PRINTED: 11/26/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45500				1	С
		345523	B. WING _			10/	24/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/RAMS	SEUR			66 JORDON ROAD		
ONIVERO	AL HEALIN OAKE/KAMIC	CON		R/	AMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	survey was conducted 10/24/19. The facility		F(	000			
	survey was conducte 10/24/19. Two of five substantiated resultin F745).	complaint investigation d on 10/21/19 through complaint allegations were g in deficiencies ( F584 &					
F 565 SS=E	<b></b>		F t	565			11/21/19
	and participate in resi (i) The facility must progroup, if one exists, we reasonable steps, with to make residents and upcoming meetings in (ii) Staff, visitors, or oresident group or family the respective group's (iii) The facility must providing assistance requests that result from (iv) The facility must or resident or family groups concerning is in the facility.	ther guests may attend ally group meetings only at a invitation.  Torovide a designated staff and who is responsible for and responding to written and group meetings.  Torousider the views of a suppose and act promptly upon accommendations of such as sues of resident care and life and to demonstrate their					
	response and rationa	ie for such response.					
ADODATODY	DIDECTOR'S OR DROVIDED!	SLIPPLIER REPRESENTATIVE'S SIGNATUR	E		TITI F		(X6) DATE

Electronically Signed 11/15/2019

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING		C 10/24/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/24/2013	
IINIVEDS/	AL HEALTH CARE/RAMS	SELID		7166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAINS	SEUR		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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 565	Continued From page	e 1	F 56	5		
		e construed to mean that the not as recommended every not or family group.				
	§483.10(f)(6) The res participate in family g					
	family member(s) or or representative(s) mee families or resident re residents in the facilit This REQUIREMENT	et in the facility with the presentative(s) of other				
	by: Based on record review, and interviews with residents and staff, the facility failed to resolve repeat concerns reported during Resident Council meetings for 6 of 6 consecutive months.			The statements included are not an admission and do not constitute agreement with the alleged deficiencing herein. The plan of correction is completed in the compliance of states.		
	minutes dated 4/29/1 related to staff utilizin in the dining room, tra and not being given fi	y Resident Council meeting 9 included, in part, concerns g cell phones when working ash cans not being emptied, resh ice throughout the day. recorded by the Activities		federal regulations as outlined. To ren in compliance with all federal and stat regulations the center has taken or wi take the actions set forth in the following plan of correction the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	nain e II ing f	
	minutes dated 5/29/1 repeat concerns of st working in the dining being emptied. The renough linens (clothir discussed at this mee recorded by the Activ	y Resident Council meeting 9 included, in part, the aff utilizing cell phones when room and trash cans not new concern of not having ng protectors) was also eting. These minutes were ities Director.  y Resident Council meeting		F565  The following will be accomplished for residents having been affected by the practice:  The newly reinstituted "Resident Cour Concern Form" was completed to incl concerns voiced by the Resident Cour	ncil ude	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	MULTIPLE CONSTRUCTION  JILDING			(X3) DATE SURVEY COMPLETED	
		345523	B. WING _			1	C 1 <b>0/24/2019</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		10/2-1/2010	
				7166	JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		RAM	SEUR, 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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETION DATE	
F 565	Continued From page	e 2	F 5	65				
	repeat concern of sta working in the dining recorded by the Activ			a <sub>l</sub> 1 <sup>o</sup> pı A	previous six months and distribute ppropriate disciplines for resolution 1- 13-19. The resolutions will be resented to the residents by the dministrator at the resident council			
	minutes dated 7/30/1 repeat concern of sta	y Resident Council meeting 9 included, in part, the ff utilizing cell phones when room. These minutes were ities Director.		T	neeting on November 19,2019.  The following will be accomplished for esidents who have the potential to be a street of the practice:			
	minutes dated 8/26/1 repeat concerns of traffresh ice not being gi clothing protectors.	f the monthly Resident Council meeting lated 8/26/19 included, in part, the neerns of trash cans not being emptied, not being given, and not having enough rotectors. These minutes were by the Activities Director.		by re R fa di	response form for concerns expressly the Resident Council has been einstituted and will be completed at tesident Council Meeting by the meanilitator as applicable. The facilitator is stribute the completed concern for the appropriate disciplines for resolute	each eting or will ns to		
	minutes dated 9/30/1 repeat concerns of no protectors, trash cans	y Resident Council meeting 9 included, in part, the ot having enough clothing s not being emptied, and ven. These minutes were ities Director.	administrator. On 11/13/19, the Administrator provided education Resident Council Facilitator (Activ Director) concerning utilizing the r council concern form to record an		he facilitator will provide copies to t	he the dent ouncil		
	10/23/19 at 10:00 AM residents who were a facility's Resident Co reported that they ha past several months	neeting was conducted on I with 4 alert and oriented active participants in the uncil. The residents I repeat concerns over the that included staff utilizing rking in the dining room,		di th A Ti pl	istributing the completed concern for the appropriate discipline with copy to dministrator.  The following system has been put in lace to ensure that the practice does ecur:	orm to o the		
	passed, and not havi protectors for the din attendees all stated t been resolved. When response was to ther	emptied, fresh ice not being ng enough clothing ner meal. The meeting hat these concerns had not a asked what the facility 's n regarding these repeat ndicated they had not		D C aı di	he Resident Council facilitator (Acti irector) will complete the Resident council Concern forms at each meet not forward the forms to the appropriscipline within twenty-four hours of neeting. The disciplines will put action	ing iate the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
						С	
		345523	B. WING _		•	10/24/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
I INIVEDS	AL HEALTH CARE/R	AMSELID		7166 JORDON ROAD			
UNIVERS	AL REALIN CARE/K	AWISEUR		RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 565	received any respresidents reported the same concern response so some reporting them.  An interview was of Director on 10/23/1 that she had assure the Resident Cours is previous Social stated that she had Council meeting in over this responsificonfirmed there we came up month and and/or resolution in Council members, meeting she report facility is former Ashe would take can activities Director the same issues we wrote them down to the former Admitish happened over sometimes she fell previous meetings to rewrite the same had not known who concerns as she we given to her by he Administrator.	I that they got tired of reporting is month after month with no etimes they just stopped conducted with the Activities 19 at 12:00 PM. She reported med responsibility for holding incil meetings when the facility worker left on 12/31/18. She is donly attended 1 Resident in December 2018 prior to taking bility. The Activities Director ere multiple repeat issues that iter month with no follow upprovided to the Resident in She explained that after each ited the issues verbally to the administrator and she indicated in the concerns. The stated that at the next meeting were brought up and she just again and then reported them inistrator. She revealed that er and over again and lit like she should just copy the iminutes, so she didn't have the things. She stated that she hat else to do with the repeat was following the instructions in boss, the former	F 5	plans in place to resolve the much as possible within for of receipt. The forms, with the will be returned to the admit the meeting facilitator to shoresidents at the next meeting will be attached to the meeting facilitator and I Grievance/Concern Log.  The following monitoring sy implemented to ensure that sustained:  The Administrator will revie Council concerns and resol monthly. Resident Council be presented to the Quality and Improvement Committee that the concerns are resolutions are resolutionally or revised as deemed in will be revised as deemed in the concerns are resolutions.	ty-eight hours the resolutions, inistrator and are with the ng. The forms ting minutes by ogged in the  vstem will be t the solution is  w all Resident lutions I concerns will Assurance ee to ensure ved and the ed. The plan		
	Administrator on 1 stated that she ha	conducted with the 0/24/19 at 12:01 PM. She d just began working as the tor at the end of August 2019					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
							c
		345523	B. WING			10/	24/2019
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMS	SEUR		7'	TREET ADDRESS, CITY, STATE, ZIP CODE 166 JORDON ROAD 2AMSEUR, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 565	members reported re month. She indicated for all issues/concern Council meetings to be investigated as needs	nat the Resident Council peat concerns month after d that her expectation was s discussed at the Resident	F	565			
F 582 SS=B	CFR(s): 483.10(g)(17)  §483.10(g)(17) The fa (i) Inform each Medic writing, at the time of facility and when the Medicaid of- (A) The items and sen ursing facility service for which the resident (B) Those other items facility offers and for y charged, and the amo services; and (ii) Inform each Medic changes are made to specified in §483.10(g section.  §483.10(g)(18) The fa resident before, or at periodically during the available in the facility services, including an covered under Medic facility's per diem rate (i) Where changes in and services covered	acility must aid-eligible resident, in admission to the nursing resident becomes eligible for  rvices that are included in es under the State plan and t may not be charged; s and services that the which the resident may be ount of charges for those  caid-eligible resident when the items and services g)(17)(i)(A) and (B) of this  acility must inform each the time of admission, and e resident's stay, of services y and of charges for those ny charges for services not are/ Medicaid or by the	F	582			11/21/19

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID INC	7. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING				C <b>24/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				71	166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		R	AMSEUR, NC 27316		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY ON EGG IDENTIFY FING IN GRAPHION		TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 582	Continued From page	e 5	F:	582			
	reasonably possible.						
	(ii) Where changes a	re made to charges for other					
	items and services th	at the facility offers, the					
	facility must inform th	e resident in writing at least					
	60 days prior to imple	ementation of the change.					
