PRINTED: 08/30/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED
		345523	B. WING			С
NAME OF PI	ROVIDER OR SUPPLIER	343323		STREET ADDRESS, CITY, STATE, ZIP CODE		07/28/2021
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		7166 JORDON ROAD RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
F 000	INITIAL COMMENTS	3	F 0	000		
	was conducted from Event ID# 1I2W11. T	mplaint investigation survey 07/27/21 through 07/28/21. wo of the eleven allegations esulting in deficiencies.				
F 585 SS=D	8/12/21. The scope a F925 have been char Grievances		F 5	85		8/6/21
	grievances to the fact that hears grievances reprisal and without for reprisal. Such grievan respect to care and to furnished as well as the furnished, the behavious that the fact that the such that	s. ident has the right to voice ility or other agency or entity s without discrimination or ear of discrimination or nces include those with reatment which has been hat which has not been or of staff and of other concerns regarding their LTC				
	facility must make pro	ident has the right to and the compt efforts by the facility to be resident may have, in paragraph.				
		ility must make information ance or complaint available				
	of all grievances rega	ility must establish a nsure the prompt resolution arding the residents' rights agraph. Upon request, the				
_ABORATORY	I DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 RE	 TITLE		(X6) DATE

Electronically Signed 08/04/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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		345523	B. WING	_		07/	28/2021
	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMS	SEUR		7	STREET ADDRESS, CITY, STATE, ZIP CODE  166 JORDON ROAD  RAMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	to the resident. The ginclude:  (i) Notifying resident i postings in prominent facility of the right to f (meaning spoken) or grievances anonymore of the grievance officican be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the coindependent entities to be filed, that is, the polymer of the grievance of the	rievance policy must  Individually or through I locations throughout the legrievances orally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone expected time frame for or of the grievance; the right cision regarding his or her with whom grievances may extinent State agency, Organization, State Survey and advocacy system; ance Official who is eeing the grievance process, or grievances through to their any necessary investigations ining the confidentiality of all d with grievances, for of the resident for those anonymously, issuing isions to the resident; and e and federal agencies as specific allegations; ing immediate action to tital violations of any resident	F	585			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD			, ا	
		345523	B. WING			1	28/2021
NAME OF P	ROVIDER OR SUPPLIER	•	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
IINIVEDS:	AL HEALTH CARE/RAM	SELID		71	166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAIM	SEUR		R	AMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	anyone furnishing se provider, to the admi as required by State (v) Ensuring that all vinclude the date the gummary statement of the steps taken to invisuomary of the pertiregarding the resider as to whether the gric confirmed, any correctaken by the facility and the date the writt (vi) Taking appropriation accordance with State of the residents' right or if an outside entity the State Survey Age Organization, or local confirms a violation frights within its area (vii) Maintaining evideresult of all grievance 3 years from the issued decision.  This REQUIREMENT by:  Based on resident, restaff interviews and refailed to resolve a gri (Resident #3). The fivitten response to gresident #1, Resident was for 5 of 5 resident The findings included	rion of resident property, by rvices on behalf of the nistrator of the provider; and law; written grievance decisions grievance was received, a of the resident's grievance, vestigate the grievance, a nent findings or conclusions at's concerns(s), a statement evance was confirmed or not ctive action taken or to be as a result of the grievance, the decision was issued; the corrective action in the law if the alleged violation is is confirmed by the facility having jurisdiction, such as ency, Quality Improvement I law enforcement agency for any of these residents' of responsibility; and the ence demonstrating the est for a period of no less than fance of the grievance.  This not met as evidenced the sponsible party (RP) and the ecord review, the facility evance reported verbally acility also failed to provide a direvances (Resident #9, and #7 and Resident #8). This arts reviewed for grievances.	F	585	F585 The statements included are not an admission and do not constitute agreement with the alleged deficiencie herein. The plan of correction is completed in the compliance of state a federal regulations as outlined. To rem in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following	ind nain e	
	decision. This REQUIREMENT by: Based on resident, r staff interviews and r failed to resolve a gri (Resident #3). The fi written response to g Resident #1, Resider was for 5 of 5 resider The findings included Review of the facility	r is not met as evidenced esponsible party (RP) and ecord review, the facility evance reported verbally acility also failed to provide a rievances (Resident #9, nt #7 and Resident #8). This nts reviewed for grievances.			The statements included are not an admission and do not constitute agreement with the alleged deficiencie herein. The plan of correction is completed in the compliance of state a federal regulations as outlined. To rem in compliance with all federal and state	ind nain e l	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345523	B. WING				28/2021	
NAME OF P	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	20/2021	
					166 JORDON ROAD			
UNIVERSA	AL HEALTH CARE/RAMS	SEUR			AMSEUR, NC 27316			
	OLUMBA DV OT	TELEVIT OF REFIGIENCIES						
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F 585	Continued From page	e 3	F	585				
		ay be submitted orally or in			correction constitutes the centers			
		at or the person filing the			allegation of compliance. All alleged			
		nt on behalf of the resident.			deficiencies cited have been or will be			
		balized to any staff member			completed by the dates indicated.			
