to have indication. He reported any orders for prophy facility and that he trige external providers surgeons to address of his residents. A follow up interview DON on 12/6/18 at 2: expected the Pharma address the use of ar no stop date and with indication for use. 2. Resident #65 was 8/5/16 and most rece with diagnoses that in personal history of Ur (UTIs). A review of Resident 9/11/18 revealed the provident of the provident of the personal for the personal for	cation for use to prevent ning resistant to antibiotics. s conducted with Resident 's Medical Director on He stated that he was nitoring of antibiotic usage at ted his expectation was for an adequate clinical ed that he had not initiated factic antibiotics at the ed to coordinate with ch as specialists or prophylactic orders for any was conducted with the 57 PM. She stated that she cy Consultant to identify and antibiotic prescribed with out an adequate clinical admitted to the facility on ntly readmitted on 5/11/17 ncluded dementia and a inary Tract Infections #65's care plan dated problem area of the risk for indicated Resident #65 was	F	756			
	orders was conducted had an active order d	#65's active physician's d on 12/5/18. Resident #65 ated 4/30/18 for Cefdinir ams (mg) once daily for UTI					

Facility ID: 991059

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345523	B. WING				C / 06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE/RAMS	SEUR			ORDON ROAD SEUR, NC 27316		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	prophylaxis. A review of Resident Administration Record 12/5/18 revealed she once daily. A review of the Pharm Drug Regimen Review was conducted. The identified that Reside UTI prophylaxis on he review, 10/8/18 review The Pharmacy Consu use of the prophylacti An interview was con 12/6/18 at 12:00 PM. #65 was on Cefdinir a history of UTIs. She had been on Cefdinir indicated that Reside UTI. An interview with the on 12/6/18 at 8:00 an antibiotics to have a co She stated she did no prophylactic antibiotic A phone interview wa Pharmacy Consultant The Pharmacy Consultant	#65's Medication d from 5/1/18 through received Cefdinir 300 mg hacy Consultants monthly ws (DRRs) for Resident #10 Pharmacy Consultant nt #10 was on Cefdinir for er 7/14/18 review, 8/10/18 w, and the 11/20/18 review. Utant had not addressed the for Cefdinir. ducted with Nurse #6 on She reported that Resident as a prophylactic related to a stated that Resident #65 for "a long time". She nt #65 did not have an active Director of Nursing (DON) n revealed she expected all clinical indication for use. of think there were any is in the building. s conducted with the t on 12/6/18 at 2:15 PM. Utant was asked if she sed the use of prophylactic orescribed indefinitely during She stated that she generally	F7	/56			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345523	B. WING				。 06/2018
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	EUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(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 756	have made any recomplysician related to the complicating medical failure. The order for prophylactic Cefdinin the 4/30/18 was reviewed Consultant. She confi recommendations related prophylactic Cefdinin. A phone interview wa Physician's Assistant revealed he was not at on Cefdinin prophylac expectation was for at adequate clinical indited residents from becom A phone interview wa #65's physician/facility 12/6/18 at 2:36 PM. It involved with the mont the facility. He indicated all antibiotics to have indication. He reported any orders for prophy facility and that he triff external providers such surgeons to address por facility and the pharmate address the use of an	nmendations to the ne order unless there were factors such as renal Resident #65 ' s that had been in place since I with the Pharmacy firmed she had made no ated to Resident #65 ' s s conducted with the on 12/6/18 at 1:50 pm. He aware that Resident #65 was tically. He stated his II antibiotics to have an cation for use to prevent ing resistant to antibiotics. s conducted with Resident y's Medical Director on He stated that he was itoring of antibiotic usage at ted his expectation was for an adequate clinical ed that he had not initiated lactic antibiotics at the ed to coordinate with	F	756			