	(iii) If a resident dies	or is hospitalized or is					
	transferred and does	not return to the facility, the					
	facility must refund to						
	representative, or est						
	deposit or charges al						
	per diem rate, for the						
	resided or reserved o						
	facility, regardless of						
	discharge notice requ						
	' '	refund to the resident or					
		ve any and all refunds due					
		days from the resident's					
	date of discharge from						
	1	dmission contract by or on					
		Il seeking admission to the					
	_	ict with the requirements of					
	these regulations.	is not met as evidenced					
		is not met as evidenced					
	by:	iew and staff interview, the			The statements included are not an		
		e a Skill Nursing Facility			admission and do not constitute	ĺ	
		y Notice (SNF ABN) and/or a			agreement with the alleged deficiencies	9	
		on-Coverage (NOMNC) was			herein. The plan of correction is	,	
		to 3 of 3 residents reviewed			completed in the compliance of state a	nd	
	l ·	ction Notification (Residents			federal regulations as outlined. To rem		
	#76, #84, and #85).	(1.100.001.10			in compliance with all federal and state		
	5, 5 ., and 55).				regulations the center has taken or will		
	The findings included	l:			take the actions set forth in the following		
	. J				plan of correction the following plan of	-	
	1. Resident #76 was	most recently admitted to			correction constitutes the center's	ĺ	
	the facility on 7/4/19.			allegation of compliance. All alleged	ĺ		
		essment dated 7/11/19			deficiencies cited have been or will be	ĺ	
		n was moderately impaired.			completed by the dates indicated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		LE CONSTRUCTION	· /	(X3) DATE SURVEY COMPLETED	
						С	
		345523	B. WING		10	/24/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				7166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAM	SEUR		RAMSEUR, NC 27316			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLÉTION DATE	
F 582	Continued From page	e 6	F 58	2			
	· -	#76 's record indicated he		F- 582			
		ed Part A Services from					
		19 and remained in the		The following will be accomplishe	ed for		
	_	erage for his Part A Services		residents having been affected by			
		evealed Resident #76 was		practice: During the survey we we			
	not provided with a S	kill Nursing Facility		unable to locate copies of these N			
	Advanced Beneficiar	y Notice (SNF		Medicare Non-Coverage (NOMN			
	ABN/CMS-10055) or a Notice of Medicare			Skill Nursing Facility Advanced B	eneficiary		
Non-Coverage (NOMNC/CMS-10		INC/CMS-10123) as		Notice (SNF ABN).	•		
	required when his co	verage for Part A services					
	ended (8/20/19).			Resident #76 remains at the facili	ity and		
				the skilled services ceased on 8-2	21-19.		
	An interview was cor	nducted with the		Resident #84 was discharged 10-			
	Administrator on 10/2	22/19 at 3:30 PM. She		Resident #85 was discharged 6-2	21-19.		
	stated that the forme	r Administrator was					
	responsible for provide			The following has been accomplis			
		sident and/or Responsible		those residents with potential to b	e		
		ealed they had no record that		affected by the practice:			
		NC was provided to Resident					
	#76. She stated that			On 11/13/19, an audit was condu	-		
		beneficiary notifications to		the Social Worker and Business (			
		she was already in the		Manager on current residents wh			
		g an action plan to correct		remained in the facility after skill			
	the issue.			services (Part A) ceased to ensur			
	0.00 4.004			NOMNC and SNF ABN was issue			
		admitted to the facility on		other issues were identified after	audit		
		cently readmitted on 7/9/19.		completion.			
	The admission Minim			The faller in a second beautiful.			
		25/19 indicated her cognition		The following measures have been placed to a provide that the provide the			
	was severely impaire	u.		place to ensure that the practice of	uoes not		
	Davious of Docidant +	t0.4 La record indicated abo		recur:			
	Review of Resident #84 's record indicated she had Medicare covered Part A Services from			On 11/12/10 the Administrates ==	rovidod		
				On 11/13/19, the Administrator preducation to the Social Worker are			
		19 and remained in the erage for her Part A Services					
	_	erage for her Part A Services evealed Resident #84 's		Business Office Manager on the p			
				for issuing NOMNC and SNF ABI	N d5		
		RP) signed the Notice of age (NOMNC/CMS-10123)		follows:			
		· ,		The Social Worker will be record	cible for		
	on the same day that	t her coverage for Part A		The Social Worker will be respon-	อเมเษ เปเ		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG	<del></del>	(	c
		345523	B. WING			1	24/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/RAM	SEUR			166 JORDON ROAD		
				R	AMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 582	revealed that a Skille Beneficiary Notification was not provided to her coverage for Part An interview was con Administrator on 10/2 stated that the forme responsible for provion notifications to the re Party (RP). She revea SNF ABN was provided the NOMNC was required timeframe. expected the regulatinotifications to be folloalready in the procest plan to correct the issuitable of the admission Minimassessment dated 5/moderately impaired. Review of Resident # had Medicare covere 6/1/19 through 6/20/7 Resident #85 was not Medicare Non-Cover when her coverage for (6/20/19).  An interview was con Administrator on 10/2 stated that the forme	d Nursing Facility Advanced on (SNF ABN/CMS-10055) Resident #84 or her RP when the Aservices ended (7/12/19).  Inducted with the 22/19 at 3:30 PM. She or Administrator was ding the beneficiary sident and/or Responsible ealed they had no record that wided to Resident #84 and is provided outside of the She stated that she ons regarding beneficiary lowed and that she was so of completing an action sue.  Inducted with the 22/19 at 3:30 PM. She stated that she was so for completing an action sue.  Inducted with the 24/19 indicated her cognition of the Part A Services from the provided with a Notice of the Aservices ended the provided with the 24/19 at 3:30 PM. She or Administrator was	F	582	issuing the NOMNC and SNF ABN form to the resident/responsible party when notified by the insuring entity that skille services will be ending. After issuing the NOMNC and SNF ABN and receiving a signed receipt, the notice will be forwarded to the Business Office Manawho maintains documentation for billing. The Business Office Manager is responsible for ensuring that the NOMI and SNF ABN has been issued and a copy is maintained in the business office file. The Business Office manager will maintain a log of all residents on a skill benefit. The log will include the date of admission, a grid to indicate days used under the benefit, date coverage ends, date NOMNC and SNF ABN issued and date a copy was provided for the busin office file.  The following monitoring system will be implemented to ensure that the solution sustained:  The Administrator will audit the NOMN SNF ABN log weekly indicating the rev with date and initials. This audit will continue for six weeks or until a pattern compliance is maintained. Results of the audit will be reported to the Quality Assurance and Improvement Committee monthly for evaluation. The plan will be revised as deemed necessary.	d de le	
	Resident #85 was no Medicare Non-Cover when her coverage for (6/20/19).  An interview was cor Administrator on 10/2 stated that the forme responsible for providence in the forme of the forme responsible for providence in the former responsible for pr	at provided with a Notice of age (NOMNC/CMS-10123) or Part A services ended aducted with the 22/19 at 3:30 PM. She r Administrator was			compliance is maintained. Results of the audit will be reported to the Quality Assurance and Improvement Committee monthly for evaluation. The plan will be	ne ee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMS	SEUR		STREET ADDRESS, CITY, STATE, ZIP CC 7166 JORDON ROAD RAMSEUR, NC 27316	DDE		
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F 582	a NOMNC was provided stated that she expect regarding beneficiary and that she was alrest completing an action	aled they had no record that ded to Resident #85. She sted the regulations notifications to be followed ady in the process of plan to correct the issue.		582			
F 584 SS=B	S483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livir The facility must prov §483.10(i)(1) A safe, homelike environment use his or her person possible. (i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall enthe protection of the ror theft.	onment. ght to a safe, clean, elike environment, including eliving treatment and ng safely.  ide- clean, comfortable, and it, allowing the resident to al belongings to the extent  ring that the resident can rices safely and that the facility maximizes resident les not pose a safety risk. exercise reasonable care for resident's property from loss  eeping and maintenance or maintain a sanitary, orderly,	F	584		11/21/19	
	in good condition; §483.10(i)(4) Private	ed and bath linens that are					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	SEUR	•	STREET ADDRESS, CITY, STATE, ZIP CO 7166 JORDON ROAD RAMSEUR, NC 27316	DE	10/2 1/20 10
(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 IE APPROPRIATE	(X5) COMPLETION DATE
F 584		e 9 ite and comfortable lighting	F 5	584		
	levels. Facilities initia 1990 must maintain a 81°F; and §483.10(i)(7) For the	table and safe temperature lly certified after October 1, a temperature range of 71 to maintenance of comfortable				
	by: Based on record rev staff interview, the fa- sufficient supply of w clothing protectors to	und levels. nis REQUIREMENT is not met as evidenced		The statements included are admission and do not constitution agreement with the alleged of herein. The plan of correction completed in the compliance federal regulations as outliness.	tute deficiencies in is e of state and	
	minutes dated 8/26/1 part, a concern with t clothing protectors fo Review of the month! minutes dated 9/30/1	y Resident Council meeting 9 and 9/30/19 included, in he facility not having enough r the residents at meal time. y Resident Council meeting		in compliance with all federa regulations the center has ta take the actions set forth in the plan of correction the following correction constitutes the center allegation of compliance. All deficiencies cited have been completed by the dates indicated in the complete of the complete o	aken or will the following ng plan of nter's alleged n or will be	
	A Resident Council m 10/23/19 at 10:00 AM residents who were a facility's Resident Co concerns with the facilinens available. The clothing protectors, w residents stated that	r the residents at meal time. neeting was conducted on I with 4 alert and oriented active participants in the		The following was accomplis residents affected by the pra those with potential to be aff practice:  To ensure an adequate supp four dozen clothing protector dozen towels, twenty-five do clothes, five dozen fitted she dozen underpads were orde	actice and for fected by the oly of linen, rs, seven ozen wash eets and eight	i e

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.125.	_		، ا	С	
		345523	B. WING				24/2019	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	2-1/2010	
				7	166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		R	AMSEUR, 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)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 584	Continued From page	e 10	F	584				
	Council meetings, bu	t they had not discussed the			October 23 and, October 24, 2019 and			
	issue with wash cloth	-			were received and processed on Octob	er		
					25, 2019. Another order was placed or	n l		
	An interview was con	ducted with Nursing			October 30, 2019 and received on			
		10/23/19 at 11:05 AM. She			11-1-2019.			
		cility had an issue with wash						
		ng available. She reported			The following measures were put in pla			
	that this was a frequent occurrence and that it was worse in the morning, but progressively got				to ensure that adequate supply linen is available:			
		nt on. She stated that this			avallable.			
		r at least 3 months. NA #1			The contract service has established li	nen		
	reported that if there were no linens on the cart				par levels which are to be available on	1011		
	· •	o to the laundry room and			specific units each shift. The facility ha	s		
		hing clean that had not been			approved these levels. Linen will contir			
	_	se a disposable towel, or wait			to be purchased to maintain the par			
		done to complete their task.			levels.			
		e Housekeeping Manager						
	was aware of the issu	ue.			The following was put in place to monit	.or		
					the performance and ensure that the			
		ducted with Nurse #2 on			corrective action is sustained:			
		She confirmed that the with wash cloths and towels			The Director of Laundry or designee, to			
		indicated it was a frequent			ensure adequate linen is always availa			
		t had been going on for at			based on an established par levels, wil			
	least 3 months. She				audit the supply of linens on each liner			
		ger was aware of the issue.			cart on each shift daily for two weeks a	_		
					weekly t hereafter for four weeks or un			
	An interview was con	ducted with Nurse #3 on			pattern of compliance has been			
		She confirmed that the			established. The results of these audits			
		with wash cloths and towels			will be presented to the Quality Assura			
	_	indicated it was a frequent			and Improvement Committee for review	٧.		
		t had been going on for at			The plan will be revised as deemed	ſ		
	least 3 months. She				necessary.	ĺ		
	nousekeeping iviana(	ger was aware of the issue.						
