**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345523

### MULTIPLE CONSTRUCTION

#### A. BUILDING _____________________________

#### B. WING _____________________________

### STATEMENT OF DEFICIENCIES

#### (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

#### ID PREFIX TAG

| ID | PREFIX | TAG | SUMMARY STATEMENT OF DEFICIENCIES
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**SUMMARY STATEMENT OF DEFICIENCIES**

An unannounced COVID-19 Focused Survey was conducted onsite 10/27/20 and continued offsite through 10/29/20. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event # 4E9X11.

An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted onsite 10/27/20 and continued offsite through 10/29/20. The facility was found in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The one complaint allegation was unsubstantiated. See Event # 4E9X11.

### NAME OF PROVIDER OR SUPPLIER

**UNIVERSAL HEALTH CARE/RAMSEUR**

### STREET ADDRESS, CITY, STATE, ZIP CODE

7166 JORDON ROAD
RAMSEUR, NC  27316

### ID PREFIX TAG

| ID | PREFIX | TAG | PROVIDER'S PLAN OF CORRECTION
|----|--------|-----|----------------------------------|

#### COMPLETION DATE

**10/29/2020**

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.

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

**Electronically Signed**

10/30/2020