Facility ID: 991059

If continuation sheet Page 94 of 110

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345523	B. WING				C 106/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE/RAMS	SEUR			7166 JORDON ROAD RAMSEUR, NC 27316		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 756	 Resident #57 was a 7/27/18 with diagnose history of falls, and de Resident #57's Physic and revealed an order milligrams one tablet needed for insomnia a A review of the Septe Administration Record he received a sedativ one tablet by mouth a for Trazodone 5 by mouth at bedtime a 9/24/18. A review of the Pharm revealed Resident #55 to an as needed med in the note that the physication for more tablet and the physication for more tablet and the physication for more tablet and the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the facility continued for Trazodone 50 mill mouth at bedtime as a factor of the factor of the facility continue factor of the factor of the factor of the f	admitted to the facility on es of right hip fracture, ementia. cian's Orders were reviewed r for Trazodone 50 by mouth at bedtime as written 9/24/18. mber 2018 Medication d for Resident #57 revealed e, Trazadone 50 milligrams once daily at bedtime for changed to an as needed 50 milligrams give one tablet as needed for insomnia on hacist's Note dated 10/9/18 9's Trazodone was changed ication. It was not recorded hysician was notified the t be used as an as needed han 14 days. er 2018 Medication d for Resident #57 revealed to have an as needed order igrams give one tablet by needed for insomnia. mber 2018 Medication d for Resident #57 revealed to have an as needed order igrams give one tablet by	F	756			

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	-	ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 01/03 FORM APPR MB NO. 0938-	OVE
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		NSTRUCTION		X3) DATE SURVEY COMPLETED	
		345523	B. WING _				C 12/06/2018	3
		SEUR			ET ADDRESS, CITY, STATE, ZIP CC JORDON ROAD	DE		
				RAM	ISEUR, NC 27316			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5 COMPLE DAT	ETION
F 756	from his wheelchair. A Pharmacist's Note Resident #57's medic there was no mention being ordered as need days. A Pharmacist's Note review of Resident #8 medications due to a of the sedative, Trazo needed for greater th A review of the most Assessment which w Assessment dated 11 #57 was moderately required extensive as and from the bed and with moving in bed, at toileting. A review of Resident updated on 11/30/18 Risk for Side Effects Medication Use due to The care plan goal st remain free of side eff medications. Reside for Risk of Alteration Insomnia with a goal nights of insomnia. A telephone interview	luated for the use of tions. He was seen for a fall dated 11/13/18 revealed cations were reviewed but n of the Sedative, Trazodone, eded for greater than 14 dated 11/20/18 revealed a 57's psychotropic history of falls but no review odone, being ordered as an 14 days. recent Minimum Data Set as a Significant Change 1/29/18 revealed Resident cognitively impaired and ssistance with transfers to a chair, extensive assistance and extensive assistance with #57's Care Plan which was revealed a care plan for related to Psychotropic to Dementia with Behaviors. ated the resident would ffects of psychotropic nt #57 also had a care plan in Sleep Pattern related to to have decreased the	F 7	756				
	Assistant on 12/6/18	v with the Physician's at 2:02 pm revealed he was tropic meds were limited to						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
		345523	B. WING		12	C 2/06/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
INIVERS	AL HEALTH CARE/RAM	SEUR		7166 JORDON ROAD		
				RAMSEUR, NC 27316		
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 756	Continued From page how long they could l	e 96 be used as needed without	F 75	6		
	re-evaluating the need stated he thought that considered psychotro he would begin order medications that were	d for the medication. He t only antipsychotics were opic medications. He stated				
	Consultant on 12/6/1	nterview with the Pharmacy 8 at 2:16 pm she stated it an to re-evaluate a resident ication use.				
F 758 SS=D	12/6/18 at 3:05 pm re would expect the pha residents on psychoti issues and notify the psychotropic medicat 14 days.	Director of Nursing on evealed she stated she armacist to monitor all ropic medications for any Physician if an as needed tion is ordered for more than vchotropic Meds/PRN Use (e)(1)-(5)	F 75	8		12/21/18
	affects brain activities processes and behave	opic Drugs. hotropic drug is any drug that s associated with mental vior. These drugs include, drugs in the following				
	Based on a compreh resident, the facility n	ensive assessment of a nust ensure that				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/03/2019 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345523	B. WING		1:	C 2/06/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODI		
UNIVERS	AL HEALTH CARE/RAM	SEUR		166 JORDON ROAD RAMSEUR, NC 27316		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	§483.45(e)(1) Reside psychotropic drugs a unless the medication specific condition as in the clinical record; §483.45(e)(2) Reside drugs receive gradua behavioral interventic contraindicated, in ar drugs; §483.45(e)(3) Reside psychotropic drugs p unless that medication diagnosed specific co in the clinical record; §483.45(e)(4) PRN o are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the PI beyond 14 days, he o rationale in the reside indicate the duration §483.45(e)(5) PRN o drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on record rev Pharmacist and Physithe facility failed to pr rationale for psychotr	ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic al dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive ursuant to a PRN order on is necessary to treat a ondition that is documented and rders for psychotropic drugs is. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced	F 758	F 758 Based on the root cause analy facility administrative staff and facility staff did not ensure psy medications had rationale and	the DON, chotropic	