	An interview was con	ducted with Nurse #4 on						
		She confirmed that the						
		with wash cloths and towels						
		indicated it was a frequent						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG	' '	(X3) DATE SURVEY COMPLETED		
		345523	B. WING			C <b>10/24/2019</b>		
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAM	SEUR	1	STREET ADDRESS, CITY, STATE, ZI 7166 JORDON ROAD RAMSEUR, NC 27316	•	16/2-4/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 584	least 3 months. She Housekeeping Mana An interview was cor Director on 10/23/19 that the residents ha facility not having enduring the August 20 Resident Council me An interview was cor Housekeeping Mana District Leader, on 10 Housekeeping Mana aware of a concern venough clean clothin meal time. She state the laundry being was enough between me sufficient supply. She laundry staff had quit one started last weel quit this week which this issue. The Housekeeping Mana aware of a concern venough clean clothin meal time. She state the laundry being was enough between me sufficient supply. She laundry staff had quit one started last weel quit this week which this issue. The Housekeeping Mana aware of a concern venough clean clean the sufficient supply. She staff that week which this issue. The Housekeeping was enough between me sufficient supply. She staff that she believe staff throwing the warather than putting the cleaned.  An interview was con Administrator on 10/3 stated that she expecting the control of the con	it had been going on for at stated that the ger was aware of the issue.  Inducted with the Activities at 12:00 PM. She stated discussed an issue with the ough clothing protectors 19 and September 2019 etings.  Inducted with the ger and her supervisor, the 20/23/19 at 12:47 PM. The ger acknowledged she was with the facility not having g protectors available at ed that this was an issue with shed and dried quickly als rather than not having a e indicated that one of her a few weeks ago, a new and then someone else could have contributed to sekeeping Manager also was aware of a concern with genough wash cloths and dithat she had just ordered els and wash cloths today as a were running low. She wed part of the issue was with she cloths and/or towels away em in the laundry to be	F	584				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING		C <b>10/24/2019</b>	
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	10/24/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPI  DEFICIENCY)	BE COMPLETION	
F 584 F 641 SS=D	residents. Accuracy of Assessm CFR(s): 483.20(g)  §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record rev staff interview, the fa Minimum Data Set (N in the areas of cognit #49), mood (Resident medications (Resident residents.  The findings included 1. Resident #15 was the facility on 5/11/17 included dementia.  A nursing note dated #15 was alert and vernumbled. She was a responses with difficut finishing thoughts.  A note dated 8/9/19 of	els to meet the needs of the nents  of Assessments. St accurately reflect the  is not met as evidenced  iew, resident interview, and cility failed to code the MDS) assessment accurately ion (Residents #15 and ts #15 and #49), and ht #79) for 3 of 19 sampled  it:  most recently admitted to	F 58	4	and main te te till ving of  e  d for	
	for Mental Status (Bli interview were attem note revealed that Re verbal and spoke a fe	MS) and resident mood pted with Resident #15. This esident #15 was alert and ew understandable words to the questions asked.		the Minimum Data Set (MDS) Coordi to accurately reflect their current state. The modification for resident #79 was completed on 10-24-19 and the modifications for resident #15 and #4 was completed on 11-13-19. The	nator us.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			l ,	С	
		345523	B. WING				24/2019	
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	10,		
				71	166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		R	AMSEUR, NC 27316			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE	
F 641	Continued From page	e 13	F	341				
	The significant change	ge MDS assessment dated			residents did not experience a negative	9		
	8/9/19 indicated Resi	ident #15 was not in a			outcome related to these findings.			
	, .	state. Section C (Cognitive						
	1	Section D (Mood section),			The following will be accomplished for			
	were coded to indicate				residents with potential to be affected by	у		
		ood and that the BIMS and terview were not conducted.			this practice:			
		re completed by MDS Nurse			By 11/21/19, an audit of all MDS			
	#2.	Te completed by MDO Nuise			assessments for the past 30 days will be	ne.		
					conducted by the MDS Coordinator or			
	An interview was con	iducted with Resident #15 on			designee to ensure accurate coding of			
	10/23/19 at 10:30 AM	Resident #15 stated her			sections C, D, and N. All negative findi	ngs		
	name and she asked	, "Are you looking for			will be corrected with the completion of	а		
	someone?".				modification for each discrepancy identified on the most current MDS			
	An interview was con Coordinator on 10/24				assessment.			
	reported that MDS N	urse #2 worked part time at			The following measures will be put in			
	the facility. She repo				place to ensure that the practice does	not		
	I .	ng questions related to MDS			recur:			
		MDS Nurse #2. The 8/9/19			The conict words a MDO condition to the	1		
		5 that indicated the BIMS terview were not conducted			The social worker, MDS coordinators, a			
		use she was rarely/never			activity director and any Interdisciplinar Team(IDT) member involved in the	у		
	understood was revie	•			completion of the MDS will by educated	d bv		
		te dated 8/9/19 completed by			the Regional MDS Consultant by	<i>-</i>		
	I .	ndicated the BIMS and the			November 21, 2019 on the facility police	:y		
	resident mood intervi	ew had been attempted with			related to the accurate completion of the	-		
	Resident #15 was rev	viewed with the MDS			MDS including sections C, D, and N.			
		OS coordinator revealed that						
		nt Assessment Instrument			The following was put in place to monit	or		
	` '	0/19 MDS for Resident #15			the performance and ensure that the			
	and mood.	ely in the areas of cognition			corrective action is sustained:			
					The MDS Coordinator or designee will			
	An interview was con				audit the accuracy of sections C, D, an			
		Assistant Director of			for 50% of the previous weeks' comple	ted		
	_	at 12:01 PM. They both			assessments to ensure accuracy of			
	indicated they expect	ted the MDS to be coded			coding utilizing the MDS Accuracy Aud	IT	1	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345523	B. WING			C <b>10/24/2019</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAN	ISEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316		10/24/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	6/24/15 with diagnost Disease.  A nursing note dated #49 was alert and verification of context.  A nursing note dated #49 occasionally rar statements and discowords being unrelated A noted dated 9/12/Data Set (MDS) Nur Interview for Mental mood interview were #49, but she had noon The quarterly MDS a indicated Resident #vegetative state. See section) and Section coded to indicate Resident mood interview were and D were completed.	s admitted to the facility on sees that included Alzheimer 's d 9/8/19 indicated Resident erbal with speech in and out d 9/11/19 indicated Resident erbal with speech in and out d 9/11/19 indicated Resident erbal with non-sensical reganized thoughts with her ed to questions asked.  19 completed by Minimum se #1 indicated the Brief Status (BIMS) and resident erattempted with Resident tresponded to any questions.  19 completed by Minimum se #1 indicated the Brief Status (BIMS) and resident erattempted with Resident tresponded to any questions.  19 completed by Minimum se #1 indicated 9/12/19 erattempted with Resident tresponded to any questions.  19 completed by Minimum se #1 indicated 9/12/19 erattempted with Resident erattempted with Patterns in D (Mood section), were erattempted was rarely/never the BIMS and the resident erattempted with Patterns in D (Mood section) in a persistent erattempted was rarely/never the BIMS and the resident erattempted with MDS Nurse #1 indicated with MDS Nurse #1	F 641	· · · · · · · · · · · · · · · · · · ·	on. The sor until a sished. The sented to provement plan will be		
	the BIMS and reside conducted for this re rarely/never underst Nurse #1. The note the BIMS and the re	r Resident #49 that indicated ent mood interview were not esident because she was ood was reviewed with MDS dated 9/12/19 that indicated sident mood interview had Resident #49 was reviewed					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	` ′	(X3) DATE SURVEY COMPLETED		
		345523	B. WING		1	C <b>0/24/2019</b>	
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	10/24/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 641	based on the Reside (RAI) manual this 9/ was coded inaccurar and mood.  An interview was con Administrator and the Nursing on 10/24/19 indicated they expect accurately.  3. Resident #79 was 6/19/18 with diagnost A physician 's order 10/10/19 indicated A milligrams (mg) ever Ciprodex Otic (antibidays.  A note dated 10/15/10 Data Set (MDS) Nurwas currently received The quarterly MDS a indicated Resident # impaired. The Mediathis MDS indicated Fantibiotic medication back period (10/9/19/19/19/19/19/19/19/19/19/19/19/19/1	MDS Nurse #1 revealed that ent Assessment Instrument 12/19 MDS for Resident #49 tely in the areas of cognition anducted with the e Assistant Director of at 12:01 PM. They both sted the MDS to be coded admitted to the facility on ses that included dementia.  for Resident #79 dated augmentin (antibiotic) 875 by 12 hours for 10 days and otic ear drop) twice daily for 7 desident #79 ing an antibiotic.  assessment dated 10/15/19 are 1 indicated Resident #79 ing an antibiotic.  assessment dated 10/15/19 cations section, Section N, of Resident #79 had received no during the 7-day MDS look of through 10/15/19). Section DS for Resident #79 was	F 64				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345523	B. WING _			C / <b>24/2019</b>	
	ROVIDER OR SUPPLIER	SEUR	1	STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO  X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656 SS=D	on 10/24/19 at 9:50 A Resident #79 that incomplete a model of the reviewed with MDS Not indicated Resident #3 on 6 of 7 days during period was reviewed Nurse #1 confirmed to She revealed that this would complete a model of the revealed that this would complete a model of the revealed that this would complete a model of the revealed that this would complete a model of the revealed that this would complete a model of the revealed that this would complete a model of the revealed that the residence of the revealed they expect accurately.  Develop/Implement (CFR(s): 483.21(b)(1)  §483.21(b) Compreh §483.21(b)(1) The fair implement a comprel care plan for each reresident rights set for §483.10(c)(3), that in objectives and timefrom medical, nursing, and needs that are identificated assessment. The cord describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.	aducted with MDS Nurse #1 AM. The 10/15/19 MDS for dicated he had received no MDS look back period was Jurse #1. The MAR that 79 had received antibiotics the 10/15/19 look back with MDS Nurse #1. MDS his MDS was inaccurate. Is was en error and she addification.  Inducted with the Iterative Assistant Director of at 12:01 PM. They both the the MDS to be coded  Comprehensive Care Plan  Comprehensive Care Plan  ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial fied in the comprehensive inprehensive care plan must		656		11/21/19	

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345523	B. WING		C 40/24/2040	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316		10/24/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION	