		ole for documenting the			' '			
	grievance/concern on the appropriate form. The How corrective action will be							
	, •	esentative will be informed of			accomplished for those residents found	d to		
	their right to a written				have been affected by the same deficie			
					practice:			
	1. Resident #3 was a	dmitted on 3/23/2017 and						
	readmitted 3/5/21 wit	h a diagnoses of			Facility failed to resolve a grievance			
	encephalopathy (a disease or damage to the				reported verbally for resident #3.			
	brain), pressure ulcer	rs and a urinary tract			Resident #3 is no longer in the facility a	as		
	infection (UTI)				of 6/20/2021. Facility failed to provide			
					written response to grievances for			
	_	ant change Minimum Data			residents #9, #1, #7, and #8. Written			
		ndicated she had moderate			response was given to the following			
	cognitive impairment	and exhibited no behaviors.			residents and/or reporting individual. Completed on 8/4/2021.			
	Review of the facility'	s grievance logs from			'			
	-	d not include any intakes by			How/ corrective action will be			
	or on behalf of Resid	ent #3.			accomplished for those residents with			
					potential to be affected by the same			
	In an interview on 7/2	28/21 at 10:45 AM, the			deficient practice:	ĺ		
	Administrator reporte	d that the facility's Social				ĺ		
	` ′	grievance official and any			All residents have the potential to be	ĺ		
		omplete a grievance form on			affected. An audit was conducted by th			
		r a Respondibile Party (RP)			Administrator of grievances over the la	st		
		int or grievance was voiced.			30 days to ensure grievances were			
	•	ed the staff to complete a			brought to resolution with written respo			
		ler to ensure the grievance			to reporting individual. Residents that	are		
		and follow up was completed			alert and oriented were interviewed by	ſ		
	with the person filing the grievance.  Ambassadors to ensure all grievances are		are					
		28/21 at 11:00 AM, the Social			recorded and/or resolved. Resident	ſ		
	, ,	ed she was the facility			Representatives were called by			
		e stated anyone could			Ambassadors to ensure all grievances			
		form and a grievance form			recorded and/or resolved. This audit wi	II		
		for any voiced concern or tated the facility staff should			be completed by 8/4/2021.	ĺ		
	runevance. The SW S	iaieu ine iacility Stall Should	- 1		0/4/∠UZ .			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
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		345523	B. WING _			07	//28/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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UNIVERSA	AL HEALTH CARE/RAINS	SEUR		R	AMSEUR, NC 27316		
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F 585	Continued From page	e 4	F t	585			
F 585	offer to assist a reside the grievance form if  In a telephone intervi Resident #3's RP sta would listen at the fact stated he spoke to the previous Director of Notes concern and he never management. He stated the opportunity to constated he thought whe about his concern, he resolution and a responding in a telephone intervi Nurse #1 stated she form on the night of 6 #3's RP voiced a conform should have been she didn't do one bed reported it to her told Administrator knew a assumed a grievance completed by someon in a follow up interviet the Administrator stated that any resident or Recomplaint should be a for a grievance form. It was a way of ensuring addressed and resoluting person with the costated a grievance for stated a	ent for a RP in completing needed.  ew on 7/28/21 at 1:34 PM, ted he informed anyone who cility about his complaint. He e Administrator and the Jursing (DON) about his r heard anything from ted nobody ever offered him implete a grievance. He en he told management e would have gotten onse.  ew on 7/28/21 at 2:25 PM, did not complete a grievance of 19/21 when of Resident cern but stated a grievance of 19/21 when of Resident cern but stated a grievance of 19/21 when of Resident cern but stated a grievance of 19/21 when of Resident cern but stated a grievance of 19/21 when of Resident cern but stated a grievance of 19/21 when of Resident cern but stated a grievance of 19/21 when of Resident cern but stated a grievance of 19/21 when of Resident cern but stated a grievance of 19/21 when of Resident cern but stated a grievance of 19/21 at 3:10 PM, and the bout it already so she would have been one else.  