Facility ID: 991059

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/03/20 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345523	B. WING		C 12/06/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316	
(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 COMPLETION
F 758	14 days for 2 of 5 sar unnecessary medical #79). Findings included: 1. Resident #57 was 7/27/18 with diagnost history of falls, and de Resident #57's Physi and revealed an order milligrams one tablet needed for insomnia A review of the Septe Administration Recor he received a sedative one tablet by mouth of insomnia, and it was order for Trazodone & by mouth at bedtime 9/24/18. A review of the Octob Administration Recor the facility continued for Trazodone 50 mill mouth at bedtime as A review of the Nove	mpled residents reviewed for tions (Residents #57 and admitted to the facility on es of right hip fracture, ementia. dcian's Orders were reviewed er for Trazodone 50 by mouth at bedtime as written 9/24/18. ember 2018 Medication d for Resident #57 revealed ve, Trazadone 50 milligrams once daily at bedtime for changed to an as needed 50 milligrams give one tablet as needed for insomnia on ber 2018 Medication d for Resident #57 revealed to have an as needed order ligrams give one tablet by needed for insomnia. mber 2018 Medication	F 758	 medication. Resident #57 psychotropic medic ordered to be used as needed (pr reviewed by physician it was deter the medication was to be discontin 12/14/18. Resident #79 psychotropic medic ordered to be used prn was revier the physician and it was determine medication was to be discontinue 12/11/18. Identification 100% audit of psychotropic medic were reviewed by the DON, ADO IPN to determine clinical rationale duration for the use of medication 12/21/18. No psychotropic medi were identified requiring new phy orders for rationale and duration. Pharmacist was in facility and cor 100% drug review on 12/17/18 wi on psychotropic medications. Systemic Measures put into place to ensure plan of correction is effective and in compliance are: Physician order be reviewed daily by DON, ADON Weekend Nurse Manager (NM) to orders for psychotropic medication rationale and duration. If clarificat indicated, physician will be contaction 	rn)was ermined inued cation wed by hed the e on cations N, UC or e and n on cations sician mpleted ith focus e the remains ers will N, UC or o ensure on shave tion is cted for
	the facility continued for Trazodone 50 mil mouth at bedtime as A review of the Pharr	nacist's Note dated 10/9/18 59's Trazodone was changed		recommendations. Education was provided by the Executive Director Physician Assistant (PA), DON, A UC and NM regarding reviewing of for psychotropic medications for r and duration. Pharmacy Director educated the Pharmacist on psyco medications requiring rationale ar	or to ADON, orders rationale r chotropic