F 656	provided due to the runder §483.10, inclutreatment under §483.10, and service provide as a result of recommendations. If findings of the PASA rationale in the reside (iv) In consultation wiresident's representation (A) The resident's good desired outcomes. (B) The resident's profuture discharge. Fact whether the resident community was assellocal contact agencies entities, for this purpose (C) Discharge plans plan, as appropriate, requirements set fort section.  This REQUIREMENT by:  Based on observation interviews and record develop and implemental plan for activities for Resident #74) of 2 reactivities. The finding 1. Resident #11 was diagnosis of Demental Resident #11's annumental resident #11	esident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized is the nursing facility will a facility disagrees with the RR, it must indicate its ent's medical record. It the resident and the active(s)-least for admission and reference and potential for collities must document as desire to return to the research and any referrals to research and any referrals to research and any referrals to research and the resident and the resident and the resident and the resident and any referrals to research and any referrals to research and for other appropriate research in accordance with the hin paragraph (c) of this  To is not met as evidenced ons, staff and resident dereview, the facility failed to rent a person-centered care 2 (Resident #11 and residents reviewed for residents reviewed for residents included:	F 6	The statements included are not ar admission and do not constitute agreement with the alleged deficien herein. The plan of correction is completed in the compliance of stat federal regulations as outlined. To re in compliance with all federal and st regulations the center has taken or take the actions set forth in the follo plan of correction the following plan correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will	cies e and emain eate will wing of	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345523	B. WING			C 10/24/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/24/2013
				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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	Continued From page	e 18	F 65	66		
	self and other, but sh behaviors. Resident a "Preferences for Cus	#11's section F titled		completed by the dates indicated	d.	
	Activities" indicated the	his section was completed f her family. It read the		F-656		
	following: doing thing religious and going o	s with groups of people, utside were very important to as using a wheelchair for		The following was accomplished residents #11and resident #74 w affected by the practice.	vho were	
	7/30/19 read per her of music, spiritual/reli outdoors and socials #11 to participate in a twice per week. Intertransportation to and	cies care plan last revised on family she had preferences gious programs, time. The goal was for Resident activities of her preference rentions included provide from activities of interest, e activity attendance, post		The care plans were reviewed a on November 13, 2019 by the D Activities based on current and pinterests and strengths and limit assessed on the Minimum Data (MDS) to ensure that the care pl person centered and that the plaindividualized and implemented.	irector of orevious ations as Set lans are an is	
	personal activity cale encourage her to par	ndar in her room, invite and ticipate in activity groups of music, spiritual/religious		The following will be accomplish other residents having the poten affected by the practice:		
		ved activities in progress in 10/21/19 at 9:45 AM, 10:30		All resident care plans on the sp Memory Care unit will be review evaluated and revised by Noven 2019 by the Director of Activities that the care plans are person-co	ed nber 21, s to ensure	
	sitting in the hallway	Resident #11 was observed		and implemented. The plans will past and current interests and st and limitations noted on the MDS	l reflect trengths	
	progress.			The following measures will be pplace to ensure the practice doe recur:		
	sitting in the hallway	1 Resident #11 was observed		The Activity Director will educate Activity Staff responsible for prog by 11-21-19 on the Memory Care how to create a person-centered	gramming e unit on	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345523	B. WING			C <b>10/24/2019</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/24/2019
				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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRINCE OF	JLD BE	(X5) COMPLETION DATE
F 656	sitting in the hallway a residents. There were progress.  In an observation of the standing in the hallway a Resident #11 was naged in an observation of F10/23/19 at 8:45 AM, calendar was observed over the head of her bestanding.  In an observation of the standing.  In an observation of the standing.  In an observation of the standing her who the hallway repeating There was observed the hallway. Observed the hallway. Observed nursing station was a calendar which read the party in the main dinir.  In an observation of the standing station was a calendar which read the party in the main dinir.	he dementia unit on Resident #11 was observed along with 14 other e no observed activities in  he dementia unit on Resident #11 was observed along with 8 other residents. oping.  Resident #11's room on the personal activity ed pinned to a cork board oed at eye level while  he dementia unit on Resident #11 was observed eelchair out of her room into "what can I do now?". 10 other residents sitting in d in the hallway near the large bulletin board activity here would be a birthday ng room at 10:30 AM.  he main dining room on l, Resident #11 was not ce.  he dementia unit on l, Resident #11 was ng in her wheelchair	F 65	care, resources utilized to develop care plan and the process of implementation.  The following monitoring initiative vimplemented to ensure the solution sustained.  The Activity Director will audit and all Activity Care Plans developed by Activity staff. The audit form will incresident name, date of activity care reviewed. The activity attendance be audited to ensure that the care has been implemented. The Activity Director will audit 25% of activity or plans and implementation weekly the weeks or until a pattern of compliant been established. The results of the audits will be presented to the Quarent Assurance and Improvement Comfor review and evaluation. The plant revised as deemed necessary.	will be as are approve y the clude e plan og will plan y are or six nce has e lity mittee	

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		STRUCTION	(X3) DATE SURVEY COMPLETED	
			7 55 5			,	c
		345523	B. WING _			10/	24/2019
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				7166 J	ORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		RAMS	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	11:14 AM with the AD Director (AAD). The A her position for appro AAD stated she had to last spring and was to stated she was responsively care plans for unit but stated it was activity care plans for unit but stated it was Interview on 10/24/19 Administrator stated to plan should be person implemented.  2. Resident #74 was 7/13/18 with diagnose without behavioral distributions without behavioral distributions was alert and up in heable to make eye con Resident #74 required encouragement, and room activities. She was stated as the plan should be person without behavioral distributions without behavioral distributions.	conducted on 10/24/19 at and Assistant Activity AD stated she had been in ximately one year and the been in her position since ained by the AD. The ADD insible for activities on the sted she completed the residents on the dementianew to her.  If at 11:38 AM, the Resident #11's activity care in centered and admitted to the facility on est that included dementia sturbance.  If annual review for ted by the Activity Director licated that Resident #74 er wheelchair daily. She was stact when spoken to. direminders, assistance to attend out of was noted to have family	Fé	856	DEFICIENCY)		
	following activities: gaspiritual/religious, mu The AD indicated in Fishe listened to music to other residents, we weather was nice, an and friends. Staff we Resident #74 to attention	nt #74 had attended the ames, crafts, sic, bingo, and exercise. Resident #74's leisure time, watched tv/movies, talked ent outdoors when the d had visits from her family re to continue to encourage id activities of interest.					
	The annual Minimum	Data Set (MDS)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345523	B. WING			C	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMS		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316			10/24/2019	
(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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	#74 's cognition was assessed with impain print but not regular pand had corrective lebehaviors daily and ethe 7-day MDS review. Preferences for Custor indicated it was very have books/magazine listen to music she likas pets, do things wit favorite activities, go the weather was good services/practices. Rextensive assistance unit and dependent ounit. She utilized a was reading, baking/cookiactivities, watching to talking/conversing, fis and community outing initiated on 7/17/19 aby the Assistant Activ goal for this problem/to participate in at leas week and to increase The interventions were to take the problem and the problem and to increase the interventions were the participate in at leas week and to increase the interventions were the problem and the problem and the problem and the problem and to increase the interventions were the problem and th	18/19 indicated Resident severely impaired. She was ed vision, able to see large wint in newspapers/books inses. She had verbal experienced delusions during a period. Section F, omary and Routine Activities, important to Resident #74 to es/newspapers to read, ed, be around animals such in groups of people, do her outside to get fresh air when id, and participate in religious desident #74 required the of 1 for locomotion on the in 1 for locomotion off the inheelchair and walker.  plan included the g unable to verbalize her her family reported she is, crafts, exercise, music, ing, spiritual/religious parties/social events, gis. This problem/need was ind last reviewed on 10/9/19 ities Director (AAD). The inneed was for Resident #74 ist 1 out of room activity per participation in activities. The ast follows:  The preferences and help me in the second of the preferences and help me in the second of the preferences and help me in the second of the preferences and help me in the second of the preferences and help me in the second of the preferences and help me in the second of the preferences and help me in the second of the preferences and help me in the second of the preferences and help me in the second of the preferences and help me in the second of the preferences and help me in the second of the preferences and help me in the preference in t	F6	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG	(X3)	(X3) DATE SURVEY COMPLETED	
		345523	B. WING _			C <b>10/24/2019</b>	
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP CO 7166 JORDON ROAD RAMSEUR, NC 27316	ODE	10/2 1/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	- Please assist me to - Please remind me was cheduled - Post personal active 's] room - Transport resident of functions  There were no observed active the dementia care under the dementia care undementia care under the dementia care under the dementia care undementia care under the dementia care under the dementia care undementia care under the dementia care undementia care undementia ca	ity schedule in [Resident #74 to activities and facility wed activities in progress in hit on 10/21/19 at 9:45 AM, 1.  Inducted with Resident #74 on She was on the dementia her wheelchair sitting in the facing the hallway. She had to self. Resident #74 apposed to doI need is just making me crazy." Industed that she was always busy and never had downtime, so at to do with her downtime. The area homemaker during her cooking, cleaning, animals, and the series were lined up against the facing each other. Several red to be sleeping. There stivities in progress and no	F6	556			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING		C 10/24/2019	
	ROVIDER OR SUPPLIER	MSEUR	7	STREET ADDRESS, CITY, STATE, ZIP CODE 166 JORDON ROAD RAMSEUR, NC 27316	10/24/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION	
F 656	Continued From page	ge 23	F 656			
	height that was eye	bed on a bulletin board at a level when standing. The ir was regular sized as in books.				