Ew on 7/28/21 at 3:10 PM, and the completion of 19/21 with a concern or 19/21 at 3:10 PM, and the completion of 19/21 with a concern or 19/21 at 3:10 PM, and the completion of	F	585	What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur:  On 7/28/2021 the Administrator and Social Worker were in-serviced by the Regional Director of Operations on the giving a written response to resident and/or reporting individual. Beginning 7/29/2021 all staff will be educated on where the grievance forms are located writing a grievance on the proper form, and providing the information to the grievance officer.  How facility plans to monitor its performance to make sure that solution are sustained:  Beginning 8/4/2021 the Administrator waudit grievance log weekly x 12 weeks ensure that grievances were brought to resolution. The Administrator will revieweekly x Ambassador call log to ensure grievances are recorded appropriately.  Results of these audits will be reviewed Quarterly Quality Assurance Meeting X for further problem resolution if needed Completion date: Aug 6, 2021  The Administrator is responsible for implementing the acceptable plan of correction	vill to w e all	
	2. Resident #9 was a	dmitted on 12/24/20 and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		345523	B. WING _			C 07/28/2021
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316		01120/2021
(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 COR  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 585	Continued From pag		F 5	85		
	Resident #9's quarte	rly Minimum Data Set dated was cognitively intact and				
	indicated a grievance The form indicated t and a one-to-one dis	Concern Form dated 7/2/21 was filed by Resident #9. he grievance was resolved cussion was had with 1. The form indicated that as not provided.				
	Administrator reported Worker (SW) was the was responsible for put decision to the individed He stated that when facility in May 2021 he SW because he notice decisions had been put party verbally. The American he informed the SW a written grievance do reporting party and he these written decision forward. The Adminitration	28/21 at 10:45 AM, the ad that the facility's Social are grievance officer and she providing a written grievance duals who filed grievances. The first started working at the first started that the regulations required ecision to be provided to the first started her to provide first for all grievances moving strator revealed that he was a followed his instructions.				
	stated the grievance, for Resident #3 read was provided to the rwritten notification was that if she spoke to the grievance in person of	28/21 at 11:00 AM, the SW concern form dated 7/2/21 that the grievance resolution resident verbally and that as not provided. She stated he individual who filed the or by phone then she thought ovide a written grievance				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345523	B. WING _			C <b>7/28/2021</b>	
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP COI 7166 JORDON ROAD RAMSEUR, NC 27316	•	1720/2021	
(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 585	to Resident #3 on 7/8 grievance form. She The SW stated she the conversation with the regulation that required decision be provided she must have misure Administrator's instruction that facility's grievance options for the method notification: 1) writter conversation; and 3) explained that becaud on the form she thoughone of these options.  In an interview on 7/2/49 recalled reporting and they assisted her from on 7/2/21. She she first spoke with a #3 stated as of 7/28/2 response either verbagrievance.  In a follow up interview the Administrator state for all individuals who provided with a written accordance with the spoke with the SW to the need to provide a to the reporting party indicated if the report	sked if she recalled speaking 3/21 as indicated on the stated she could not recall. nought she recalled a Administrator regarding the ed a written grievance to the reporting party but aderstood the ctions. She indicated that e form had three checkbox and of grievance resolution in notification; 2) phone one to one discussion. She se there were three options ght it was okay to select only	F 5	85			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG		(X3) DATE S COMPLI	
		345523	B. WING _			07/2	8/2021
	ROVIDER OR SUPPLIER	SEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316		, ,,,,	
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 585	Continued From page 3. Resident #1 was in	e 7 nitially admitted to the facility	F 5	585			
	8/12/20 with diagnos	ecently readmitted on es that included dementia.					