Facility ID: 991059

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SUR COMPLETE	
		345523	B. WING		C 12/06/2	018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
UNIVERS	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
(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 APPI DEFICIENCY)	OULD BE CO	(X5) MPLETIO DATE
F 758	A review of a Physicia 11/12/18 by the Phys resident was not eval psychotropic medicat from his wheelchair. A Pharmacist's Note Resident #57's medic there was no mentior being ordered as nee A Pharmacist's Note review of Resident #5 medications due to a of the sedative, Trazo needed. A review of the most Assessment which w Assessment dated 11 #57 was moderately required extensive as and from the bed and with moving in bed, a toileting. A review of Resident updated on 11/30/18	an's Progress Note dated ician's Assistant revealed the uated for the use of ions. He was seen for a fall dated 11/13/18 revealed cations were reviewed but n of the Sedative, Trazodone, eded. dated 11/20/18 revealed a	F 75	 8 duration on 12/11/18. Licensed nu staff were re-educated on unnece medications, 14 days prn use and dates on psychotropic medication supporting documentation is in pla DON, ADON, UC and IPN. Staff r educated by 12/21/18 will not be to work until educated. This educ be added to new hire orientation f licensed nursing staff. Monitoring Physician orders for psychotropic medications will be reviewed daily clinical rounds Monday through F discussed by the DON, ADON an ensure physician orders have rati and duration of use. This will be completed daily x 2 weeks, then w 2 weeks, then monthly x 3 month- Results will be presented in QAPI by DON for recommendations an modifications until substantial cor is achieved. Date of Compliance 12/21/2018 	essary I stop s unless ace by not allowed cation will for / in riday and d UC to onale veekly x s. meeting d	
	Medication Use due t The care plan goal st remain free of side ef medications. Reside for Risk of Alteration	o Dementia with Behaviors. ated the resident would				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345523	B. WING				_ 06/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE/RAMS	EUR			166 JORDON ROAD RAMSEUR, NC 27316		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	Assistant on 12/6/18 a not aware all psychot how long they could b re-evaluating the need stated he thought that considered psychotro he would begin order medications that were 14 days and then re-en- medication. During a telephone in Consultant on 12/6/18 was up to the physical for psychotropic medicat needed to be re-evalue use of the psychotropic expect the pharmacis psychotropic medicat 2. Resident # 79 was 7/13/18 with multiple dementia. The quarte (MDS) assessment da Resident #79 had sevand had other behavit towards others. On 9/10/18, Resident Ativan (antianxiety dru mouth twice a day as had no stop date. On 10/26/18, Resident	at 2:02 pm revealed he was ropic meds were limited to be used as needed without d for the medication. He t only antipsychotics were pic medications. He stated ing all psychotropic as needed to be used for evaluate the need for the terview with the Pharmacy 3 at 2:16 pm she stated it an to re-evaluate a resident cation use. Director of Nursing on vealed she expected all ions that are ordered as lated every 14 days for the ic. She stated she would t to monitor all resident's on ions for any issues. admitted to the facility on diagnoses including erly Minimum Data Set ated 11/14/18 indicated that vere cognitive impairment oral symptoms not directed #79 had a doctor's order for ug) 1 milligrams (mgs) by needed (PRN). The order	F	758			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345523	B. WING				C 06/2018
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/RAMS	EUR			66 JORDON ROAD AMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	9 101	F 7	758			
	(MARs) revealed that the Ativan one time in	tion Administration Records Resident #79 had received September 2018 (9/18/18) 2018 (10/9 and 10/10) and 18.					
	notes revealed that R 9/18/18 and Ativan wa	's notes were reviewed. The esident #79 had agitation on as administered. There 26/18 to indicate as to why ordered for 4 months.					
	were reviewed for Se November 2018. The	notes did not have for the use of the PRN					
	(PA) was interviewed. the one who ordered for 4 months. He indi familiar with the regul PRN psychotropic dru he had to document to	AM, the Physician Assistant The PA stated that he was the PRN Ativan on 10/26/18 cated that he was not ations regarding the use of ugs. He was not aware that he rationale if he ordered c drug beyond 14 days.					
F 004	(DON) was interviewed she expected the doc follow the regulations drugs. She indicated drugs should only be indicated and the ratio						12/24/42
F 881 SS=E	Antibiotic Stewardship CFR(s): 483.80(a)(3)	Program	F8	oo I			12/21/18