	10/23/19 at 2:41 PN seated in her wheel 7 other residents. T against the walls of Several residents w There were no obse	f the dementia care unit on M Resident #74 was observed chair in the hallway along with he residents were lined up the hallway facing each other. were observed to be sleeping. erved activities in progress teractions between staff and				
	10/24/19 at 9:55 AN was in charge of proceedings on the dereported that she had the dementia care to 10/23/19. She reported that the dementia care to 10/23/19.	onducted with Nurse #1 on  M. She stated that the AAD oviding activities to the mentia care unit. Nurse #1 ad not seen any activities on unit when she was working on rted that Resident #74 was njoyed attending activities.				
	AM with the AD and had been in her posyear and the AAD syear and the ABD syear and t	Inducted on 10/24/19 at 11:14 I AAD. The AD stated she sition for approximately one tated she had been in her pring. The AAD reported she activities on the dementia rained by the AD. She de that she was responsible for a activities, but that she was uning process. Resident #74 ' to activities that indicated the activity per week was AD. The AAD revealed that on-centered goal for Resident y social and 1 activity per				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345523	B. WING			C <b>24/2019</b>
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	1 10/	2-1/2013
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	intervention of postin activity calendar in he the AAD. The placer activity calendar at a when standing, Residindependently, and his reviewed with the AA Resident #74 would right what was printed on following care plan in with the AAD:  - I enjoy reading bool newspapers  - I love to be around a light prefer activities that The AAD acknowledge actual interventions to implemented. She incontents that the contents in the contents would be activitied actual interventions would be activitied actual interventions would be activitied activities actual interventions would be activities activities activities actual interventions would be activities activities activities actual interventions would be activities acti	n for her. The care plan g Resident #74 's personal er room was reviewed with nent of Resident #74 's height that was at eye level dent #74 's inability to stand er impaired vision were D. She acknowledged that not have been able to see this activity calendar. The terventions were reviewed as, magazines, and enimals at involve music ged that these were not	F 65	66		
F 677 SS=D	AM with the Administ her expectation was centered, to address of the residents, and implemented. ADL Care Provided fr CFR(s): 483.24(a)(2)  §483.24(a)(2) A residunt activities of daily services to maintain opersonal and oral hygo	ent who is unable to carry living receives the necessary good nutrition, grooming, and	F 67	77		11/21/19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBED:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345523	B. WING			1	C <b>24/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER		<del>-</del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	24/2019	
TO UNIC OF T	TO VIDER OR OUT FEEL				166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAN	ISEUR			RAMSEUR, NC 27316			
					 T			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC 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 677	Continued From page	ge 25	F 6	677				
	Based on observati	ons, staff interviews and			This Plan of Correction constitutes a			
	record review, the fa	acility failed to provide nail			written allegation of compliance.			
	care for resident's d	ependent of staff assistance			Preparation and submission of this Pla	ın of		
		y living (ADLs) with hand			Correction does not constitute an			
		as for 2 (Resident #24 and			admission or agreement by the provide	er of		
		esidents reviewed for ADLs.			the truth of the facts or alleged, or the			
	The findings included:				correctness of the conclusions set fort			
	4 5				on the statement of deficiencies. The F			
		s admitted on 7/25/14 with			of Correction is prepared and submitte			
	bilateral hand contra	actures.			solely because of the requirement und state and federal law, and to demonstr			
	Pecident #2//c quar	terly Minimum Data Set			the good faith attempts by the provider			
	-	9 indicated moderate			improve the quality of life of each resid			
	cognitive impairment and she exhibited no				improve the quality of the or each resid			
		coded for extensive staff			F677			
	assistance with her	personal hygiene and coded						
	for bilateral upper ex	· · · · · · · · · · · · · · · · · · ·			IMMEDIATE ACTION			
	Review of Resident	#24's care plan dated 6/22/18			On 10/22/2019 the fingernails of Resid	lent		
		lp with her ADLs related to			#24 and Resident #46 were cleaned a	nd		
		oth hands. Interventions			trimmed by staff.			
	-	n assistance with grooming						
	and personal hygier	ne.			IDENTIFICATION OF OTHERS			
		#24's care plan dated 5/31/19			On 10/ 22/ 2019, the Director of Nursir			
	•	ght-hand and left-hand splints			or Unit Coordinators audited 100% of a			
		ractures. Interventions			residents with hand contractures. Care	;		
	included to assess h	ner skin integrity for			plans for all identified residents since			
	compromise.				10/22/2019 have been updated by MD			
	Deview of Desident	#24'a Ostaba - 2040			Coordinator to reflect nail care needs a			
	Review of Resident				care preferences. On 11/13/2019, the			
		cluded an order dated 1/7/19 heep orthotic hand splints at			Director of Nursing or Unit Coordinator reviewed the Activities of Daily Living			
		the morning. Monitor for skin			(ADL) care plans and audited 100% of			
	irritation, bruising or	<u> </u>			dependent residents with no further			
		J. J			issues identified.			
	Review of Resident	#24's undated electronic						
		ng assistants (NA) follow			SYSTEMIC CHANGES			
		read: Donn sheep orthotic						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345523	B. WING _	B. WING		C 10/24/2019	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	724/2019	
				7166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		RAMSEUR, NC 27316			
(X4) ID PREFIX TAG			IMMARY STATEMENT OF DEFICIENCIES ID DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		RECTION SHOULD BE PPROPRIATE	(X5) COMPLETION DATE	
F 677	Continued From page	e 26	F 6	77			
	Monitor for skin irritati breakdown.  Review of Resident #	24's electronic NA		Effective 11/15/2019, all identification residents with hand contracture monitored weekly for nail care identified resident with hand cowill receive timely nail care as it	es will be needs. Any ontractures needed.		
	documentation from 1 revealed documented applying her hand spl	evidence of the aides		Audit forms will be utilized by the of Nursing and Unit Coordinate and monitor identified depende	rs to track		
	removing them in the	morning. The electronic NA 0/1/19 to 10/22/19 also		residents nail care.			