	The quarterly Minimu assessment dated 7/ cognition was severe	2/21 indicated Resident #1's					
	indicated a grievance her Responsible Part completed by the So- indicated that a one of to notify the RP of the	- ·					
	7/28/21 at 10:45 AM SW was the grievand responsible for provide decision to the individed He stated that when facility in May 2021 h SW as he noticed that had been provided to The Administrator incomparty and he instructed written decisions for a forward. The Adminitunsure if the SW had	with the Administrator on the reported that the facility's the official and she was ding a written grievances duals who filed grievances, the first started working at the the had a discussion with the the some grievance decisions to the reporting party verbally. Idicated that he informed the the started written to be provided to the reporting the decisions of the reporting that the wind the started and the started and the started that he will grievances moving the started with the SW on					
	7/28/21 at 11:00 AM. Form dated 7/13/21 f	The Grievance/Concern for Resident #1 that revealed fion was provided to the RP					

OLIVILITO I OIL MEDIO/ IILE G MEDIO/					<del></del>	<del>7. 0000 000 1</del>
_ ` · · ·	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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	345523	B. WING			1	28/2021
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UNIVERSAL HEALTH CARE/RAMSEUR			R	RAMSEUR, NC 27316		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 585 Continued From page 8 via a one to one discussion a notification was not provided the SW. She verified that write not provided or offered to the grievance for Resident #1. She spoke to the individual will grievance in person or by phosit was okay not to provide a will decision. She was asked if she with the Administrator about the required a written grievance of to the reporting party. The SN recalled this conversation, but the Administrator's instruction that the facility's grievance for checkbox options for the method resolution notification: 1) written phone conversation; and 3) of discussion. She explained the were three options on the formoday to select only one of the stated that prior to this intervity. AM) she spoke with the Adminiformed her that written notification was completed. A follow up interview was concompleted a grievance to be progrievance decision in accordate regulations. He confirmed her today and re-educated her or a written grievance decision to for all grievances. He indicated party declined the written grievance decision to grievance decision the written grievance decision the party declined the written grievance decision to grievances. He indicated party declined the written grievance decision to grievance decision the written grievance decision the grievan	nd that written was reviewed with tten notification was RP who filed this he explained that if ho filed the one that she thought written grievance he recalled speaking he regulations that decision be provided W revealed she had t she misunderstood as. She indicated rm had three hod of grievance ten notification; 2) one to one at because there m she thought it was se options. She ew (7/28/21 at 11:00 nistrator and he fication was to be versation or one on ad.  ducted with the 2:05 PM. He stated Il individuals who ovided with a written ance with the e spoke with the SW in the need to provide o the reporting party ed if the reporting		585	,		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3	B) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  AL HEALTH CARE/RAMS			STREET ADDRESS, CITY, STATE, Z 7166 JORDON ROAD RAMSEUR, NC 27316	ZIP CODE	07/28/2021
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F 585	Continued From page	9	F t	585		
		dmitted to the facility on es that included orthopedic				
	indicated a grievance and the form was cor Worker (SW). This for grievance was resolved documentation that Formula the grievance resolute that asked what method in the resolute that of the resolute that asked what method in the resolute that asked what method is the resolute that the resolute that the resolute that asked what method is the resolute that the res	orm indicated that the				
	7/28/21 at 10:45 AM SW was the grievance responsible for provious decision to the individed He stated that when I facility in May 2021 h SW as he noticed that had been provided to The Administrator ind SW that the regulation grievance decision to party and he instructed written decisions for a forward. The Administrunted written decisions for a forward. The Administrator in the SW had An interview was con 7/28/21 at 11:00 AM. Form dated 7/2/21 for	be provided to the reporting ed her to provide these all grievances moving strator revealed that he was followed his instructions.  ducted with the SW on The Grievance/Concern r Resident #8 that included				
	Form dated 7/2/21 fo no documentation that					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345523	B. WING		C <b>07/28/2021</b>	