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM): 01/03/2019 1 APPROVEL 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345523	B. WING _				06/2018
NAME OF P	ROVIDER OR SUPPLIER		·		IREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAM	SEUR			166 JORDON ROAD AMSEUR, NC 27316		
	SI IMMADY ST	ATEMENT OF DEFICIENCIES		<u>г</u>	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 881	Continued From page	e 102	F	381			
		prevention and control					
	program.						
		ablish an infection prevention					
	and control program a minimum, the follow	(IPCP) that must include, at wing elements:					
		ibiotic stewardship program ic use protocols and a					
	system to monitor an	•					
	· ·	Γ is not met as evidenced					
	by:						
		view and interviews with the			F 881		
		vsician's Assistant, Pharmacy			Based on the root cause analysis by th		
		, the facility failed to follow dship Program as evidenced			facility administrative staff and the DO facility staff did not follow antibiotic	N,	
	by the use of prophyl				stewardship program.		
	antibiotics for 3 of 3 s				Immediate		
		and #84) reviewed for			Resident #10 antibiotic was reviewed	by	
	antibiotic usage.				physician to determine adequate clinic	al	
					rationale and duration of treatment.		
	The findings included	1:			Antibiotic was discontinued 12/14/18.	b	
					Resident #65 antibiotic was reviewed physician to determine adequate clinic	-	
	1. Resident #10 was	admitted to the facility on			rationale and duration of treatment.	ai	
		ses that included Alzheimer's			Appointment is set for 1/9/19 with the		
	and a personal histor	ry of Urinary Tract Infections			Urologist as recommended by the		
	(UTIs).				physician to determine the medical ne	ed	
	The energy Alasia				of the medication and duration.	b. /	
	The annual Minimum	1 Data Set (MDS) (10/18 indicated Resident			Resident #84 antibiotic was reviewed physician to determine adequate clinic	-	
		severely impaired. She			rationale and duration of treatment.		
	U U	c on 7 of 7 days. Resident			Appointment set for 1/9/19 with the		
		agnosis of a UTI or any other			Urologist as recommended by the		
	infection. She was a	ssessed as requiring the			physician to determine the medical ne		
		of 2 or more staff with			of the medication and duration. Resid	ent	
	-	always incontinent of			discharged home on 12/22/18.		
	bladder and bowel.				Identification	anta	
		esment related to urinery			100% audit was conducted of all resid		
	The Cale Alea Asses	ssment related to urinary			receiving antibiotics was conducted by		

Facility ID: 991059

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/03/2019 ORM APPROVED 3 NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345523	B. WING				C 12/06/2018
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	AL HEALTH CARE/RAMS	SEUR		71	166 JORDON ROAD		
UNIVERSI				R	AMSEUR, NC 27316		
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 881	MDS indicated she w history of UTI and inc received Trimethoprir (preventative) measu A review of Resident 9/11/18 revealed the UTIs. This care plan on a prophylactic anti an acute UTI. A review of Resident orders was conducted had an active order d Trimethoprim (antibio once daily for UTI pro- A review of Resident Administration Recor- 12/5/18 revealed she 100 mg once daily. An interview was con 12/5/18 at 4:00 PM. #10 was on Trimetho related to a history of Resident #10 had be her admission to the She stated that Resid acute UTI. An interview with the on 12/6/18 at 8:00 an antibiotics to have a of She stated she did no	dent #10's 9/10/18 annual as at risk for UTIs related to continence. Resident #10 m as a prophylactic re and had no acute UTIs. #10's care plan dated problem area of the risk for indicated Resident #10 was biotic with no symptoms of #10's active physician's d on 12/5/18. Resident #10 ated 11/26/15 for tic) 100 milligrams (mg) ophylaxis. #10's Medication ds from 1/1/2018 through had received Trimethoprim ducted with Nurse #6 on She reported that Resident prim as a prophylactic UTIs. She revealed en on Trimethoprim since facility in November of 2015. Ient #10 did not have an Director of Nursing (DON) n revealed she expected all clinical indication for use. ot think there were any	F	381	DON, ADON, UC or IPN. No other residents were identified to be re- prophylactic antibiotics. Pharmace facility and completed 100% drug on 12/17/18 with focus on antibio- medications. Systemic Measures put into place to ensur- plan of correction is effective and in compliance are: Physician order be reviewed daily by DON, ADON Weekend Nurse Manager (NM) to the physician orders for antibiotic have proper rationale and duration clarification is indicated, physician contacted for recommendations. Education on antibiotic stewardsh provided by the Executive Director Physician Assistant (PA), DON, A UC and NM regarding reviewing for antibiotics for rationale and du Pharmacy Director educated the Pharmacist on antibiotic stewardsh Licensed nursing staff were educ antibiotic stewardship by DON, A UC or NM on 12/12/18. Staff not by 12/21/18 will not be allowed to until educated. Monitoring Physician orders for antibiotic me will be reviewed daily in clinical re Monday through Friday and discu- the DON, ADON and UC to ensu physician orders have rationale and duration of use. This will be com	ceiving ist was in preview tic e the remains ers will N, UC or o ensure s will N, UC or o ensure s will on. If n will be hip was or to NDON, orders uration. ship. ated on DON, educated o work edications punds ussed by re ind pleted	
	Director of Nursing in	cs in the building. The dicated that prophylactic n accordance with the			daily x 2 weeks, then weekly x 2 then monthly x 3 months. Results presented in QAPI meeting by D0	s will be	