	revealed Resident #24 required limited to total assistance with her personal hygiene.  Review of the October 2019 activity calendar read "nifty nails" was done on 10/8/19. Review of Resident #24's activity attendance sheet indicated #24 was in attendance.  Observation on 10/21/19 at 12:25 PM, Resident #24 was sitting in her wheelchair in the main dining room. She had severe bilateral hand contractures with long, jagged fingernails painted pink. Her fingernails were noted pressing into her palms. There was no observed evidence of skin breakdown.			MONITORING PROCESS	tan af		
				Effective 11/15/2019, the Direct Nursing and Unit Coordinators compliance by reviewing all aurensure the initiation and complicate for identified residents. Commonitoring will occur weekly for then bi-weekly for 4 weeks or upattern of compliance is mainta QAPI Committee can modify the ensure that the facility remains substantial compliance.	will monitor dit forms to etion of nail ompliance r 8 weeks, until a ained. The		
	#24 was in her wheeld She had severe bilate long, jagged fingernal fingernalls were noted and voiced no discomt observed evidence of In an interview on 10/ Activity Director (AD) residents' fingernalls	d pressing into her palms infort. There was no skin breakdown.  22/19 at 3:45 PM, the stated during "nifty nails" were trimmed, filed and ed Resident #24 was in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<b>'</b> '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING		C 10/24/2019
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAI	MSEUR	7	TREET ADDRESS, CITY, STATE, ZIP CODE 166 JORDON ROAD LAMSEUR, NC 27316	10/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 677	was assigned Residher first day back at Resident #24 was in her fingernails and there was potential fingernails were not she last worked with liked to come in and fingernails but since had not seen her dadaily. She stated shher fingernails needs skin breakdown.  In an interview on 1 Administrator stated Resident #24's fingimmediately, and shands to be as concerns such has hygiene and long, jaily was in her whe Her fingernails were reported the staff tri 10/22/19.  2. Resident #46 was cumulative diagnos Accident and a left-Review of Resident 12/21/18 for refusal (ADLs) included th re-approach for refusal resident refusal (ADLs) included th re-approach for refusal resident refusal refusa	O/22/19, NA #5 confirmed she dent #24 and stated this was fiter a month of leave. In bed when NA #5 assessed agreed they were too long and for skin breakdown if her at trimmed. NA #5 stated when he Resident #24, her daughter depaint Resident #24's are it was her first day back, she aughter but thought she visited are would let her daughter know ded to be trimmed to prevent  O/22/19 at 4:15 PM, the dit was her expectation that ternail be addressed and expected her fingernails sessed daily for any skin skin breakdown, hand agged fingernails.  23/19 at 11:45 AM, Resident elchair sitting in the day room. The trimmed and filed. She admitted on 4/25/13 with the sof Cerebral Vascular hand contracture.  #46's care plan dated of activities of daily living the intervention of staff	F 677		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345523	B. WING		C <b>10/24/2019</b>	
	ROVIDER OR SUPPLIER	ISEUR	1	STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	10/24/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 677	improve her left-har included donning he night and removing monitor for skin irrital Review of Resident read she had a self-assistance with grow Interventions include and hygiene assistance with grow Interventions include and hygiene assistance with a book of the personal hygiene are one side to her upper Review of Resident Physician orders incomplete which read: Please on at night and remover for skin irritation and Review of Resident care-guide the nursing when providing care splint at bedtime and Monitor for skin irritation from revealed documentation from revealed documentation from removing it in the midocumentation from the	colint application to maintain or and contracture. Interventions or resting left-hand splint at it in the morning. Staff were to ation or redness.  #46's care plan dated 1/11/19 care deficit and required staff oming and personal hygiene. ed staff providing grooming nce.  terly Minimum Data Set indicated moderate cognitive ehavior of rejection of care. otal staff assistance with her and coded for impairment on er extremity.  #46's October 2019 cluded an order dated 6/2/18 put on left resting hand splint ove in the morning. Monitor direction in the morning. Monitor direction in the morning. In the morning assistants (NA) follow eread: Donn left resting hand diremove in in the morning.  #46's electronic NA in 10/1/19 to 10/22/19 ed evidence of the aides and splint at bedtime and orning. The electronic NA in 10/1/19 to 10/22/19 also each splint at order dates assistance.	F 677			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING		C 10/24/2019
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	1 10/2-12010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 677	#46 was sitting in he dining room. She had finger contracture. It jagged and pushing pain. There was no obreakdown.  Observation on 10/2 #46 was sitting up in She had a severe le contracture. Her fing jagged and pushing pain. There was no obreakdown.  In an interview on 10 confirmed she was a 10/21/19 and 10/22/stated she always as before applying her limited in an interview and 4:10 PM, NA #6 was Resident #46 stated going to was going to yesterday." NA #6 rethat she forgot to do gave her a shower.	1/19 at 12:25 PM, Resident of wheelchair in the main da severe left-hand middle of the fingernails were long and into her palm. She voiced no observed evidence of skin 2/19 at 11:20 AM, Resident of the wheelchair in her room. It is the wheelchair in her room. It is the palm. She voiced no observed evidence of skin 2/22/19 at 3:50 AM, NA #6 assigned Resident #46 on 19 on second shift. NA #6 assessed her fingernails left-hand splint at night.  Observation on 10/22/19 at a in Resident #46's room.  "I thought someone was o cut my fingernails esponded to Resident #46 them yesterday when she	F 67	,	
	Administrator stated Resident #46's finge immediately, and sh and hands to be ass	e expected her fingernails essed daily for any skin skin breakdown, hand			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345523	B. WING _			C <b>10/24/2019</b>
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP COL 7166 JORDON ROAD RAMSEUR, NC 27316	DE	10/2-7/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677	#46 was in her whee outside of her room. and filed. She reporte	3/19 at 12:10 PM, Resident Ichair sitting in the hallway Her fingernails were trimmed ed the staff trimmed her	F 6	577		
F 679 SS=E	fingernails on 10/22/ Activities Meet Intere CFR(s): 483.24(c)(1)	st/Needs Each Resident	F 6	779		11/21/19
	the comprehensive a and the preferences program to support reactivities, both facility individual activities at designed to meet the physical, mental, and each resident, encou and interaction in the This REQUIREMENT by:  Based on record revinterview, and staff in provide an ongoing reprogram that included 1 activities based on of individual residents for 2 of 2 sampled reactivities (Residents:  The findings included 1. Resident #74 was 7/13/18 with diagnos without behavioral distributions and the resident #74 was 7/13/18 with diagnos without behavioral distributions and the resident #74 is 7/17	cility must provide, based on ssessment and care plan of each resident, an ongoing esidents in their choice of responsored group and and independent activities, interests of and support the psychosocial well-being of raging both independence community.  To is not met as evidenced iew, observation, resident atterview, the facility failed to esident centered activities digroup activities and/or 1 on the strengths and limitations is on the dementia care unit sidents reviewed for #11 and #74).		The statements included are admission and do not constit agreement with the alleged dherein. The plan of correction completed in the compliance federal regulations as outline in compliance with all federal regulations the center has tal take the actions set forth in the plan of correction the following correction constitutes the certallegation of compliance. All deficiencies cited have been completed by the dates indictive.	ute leficiencies n is of state and d. To remain l and state ken or will ne following ng plan of nter's alleged or will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245522	B. WING			С	
		345523	B. WING		1	0/24/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
IINIVERSA	AL HEALTH CARE/RAMS	SELIR		7166 JORDON ROAD			
ONIVERO	AL HEALIH OAKE/KAIK	SEOK		RAMSEUR, NC 27316			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 679	Continued From page	e 31	F 67	9			
	` <i>'</i>	dicated that Resident #74 er wheelchair daily. She was ntact when spoken to.		The following was accomplishe resident #11and resident #74 w affected by the practice:			
	Resident #74 require	d reminders,					
	encouragement, and	assistance to attend out of		Based on past interests, curren			
		was noted to have family		and the MDS assessment, the	•		
	assist with the completion of her activity			and activity programming of bot			
	assessment. Resident #74 had attended the			#11 and resident #74 were revis	•		
	following activities: games, crafts, spiritual/religious, music, bingo, and exercise.			Director of Activities to reflect co	urrent		
		• •		status on 11-14-19.			
		Resident #74 's leisure time		The following will be accomplisi	and for		
		, watched tv/movies, talked ent outdoors when the		other residents having the pote			
		d had visits from her family		affected by the practice:	illiai to be		
		re to continue to encourage		anceted by the practice.			
		nd activities of interest.		By 11/21/19, all care plans for roon the Memory Care unit will ha			
	The annual Minimum	Data Set (MDS)		care plans reviewed and revise			
		18/19 indicated Resident		needed by the Activity Director.			
	#74 's cognition was	severely impaired. She had		plans and the residents' activity			
	verbal behaviors daily	y and experienced delusions		programing will be based on cu			
	during the 7-day MDS	S review period. Section F,		past interests and strengths and	b		
		omary and Routine Activities,		limitations assessed on the MD			
	-	important to Resident #74 to		11/13/19, the Administrator (a fo			
	_	es/newspapers to read,		Activities Director Consultant) e			
		ted, be around animals such		the Activities Director and Activi	•		
		h groups of people, do her		formulating resident centered a			
		outside to get fresh air when		programs that include group ac			
	_	d, and participate in religious		and/or 1 on 1 activities based o			
	-	Resident #74 required the of 1 for locomotion on the		strengths and limitations of dem residents. Also, additional progr			
		n 1 for locomotion off the		has been added to the Activity	•		
		heelchair and walker.		on the Memory Care unit to ens			
	a.n. one dilized a W	nosonan ana walker.		ongoing resident centered grou			
	Resident #74 ' s care	plan included the		individual 1 on 1 are available to			
		g unable to verbalize her		residents. Additional programs			
		her family reported she		on 1 and small group sensory s			
		s, crafts, exercise, music,		five mornings weekly; Music an			
	reading, baking/cook			Movement; Name that Sound; E			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
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LININ/EDO		orup.		71	166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAM	SEUR		R	AMSEUR, NC 27316		
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F 679	talking/conversing, fi and community outin initiated on 7/17/19 at The goal for this problem. The goal for this problem are week and to increastivities. The interverse Resident #74 when a about her activity preand to transport her functions.  Resident #74's 10/9 activities was compled Director (AAD). This 7/17/19 annual revies The quarterly MDS a indicated Resident # moderately impaired and other behavioral and experienced deliveriew period. Resident # and other behavioral and experienced deliveriew period. Resident was activities of the dementia care untoward the residents activities were held to open to all residents	a/movies, gardening/plants, shing, parties/social events, ags. This problem/need was and last reviewed on 10/9/19. Dem/need was for Resident at least 1 out of room activity ease participation in entions included reminding activities were scheduled, ask afterences, help plan activities, to activities and facility  all quarterly review for eted by the Assistant Activity areview was identical to the ew completed by the AD.  assessment dated 10/10/19 and 's cognition was  She had verbal behaviors symptoms on 1 to 3 days usions during the 7-day MDS dent #74 required the exist of 1 for locomotion on and utilized a wheelchair.  The member 2019 Activity Calendar experiments and geared specifically on that unit. The remaining on the main unit and were in the facility. There were no on the dementia care unit on	F	6379	Complete the adage; What do you do vit; What is it; Card Pairing; Hokey Poke and Making Music. These activities we designed to address a variety of interest and a range of strengths and limitations for both active and passive participation Each program will be evaluated for resident participation and interest. Activ programs will be revamped or replaced needed.  The following measures are being put it place to ensure the practice does not recur:  With the revision of resident activity car plans and programming based on individual interests and strengths and limitations as well as the increased number of activity programs on the schedule, the residents will be provided with ongoing resident centered activities.  The following will be put in place to monitor performance and ensure that the solutions are sustained:  The Director of Activities will review the attendance log weekly for six weeks, or until a pattern of compliance is sustained of 25% of residents on the Memory Carunit and compare with the care plan to ensure that the plan is implemented an residents are provided with ongoing resident centered activities. The results this audit will be presented to the Qualit Assurance and Improvement Committee the plan is implemented and residents are provided with ongoing resident centered activities. The results this audit will be presented to the Qualit Assurance and Improvement Committee.	y rests s. n. vity as n re d. s. ne e. r. ed, re d. s. of	