	ROVIDER OR SUPPLIER	ISEUR		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316	, 6772672421	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 585	with the SW. The S notification was not Resident #8 for this spoke with Resident grievance was filed okay not to provide to the resident since family member. She speaking with the Adregulations that regulations that regulations be provided SW revealed she had but she misundersto instructions. She interview for many the method of grieval written notification; 2 one to one discussion because there were she thought it was on these options. She interview (7/28/21 at the Administrator an notification was to be conversation or one completed.  An interview was conficted in the exact date been provided with a until this afternoon (1/2 that his expectation)	W revealed that written provided or offered to grievance. She explained she at #8's family member after the and that she thought it was a written grievance decision she had discussed it with the explained a written grievance deministrator about the ulired a written grievance do to the reporting party. The red recalled this conversation, and the Administrator's dicated that the facility's three checkbox options for ance resolution notification: 1) (2) phone conversation; and 3) on. She explained that three options on the form kay to select only one of stated that prior to this to 11:00 AM) she spoke with do he informed her that written the provided even if a phone on one discussion was alert and oriented the indicated she recalled few weeks ago (unable to explain and revealed she had not a written grievance decision	F 58	5		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
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F 585	regulations. He conf today and re-educate a written grievance d for all grievances. H	accordance with the irmed he spoke with the SW ed her on the need to provide ecision to the reporting party e indicated if the reporting itten grievance decision then	F 5	585		
	A/26/18 with diagnos  A Facility Grievance/ indicated a grievance her Responsible Part completed by the So indicated that a phon notify the RP of the g form further indicated	dmitted to the facility on es that included dementia.  Concern Form dated 7/15/21 e was filed for Resident #7 by ty (RP) and the form was cial Worker (SW). This form e discussion was used to rievance resolution. The I that written notification was m was signed by the SW on				
	7/28/21 at 10:45 AM SW was the grievand responsible for provide decision to the individed He stated that when facility in May 2021 h SW as he noticed that had been provided to The Administrator in SW that the regulation grievance decision to party and he instructive written decisions for forward. The Administrations for the Administration of the Admi	with the Administrator on the reported that the facility's the official and she was ding a written grievances duals who filed grievances, the first started working at the the had a discussion with the the started that he informed the the reporting party verbally. Idicated that he informed the the provided to the reporting the provided to the reporting the her to provide these that I grievances moving the strator revealed that he was to followed his instructions.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BUILDI		<del></del>	(	3
		345523	B. WING				28/2021
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/RAM	SEUR		7	166 JORDON ROAD		
J.117 E1(O				F	AMSEUR, NC 27316		
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 585	Continued From pag	e 12	F	585			
	Continued From page 12  An interview was conducted with the SW on 7/28/21 at 11:00 AM. The grievance/concern form dated 7/15/21 for Resident #7 that revealed the grievance resolution was provided to the RP by phone and that written notification was not provided was reviewed with the SW. She verified that written notification was not provided was reviewed with the SW. She verified that written notification was not provided or offered to the RP who filed this grievance for Resident #7. She explained that if she spoke to the individual who filed the grievance in person or by phone then she thought it was okay not to provide a written grievance decision. She was asked if she recalled speaking with the Administrator about the regulations that required a written grievance decision be provided to the reporting party. The SW revealed she had recalled this conversation, but she misunderstood the Administrator 's instructions. She indicated that the facility's grievance form had three checkbox options for the method of grievance resolution notification: 1) written notification; 2) phone conversation; and 3) one to one discussion. She explained that because there were three options on the form she thought it was okay to select only one of these options. She stated that prior to this interview (7/28/21 at 11:00 AM) she spoke with the Administrator and he informed her that written notification was to be provided even if a phone conversation or one on one discussion was completed.  A follow up interview was conducted with the Administrator on 7/28/21 at 12:05 PM. He stated that his expectation was for all individuals who reported a grievance to be provided with a written grievance decision in accordance with the						

OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED		
	345523	B. WING		07/2	) 28/2021		
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/RAMSEUR			STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