Facility ID: 991059

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DA	10. 0938-039	
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED	
		345523	B. WING		1	C 2/06/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/00/2010		
UNIVERS	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316			
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE	
F 881	Continued From page 104 Antibiotic Stewardship Program (ASP). A phone interview was conducted with the Physician's Assistant on 12/6/18 at 1:50 pm. He revealed he was not aware that Resident #10 was on Trimethoprim prophylactically. He stated his expectation was for the ASP to be followed to prevent residents from becoming resistant to antibiotics. A phone interview was conducted with Resident #10's physician/facility's Medical Director on 12/6/18 at 2:36 PM. He stated that he was involved in the ASP at the facility. He indicated that prophylactic antibiotics were not in accordance with the ASP. He reported that he had not initiated any orders for prophylactic antibiotics at the facility and that he tried to coordinate with external providers such as specialists or surgeons to address prophylactic orders for any of residents. A phone interview was conducted with the		F 88				
	She indicated she be August 2018. The Pl asked if she identified prophylactic antibiotic indefinitely during her Reviews. She stated her review if a reside antibiotic, but that she recommendations to order unless there we factors such as renal Resident #10's proph had been in place sin	t on 12/6/18 at 2:15 PM. gan working at this facility in narmacy Consultant was d and addressed the use of es that were prescribed r monthly Drug Regimen d that she generally noted on nt was on a prophylactic e would not have made any the physician related to the ere complicating medical failure. The order for hylactic Trimethoprim that use 11/26/15 was reviewed onsultant. She confirmed					