	A review of Resident Activity Attendance F	#74 's September 2019 Record indicated she			for evaluation. The plan will be revised deemed necessary.	as	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING		C 10/24/2019
	ROVIDER OR SUPPLIER	ISEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	10/24/2010
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F 679	activities being held These activities incl spiritual/religious ace events (3), music (3 exercise (1). Residuactivity attendance of September.  A review of the Octothe dementia care unit attendance residents on that were held on the maresidents in the facil scheduled on the deweekend days in Octothe dementia care unit attendance Record 10/20/19 indicated sactivities with 1 of the dementia care unit attendance Record 10/20/19 indicated sactivities with 1 of the dementia care unit games (6), bingo (3 (2), music (2), exercisedent #74 was in	on the dementia care unit. uded: bingo (7), games (5), tivities (5), parties/social ), movies (1), cooking (1), ent #74 was noted with no on 4 of 5 weekends in  ober 2019 Activity Calendar for init indicated there was 1 nat month that was held on the and geared specifically toward t unit. The remaining activities ain unit and were open to all lity. There were no activities ementia care unit on any	F 679	,	
	the dementia care u 10:30 AM or 3:30 Pl An interview was co 10/21/19 at 3:31 PM care unit, seated in	erved activities in progress in init on 10/21/19 at 9:45 AM, M.  Inducted with Resident #74 on Inducted with Resident #64 on Inducted wheelchair sitting in the infacing the hallway. She			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345523	B. WING			24/2019
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(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 679	something to doit 'The resident reporteduring her lifetime are she didn't know who she indicated she would life and she enjoyed music, and church.  In an observation of 10/22/19 at 9:45 AM seated in her wheeled 14 other residents. The against the walls of the Several residents would be several residents would be several residents would be several residents.  In an observation of 10/22/19 at 10:30 AM observed seated in her along with 14 other relined up against the weach other. Several be sleeping. There we progress and no observation of 10/22/19 at 11:30 AM seated in her wheeled 14 other residents. The against the walls of the residents.	upposed to doI need 's just making me crazy." d that she was always busy nd never had downtime, so at to do with her downtime. as a homemaker during her cooking, cleaning, animals,  the dementia care unit on Resident #74 was observed thair in the hallway along with the residents were lined up the hallway facing each other. are observed to be sleeping. The dementia care unit on A Resident #74 was the dementia care unit on A Resident #74 was the wheelchair in the hallway tesidents. The residents were walls of the hallway facing residents were observed to were no observed activities in the dementia care unit on A Resident #74 was observed the dementia care unit on A Resident #74 was observed the dementia care unit on A Resident #74 was observed the dementia care unit on A Resident #74 was observed the dementia care unit on A Resident #74 was observed the hallway facing each other.	F 67	9		
	10/22/19 at 11:30 AM seated in her wheeld 14 other residents. T against the walls of t Several residents we There were no obser	A Resident #74 was observed hair in the hallway along with he residents were lined up				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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				7166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAM	SEUR		RAMSEUR, NC 27316			
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F 679	Continued From page	e 35	F 6	79			
	observed in a musica	PM Resident #74 was all activity on the main unit of alert and smiling during this					
	10/23/19 at 2:41 PM seated in her wheelc 7 other residents. The	the dementia care unit on Resident #74 was observed thair in the hallway along with the residents were lined up					
	against the walls of the hallway facing each other. Several residents were observed to be sleeping. There were no observed activities in progress						
	residents.	ractions between staff and					
	10/24/19 at 9:55 AM. was in charge of provresidents on the dem reported that she had	ducted with Nurse #1 on She stated that the AAD viding activities to the entia care unit. Nurse #1 I not seen any activities on it when she was working on					
	10/23/19. She reporte	ed that Resident #74 was joyed attending activities.					
	AM with the AD and A had been in her posit year and the AAD sta	AAD. The AD stated she ion for approximately one sted she had been in her ring. The AAD reported she					
	was responsible for a care unit and was tra indicated that someti	activities on the dementia ined by the AD. The AAD mes she had activities on the					
	calendar, such as ba reported she hadn ' t	at were not on the activity Il toss and bowling. She scheduled or attempted any					
	AM due to residents busy with getting the	entia care unit before 10:00 eating breakfast and being r activities of daily living She stated that she invited					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 679	activities on the mai the residents were set the hallway and she them. She further set from the dementia comain unit, she had to main unit is activity an activity on the detimeframe. The AAI scheduled activities the weekends as she during the week.  An interview was concarred and interview was concarred at the indicated that her exprogram to address of the facility resider activities on the mai residents regardless capabilities, but othe complex and not be She further explained geared toward the remained to the weekend and on the weekend and on the weekend activities on the mai residents regardless capabilities, but othe complex and not be She further explained geared toward the remained to be held considered toward the remained and on the weekend activities on the main residents and on the weekend activities on the main residents and on the weekend activities on the main residents and on the weekend activities on the main residents and on the weekend activities on the main residents and on the weekend activities on the main residents and on the weekend activities on the main residents and on the weekend activities on the main residents and on the weekend activities on the main residents and on the weekend activities on the main residents and on the weekend activities and on the weekend activities and on the weekend activities and on the we	nentia care unit to attend n unit, but most of the time aleeping in the wheelchairs in had not wanted to wake tated if she took residents are unit to an activity on the costay with them during the and therefore could not hold mentia care unit during that to revealed there were no on the dementia care unit on e only worked in her AAD role and therefore could not hold mentia care unit on e only worked in her AAD role and the form of the strator. She stated that she sing as the Interim end of August 2019. She expectation was for the activity the strengths and limitations and their cognitive status and er activities may be more appropriate for all residents. It is defined that she expected activities esidents on the dementia care stently throughout the week its.	F 679		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3)	) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	<b>!</b>	10/24/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 679	Continued From pag	e 37	F 6	79		
	following: doing thing religious and going o her. She was coded mobility and unable t	of her family. It read the gs with groups of people, gutside were very important to as using a wheelchair for o ambulate.  note completed by the				
	Activity Director (AD) read as follows: Resi facility environment a off the dementia unit reminders, encourag from all activities. Rereligious, social, mus Staff would continue attendance and contiand assist to activitie Resident #11's leisur	dated 7/30/19 at 3:55 PM dent #11 was active in the and attended activities on and . She attended with ement and assistance to and sident #11 attended sic and exercise programs. to monitor her activity inue to remind, encourage s of interest. During				
	7/30/19 read per her of music, spiritual/rel outdoors and socials #11 to participate in a twice per week. Inte transportation to and encourage and prais personal activity cale encourage her to par	ties care plan last revised on family she had preferences igious programs, time . The goal was for Resident activities of her preference rventions included provide from activities of interest, e activity attendance, post andar in her room, invite and ticipate in activity groups of music, spiritual/religious utdoors.				
	8/9/19 read she was with anxiety. Interver were to console Res	plan for depression dated tearful at times associated ntions read as follows: staff ident #11 when she was nibited a verbal behavior of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316		0/24/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 679	Resident #11 "responding with gentle conversal."  There were no observation of the dementia unit on AM or 3:30 PM.  In an observation of the 10/22/19 at 9:45 AM sitting in the hallway residents. There were progress.  In an observation of the 10/22/19 at 10:30 AM sitting in the hallway residents. There were progress.  In an observation of the 10/22/19 at 11:15 AM sitting in the hallway residents. There were progress.  In an observation of the 10/23/19 at 8:35 AM sitting in the hallway Resident #11 was nature.  In an observation of the 10/23/19 at 8:35 AM sitting in the hallway Resident #11 was nature.	n I supposed to do now?" nds well to sunshine and light tion."  ved activities in progress in 10/21/19 at 9:45 AM, 10:30  the dementia unit on Resident #11 was observed along with 14 other e no observed activities in  the dementia unit on Resident #11 was observed along with 14 other e no observed activities in  the dementia unit on Resident #11 was observed along with 14 other e no observed activities in  the dementia unit on Resident #11 was observed along with 14 other e no observed activities in  the dementia unit on Resident #11 was observed along with 8 other residents. pping.  Resident #11's room on	F 6	79			
	calendar was observ	the personal activity ed pinned to a cork board bed at eye level while					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 679	10/24/19 at 9:30 AM self-propelling her with hallway repeating. There was observed the hallway. Observing station was calendar which read party in the main dir was only one listed residents on the derititled "balloon stamp indicated as being of the hallway. Observed in attenda In an observation of 10/24/19 at 10:30 A observed in attenda In an observation of 10/24/19 at 10:35 A observed self-proper repeating "what can Review of Resident record for August 20 in 1 social event, 20 cooking activity and Review of Resident record for September participated in 2 social events, 10 activity.  Review of Resident record for October 2 she participated in 1 religious events and	the dementia unit on I, Resident #11 was observed wheelchair out of her room into g "what can I do now?". If 10 other residents sitting in ed in the hallway near the a large bulletin board activity I there would be a birthday sing room at 10:30 AM. There activity on the calendar for mentia unit dated 10/17/19 bing". All other activities were in the main unit.  The main dining room on M, Resident #11 was not noce.  The dementia unit on M, Resident #11 was lling in her wheelchair I do?".  #11's activity attendance on indicated she participated games, 4 religious' events, 1	F 679		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