a written grievance de for all grievances. He party declined the writhis was to be recorded Maintains Effective Pour CFR(s): 483.90(i)(4)  §483.90(i)(4) Maintain program so that the farodents.  This REQUIREMENT by:  Based on observation resident and staff interthe facility failed to main environment on 2 of 4 findings included:  In a telephone intervior Resident #3's responsification family member resident her death on 6/20/21. facility to see Resident she was near death. In her room, he noted she was near death. In her room, he noted she was near death. In her covers. He stated Resident #3. The RP who would listen at the far back as May 2020 and the previous Direct stated it wasn't until the fact and sin Resident #3 the ants in Resident #3 some ant spray on the	ecision to the reporting party indicated if the reporting ten grievance decision then ed on the form.  est Control Program  In an effective pest control acility is free of pests and is not met as evidenced ins, responsible party, erviews and record review, aintain a pest free is halls (300 and 400). The lew on 7/28/21 at 1:34 PM, sible party (RP) stated his ed on the 300 hall up until He stated he went to the ent #3 on 6/19/21 because He stated when he entered mall black ants in the r, on her nightstand and on he did not see any ants on stated he informed anyone he facility about the ants as to include the Administrator cotor of Nursing (DON). He he night before she died if responded after she saw its is room. She sprayed e window seal and floor then		F925 The statements included are not an admission and do not constitute agreement with the alleged deficient herein. The plan of correction is completed in the compliance of state federal regulations as outlined. To rin compliance with all federal and stregulations the center has taken or take the actions set forth in the following plan of correction. The following placorrection constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be accomplished for those residents for have been affected by the same definition provider.  The facility failed to maintain a pest environment for 300 and 400. The pest control provider) visit on 7/28/2	cies e and emain ate will wing in of d be und to ficient free facility	8/6/21		
During a facility tour of	on 7/28/21 at 12:20 PM,						
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST, (EACH DEFICIENC' REGULATORY OR LETTER CONTINUED FOR PROPERTY OF LETTER CONTINUED FOR SUMMARY ST.  CONTINUED FOR SUMMARY ST.  CONTINUED FOR SUMMARY ST.  CONTINUED FOR SUMMARY ST.  SUMMARY ST.  (EACH DEFICIENCY  REGULATORY OR LETTER  Maintains Effective Property of Letter  Maintains Effectiv	AL HEALTH CARE/RAMSEUR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  a written grievance decision to the reporting party for all grievances. He indicated if the reporting party declined the written grievance decision then this was to be recorded on the form.  Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)  §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by:  Based on observations, responsible party, resident and staff interviews and record review, the facility failed to maintain a pest free environment on 2 of 4 halls (300 and 400).The	A BUILDING  345523  B. WING  ROVIDER OR SUPPLIER  ALHEALTH CARE/RAMSEUR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  a written grievance decision to the reporting party for all grievances. He indicated if the reporting party declined the written grievance decision then this was to be recorded on the form.  Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)  §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.  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She sprayed some ant spray on the window seal and floor then wiped down Resident #3's bed.	A BUILDING  345523  ROWIDER OR SUPPLIER  AL HEALTH CARE/RAMSEUR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPROISENCY MUST BE PRECEDED BY TILL) REGULATORY OR LSC DENTIFYING INFORMATION)  Continued From page 13  a written grievance decision to the reporting party for all grievances. He indicated if the reporting party declined the written grievance decision then this was to be recorded on the form.  Maintains Effective Pest Control Program  CFR(s): 483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by:  Based on observations, responsible party, resident and staff interviews and record review, the facility failed to maintain a pest free environment on 2 of 4 halls (300 and 400). 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WING  STREETADDRESS, CITY, STATE, ZIP CODE THES JORDON ROAD  RAMSEUR, NC 27316  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST EF PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  a written grievance decision to the reporting party for all grievances. He indicated if the reporting party declined the written grievance decision then this was to be recorded on the form. Maintains Effective Pest Control Program CF(R)s; 483.90(I)(4)  S483.90(I)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This RECUIREMENT is not met as evidenced by: Based on observations, responsible party, resident and staff interviews and record review, the facility failed to maintain a pest free environment on 2 of 4 halls (300 and 400). The findings included: In a telephone interview on 7/28/21 at 1:34 PM, Resident #3's responsible party (RP) stated his family member resided on the 300 hall up until her death on 6/20/21. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				С			
		345523	B. WING _			07/	28/2021
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				71	166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		R	AMSEUR, NC 27316		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 925	Continued From page 14		F 92				
	numerous black, dead	d ants and several live black			How/ corrective action will be		
	ants were observed in	room 305 on the window			accomplished for those residents with		
	seal and on the floor	around the heating/cooling			potential to be affected by the same		
	unit. The window sea	l appeared to have a clear			deficient practice:		
	liquid around the wind	dow and window seal. Small					
		observed in rooms 301 and			All residents have the potential to be		
	303 on the floor near	the heating/cooling unit.			affected. An audit was conducted by th		
					Ambassadors of the facility on 7/29/202	21	
	•	ocked unit (400 hall) on			to ensure facility was pest free. There		
		no ants were observed in			was no pest found during rounding.		