Facility ID: 991059

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE	
		345523	B. WING	NG _			C
NAME OF P	ROVIDER OR SUPPLIER	040020		S	STREET ADDRESS, CITY, STATE, ZIP CODE	12	/06/2018
10 112 01 1					7166 JORDON ROAD		
UNIVERS	AL HEALTH CARE/RAMS	SEUR			RAMSEUR, NC 27316		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 881	Resident #10's proph Pharmacy Consultant that prophylactic antik accordance with the A A follow up interview of DON on 12/6/18 at 2: expected the ASP to b 2. Resident #65 was 8/5/16 and most rece with diagnoses that in personal history of Ur (UTIs). The annual Minimum assessment dated 8/7 #65's cognition was in antibiotic on 7 of 7 da active diagnosis of a She was assessed as assistance of 2 or mo Resident #65 was fre bladder and always in The Care Area Assess incontinence for Resident bladder and had freq She was noted to be but had not shown an A review of Resident 9/11/18 revealed the UTIs. This care plan on a prophylactic anti	ylactic Trimethoprim. The trevealed she was unaware biotics were not in ASP. was conducted with the 57 PM. She stated that she be followed. admitted to the facility on ntly readmitted on 5/11/17 ncluded dementia and a rinary Tract Infections Data Set (MDS) 10/18 indicated Resident ntact. She received an tys. Resident #65 had no UTI or any other infection. a requiring the extensive ore staff with toileting. quently incontinent of ncontinent of bowel. sment related to urinary dent #65's 8/10/18 MDS d staff assistance with uent bladder incontinence. at risk for UTI recurrence by acute UTI symptoms. #65's care plan dated problem area of the risk for indicated Resident #65 was	F	881			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345523	B. WING				C 06/2018
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAMS	SEUR			166 JORDON ROAD RAMSEUR, NC 27316		
(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 881	had an active order d (antibiotic) 300 milligr prophylaxis. A review of Resident Administration Record 12/5/18 revealed she once daily. An interview was con 12/6/18 at 12:00 PM. #65 was on Cefdinir a history of UTIs. She had been on Cefdinir indicated that Resider UTI. An interview with the on 12/6/18 at 8:00 and antibiotics to have a co She stated she did no prophylactic antibiotic Director of Nursing in antibiotics were not ir Antibiotic Stewardship A phone interview wa Physician's Assistant revealed he was not a on Cefdinir prophylac expectation was for th prevent residents fror antibiotics. A phone interview wa #65's physician/facilit 12/6/18 at 2:36 PM.	d on 12/5/18. Resident #65 ated 4/30/18 for Cefdinir ams (mg) once daily for UTI #65's Medication d from 5/1/18 through received Cefdinir 300 mg ducted with Nurse #6 on She reported that Resident as a prophylactic related to a stated that Resident #65 for "a long time". She nt #65 did not have an acute Director of Nursing (DON) n revealed she expected all clinical indication for use. of think there were any es in the building. The dicated that prophylactic n accordance with the o Program (ASP). s conducted with the on 12/6/18 at 1:50 pm. He aware that Resident #65 was tically. He stated his ne ASP to be followed to m becoming resistant to s conducted with Resident y 's Medical Director on	F	881			

Facility ID: 991059

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	-	ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/03/201 ORM APPROVEI NO: 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		DATE SURVEY COMPLETED
		345523	B. WING				C 12/06/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVERS	AL HEALTH CARE/RAM	SEUR			7166 JORDON ROAD		
				F	RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 881	Continued From page	e 107		881			
1 001	that prophylactic anti			001			
		ASP. He reported that he					
		orders for prophylactic					
		ity and that he tried to nal providers such as					
		ns to address prophylactic					
	orders for any of his						
	A phone interview wa	as conducted with the					
		t on 12/6/18 at 2:15 PM.					
		gan working at this facility in					
	-	harmacy Consultant was d and addressed the use of					
		cs that were prescribed					
		r monthly Drug Regimen					
		I that she generally noted on nt was on a prophylactic					
		e would not have made any					
	recommendations to	the physician related to the					
		ere complicating medical failure. The order for					
		ivlactic Cefdinir that had					
		/30/18 was reviewed with					
		Itant. She confirmed she					
	had made no recomr	nendations related to					
		t revealed she was unaware					
	that prophylactic anti with the ASP.	biotics were not accordance					
		was conducted with the 57 PM. She stated that she be followed.					
	11/12/18 with diagnos	admitted to the facility on ses of encephalopathy, tia, and hypertensive kidney ecent comprehensive					
	Minimum Data Set As	ssessment dated 11/19/18					

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DEPART	FORM	APPROVED						
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 12/06/2018		
		345523	B. WING					
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSAL HEALTH CARE/RAMSEUR				7166 JORDON ROAD RAMSEUR, NC 27316				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 881	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	881				

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		ID HUMAN SERVICES				FORM	APPROVED			
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL		LTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		345523	B. WING _		C 12/06/2018					
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
UNIVERSAL HEALTH CARE/RAMSEUR					7166 JORDON ROAD RAMSEUR, NC 27316					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE				
F 881	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 109 Trimethoprim prophylactically. He stated his expectation is that the Antibiotic Stewardship would be followed to prevent residents from becoming resistant to antibiotics.		F	381						

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