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F 679	the dementia unit on activity calendar.  An interview on was 11:14 AM with the AI Director (AAD). The her position for approact AAD stated she had last spring. The ADD for activities on the coby the AD. She stated dementia unit to atted dining room but moswere sleeping in the and she did not wan she did ball toss and unit residents and ot on the activity calend doesn't attempt any 10:00 AM due to result busy with getting the (ADLs) completed. The AAD stated she residents from the dementia unit, she had from the dementia unit the AAD stated she residents in the dementia unit he dementia unit he dementia unit he dementia unit he dementia unit, she had from the dementia unit he dementia unit he dementia unit he AAD stated she residents in the dementia unit he deme	alloon stamping conducted in 10/17/19 as indicated on the 20 and Assistant Activity AD stated she had been in eximately one year and the been in her position since to stated she was responsible dementia unit and was trained and she invited residents on the end activities in the main to fithe time the residents wheelchairs in the hallway to wake them. She stated bowling with the dementia ther things that did not appear dar. The AAD stated she activities on the unit before idents eating breakfast and in activities of daily living She further stated if she took ementia unit to activities on ad to stay with the residents in the halloon toss with the entia unit after 11:00 AM on 19. The AAD stated there he dementia unit on on weekends, she worked as tated Resident #11 was a group settings and that was a her to group activities off the	F			
	provided for Resider Interview on 10/24/1	a asked if any 1:1 activity was at #11, she stated "no".  9 at 11:38 AM, the it was her expectation an				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	BEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	10/24/2019
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F 745 SS=B	activity be attempted daily and that she be preference and if she of her preference sho further stated resider should have activites Provision of Medicall CFR(s): 483.40(d)  §483.40(d) The facility medically-related soot maintain the highest and psychosocial we This REQUIREMENT by:  Based on record rev Services (DSS) intenfacility failed to subm for Resident #72's re application resulting application which del for 1 of 1 residents resocial services.  The findings included Resident #72 was add 1/22/19 with diagnos aftercare and heart faminimum Data Set (National Province) indicated Reseverely impaired.  A review of Resident stay at the facility ind Medicare to private provides and indicated provides at the facility indicated to private provides and indicate to private provides and indicated provides at the facility indicated to private provides and in the facility in the facility in t	with Resident #11 twice taken to activities per her was disruptive, 1:1 activities ould be attempted. She its on the dementia unit on the weekends. y Related Social Service  Ty must provide ital services to attain or practicable physical, mental ll-being of each resident. T is not met as evidenced  iew, Department of Social view, and staff interview, the it all required documentation quest for Medicaid Services in the denial of the initial ayed the application process eviewed for medically related  it:  mitted to the facility on the sthat included orthopedic ailure. The quarterly MDS) assessment dated sident #72's cognition was  #72's payor source for her icated she converted from ay with Medicaid pending on the with this same payor	F 74		nd ain e ng

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	1' '	E SURVEY IPLETED
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F 745	application document indicated the initial pa 3/15/19. On 3/25/19 requested from the fa submitted within 10 be additional information the facility and was rewithin 10 business dawas notified that the Services application missing required info indicated that on 5/22 was requested from to be submitted within 6/11/19 the facility reinformation requested 6/6/19 and had not be additional information from the facility and vidays. On 8/21/19 that all required documenceived for the requested for the reported for the repo	est for Medicaid Services tation for Resident #72 aperwork was submitted on additional information was acility and was required to be business days. On 3/29/19 in was again requested from equired to be submitted ays. On 4/22/19 the facility initial request for Medicaid was not approved as it was rmation. Further review 1/19 additional information the facility and was required in 10 business days. On ceived notification that the don 5/21/19 was due on e received. On 8/7/19 in was once again requested was due within 10 business a facility received notification imentation had been est for Medicaid Services ent #72. This was over 5 all paperwork was submitted.  Inducted with the Business and on 10/22/19 at 10:35 AM. For source information from 1/19 was reviewed with the that the former Administrator consible for submitting the	F 7	retro back to 5-28-19 which was month of the original request.  The following was accomplished residents who have the potential affected by the practice:  An audit was conducted by the Admissions Coordinator on Nove 2019 of all FL2 requests in the I months. All 15 FL2s were submitimely.  The following system has been place to ensure that the practice recur:  The Social Worker will be responsively ensuring that requested FL2s as submitted timely. Effective 11/14. Social Worker now has access Tracks. Additionally, education approcess was provided on 11/14. Admissions Coordinator and a version Social Worker at a "sister facility Social Worker will maintain a logiful FL2 requests. The log will include resident name, the entity request FL2, the date of the request, sure date and approval date.  The following monitoring initiative been put in place to make sure solutions are sustained:  The administrator will audit the ensure the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of weekly for four weeks and monitoring the timely submission of the timely submission of the time	d for other all to be  ember 13, ast six itted  put in exist will not exist on NC on the FL2 f19 by the exeteran r.". The g of all de the esting the bimission  we has that  FL2 log to FL2s hly	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 745	former Administrator facility.  An interview was con 10/22/19 at 10:46 AM former Administrator request for Medicaid March 2019. She also until August 2019 than otification that all received been submitted and taccepted. She was un process had not been former Administrator.  A phone interview was Department of Social 10/22/19 at 4:30 PM. Resident #72's required application was delay not submitting the received additional information. A phone interview was deadlines provided to that it was the former submitted the initial and failed to follow the additional information. A phone interview was Administrator on 10/2 request for Medicaid Resident #72 was revealed that this lack.	ducted with the AC on I. The AC confirmed the initiated Resident #72's Services application in confirmed that it was not to the facility received quired documentation had he application was nable to explain why this in fully completed by the  Is conducted with Services (DSS) staff on She confirmed that test for Medicaid services red as a result of the facility quired paperwork by the time them. DSS staff indicated Administrator who had pplication for Resident #72 rough with sending in the that was requested.  Is conducted with the former text (2/19 at 4:32 PM. The Services application for viewed with the former former Administrator revealed with the online system a submission. She further to of familiarity caused a on of the required paperwork	F 7	45	of compliance has been established. To results of these audits will be presented the Quality Assurance meeting monthly review. The plan will be revised as deemed necessary.	d to	

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			, 50.25		С
		345523	B. WING _		10/24/2019
	VIDER OR SUPPLIER . HEALTH CARE/RAMS	EUR	•	STREET ADDRESS, CITY, STATE, ZIP OF 7166 JORDON ROAD RAMSEUR, NC 27316	CODE
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE
A r ii S r f t	eported that she just nterim Administrator a She acknowledged th equest for Medicaid S or Resident #72 that he facility. She indica	4/19 at 12:01 PM. She began working as the at the end of August 2019. at there was a delay in the Services application process occurred prior to her time at the that it was her cation documentation be	F	745	
SS=B C S a li S C C C C C C C C C C C C C C C C C C	CFR(s): 483.95(g)(1)-6483.95(g) Required aides. n-service training muses as a service training muses as and facility assessment and facility assessment at the service training and resident as a service training and resident as the special numbers of the service training as a service training	in-service training for nurse st- icient to ensure the se of nurse aides, but must surs per year.  dementia management abuse prevention training. s areas of weakness as sides' performance reviews int at § 483.70(e) and may seeds of residents as	F	This Plan of Correction co written allegation of compli Preparation and submissic	iance.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345523	B. WING				C (24/2040
NAME OF D	ROVIDER OR SUPPLIER	040020		ς.	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	24/2019
NAME OF T	NOVIDEN ON 3011 LIEN				166 JORDON ROAD		
UNIVERS	AL HEALTH CARE/RAN	ISEUR					
	Γ				AMSEUR, NC 27316		ı
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R 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 947	Continued From pag	ge 45	F 9	947			
	NA #4) of 5 NAs rev	riewed for staffing.			admission or agreement by the provide	er of	
	The findings include	ed:			the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. The F		
		the facility on 6/5/12 as a NA.			of Correction is prepared and submitte		
	I .	n-service training records			solely because of the requirement und		
		ad not received a dementia raining since 10/2018.			state and federal law, and to demonstrate the good faith attempts by the provider		
	management care t	raining since 10/2010.			improve the quality of life of each resid		
	NA #4 was hired by	the facility on 8/19/15 as a			improve the quality of the or each resid	Oric.	
	_	#4's in-service training records			F947		
		ad not received a dementia					
	management/care to	raining since 10/2018.			IMMEDIATE ACTION		
	NA #3 was hired by	the facility on 5/23/18 as a			On 10/24/2019, the Staff Development		
	NA. Review of NA	#3's in-service training records			Coordinator (SDC) audited education f	or	
		ad not received a dementia			identified nursing assistants (NAs).		
	management/care to	raining since 10/2018.			Nursing Assistant #2 completed demer	ntia	
	Op 10/24/10 at 0:50	AM, the Staff Development			education on 11/11/2019. Nursing Assistant #4 completed dementia		
		was interviewed. The SDC			education on 11/15/2019. Nursing		
	, ,	ed working at the facility as			Assistant #3 is no longer employed wit	h	
	I .	The SDC stated that the facility			the facility.		
	provided a dementia	a virtual tour last June 2019			_		
		es including NA #2, NA #3 and I. She added that she			IDENTIFICATION OF OTHERS		
	planned to include t				On 11/04/2019, the Director of Nursing	Į	
	management/care to	raining during orientation and			and Staff Development Coordinator		
	then yearly.				audited 100% of all nursing assistants'		
					electronic continuing education system		
		2 PM, the Administrator was			training compliance. Dementia education		
	expected all NAs re	dministrator stated that she			for all identified nursing assistants who were out of compliance with dementia		
	· •	raining at least yearly.			education since 11/13/2019 has been		
	management date t	dining at least yearry.			assigned dementia education by the St	taff	
					Development Coordinator. All nursing		
					assistants will be in compliance with		
					dementia education on or before		
					11/21/2019.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		245522	B. WING					
		345523	B. WING _			10/	24/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HMIVEDS/	AL HEALTH CARE/RAMS	SELID		71	166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAIVIS	SEOR		R	AMSEUR, NC 27316			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION				
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛTE	DATE	
					DEI IOIENOT)			
F 947	Continued From page	e 46	F 9	947				
					SYSTEMIC CHANGES			
					Effective 11/21/2019, all assigned			
					dementia education for nursing assista	nts		
					will be tracked and monitored by the			
					Director of Nursing/Designee and Staff			
					Development Coordinator in the electron			
					continuing education system monthly for			
					completion and compliance with assign			
					dementia competency. Education on			
					dementia care will be incorporated into	the		
					facility orientation process for all newly			
					hired nursing assistants (NAs), and will			
					facilitated by the Staff Development			
					Coordinator on or before 11/21/2019.			
					MONITORING PROCESS			
					Effective 11/21/2019 the Director of			
					Nursing/Designee and Staff Developme	ent		
					Coordinator will monitor compliance by			
					reviewing all assigned dementia educa			
					for nursing assistants in the electronic			
					continuing education system to ensure			
					competency and completion of assigne			
					education. Compliance monitoring will			
					occur weekly for 8 weeks, then bi-week	dy		
					for 4 weeks or until a pattern of	-		
					compliance is maintained. The QAPI			
					Committee can modify this plan to ensu	ure		
					that the facility remains in substantial			
					compliance.			