		ıt several live ants were			Audit completed on 7/30/2021.		
	observed on the floor at the nurses station. Nurse #2 and Nursing Assistant (NA) #2 stated there had been a problem with ants at the nurses station and at the door leading to the courtyard.						
					What measures will be put into place o		
					systemic changes made to ensure that		
					the deficient practice will not recur:		
		Maintenance Director and					
	previous DON were a	ware of the ant problem.			Administrator educated the Maintenand		
					Director of the expectation that the faci		
		ducted with the Maintenance			remains free from crawling insects and		
		t 11:31 AM. He stated he			that the Maintenance Director is to call		
	had previously worke				pest control company between schedu		
	Director at the facility and returned to the role on 6/14/21. He stated he was aware that there was an ant problem on the 300 hall but not aware of ants at the 400 hall nurses station. He stated the				visits should the flying or crawling insec	CIS	
					reappear. Completed on 7/29/2021.		
					System Change: Maintenance Directo	r	
		re tiny black ants that's			has implemented a new system for pes		
		left out. He provided a copy			sight reporting as of 8.4.21. This include		
	•	st control invoice dated			a 3-ring binder at each nurses' station		
	•				any staff member can document any p		
	6/22/21 where the exterior courtyard of the 300 hall was treated. The Maintenance Director stated he was made aware of the ant problem in				sighting. The Maintenance Director wil		
					review this binder daily during the facili		
		II. He stated on 6/22/21, he			preventive maintenance rounds to ensi	•	
	had the pest control p				that any new pest sighting is noted and		
		treatment outside the 300			the pest control company will be		
		tructed the pest control			contacted for visit in between monthly		
		ed to treat one hall at a time			scheduled visit.		
	•	of 300 hall was treated for			All facility staff have received training o	n	
	_	y he did not have all the			the new process for noting pest sight		
		he replied the pest control			reporting and location of the 3-ring bind	der	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		345523	B. WING _			07	//28/2021
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		SUB		71	166 JORDON ROAD		
UNIVERSA	AL HEALTH CARE/RAMS	SEUR		R	AMSEUR, NC 27316		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG			PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 925	Continued From page	÷ 15	F 9	925			
		ing inside the quarantine dents were quarantined on			at each nurse station by the MD and/or facility administrator as of 8.6.21	-	
		to only spray outside of			radinty durining ator do or o.c.21		
		e. He stated the pest control			How facility plans to monitor its		
	-	out today and would treat			performance to make sure that solution	าร	
		e Maintenance Director was ether he thought the ant			are sustained:		
		d, he stated he had not			Effective 8/4/2021 Maintenance Directo	or	
	•	rs about ants so he thought			will conduct audits of resident rooms a		
	the problem was reso				hallways to ensure there are no crawlir	ng	
					insects. This audit be conducted week	ly	
	Review of a pest control invoice dated 6/22/21 read as follows: Ant treatment needed in room				and will consist of 20 resident		
	305 and the 300 hall. Exterior treatment in the courtyard was completed.				rooms/hallway x 4 weeks, 15 resident rooms/hallway x 4 weeks and 10 reside	-nt	
					rooms/hallway x 4 weeks.	5110	
					Results of these audits will be reviewed		
	_	n 7/28/21 at 11:45 AM, the			Quarterly Quality Assurance Meeting X		
		visor stated she and her			for further problem resolution if needed	l.	
	staff had observed small black ants in the facility. She stated when the staff reported ants, she would notify the Maintenance Director but did not write a work order.				Completion date: Aug 6, 2021		
					Completion date. Adg 0, 2021		
					The Administrator is responsible for		
					implementing the acceptable plan of		
	_	n 7/28/21 at 12:35 PM, NA			correction.		
		de (MA) #1 stated they were all. Both stated ants were a					
	-	MA #1 recalled the incident					
	·	by Resident #3's RP in her					
	room on the window s	•					
	nightstand. NA #1 sta	•					
		ants in some of the rooms					
	on the 300 hall. When asked if she had reported the problem to anyone, she stated she had not						
		e, sne stated sne had not as aware of the ant problem.					
		s. o din problem					
		terview on 7/28/21 at 2:25					
		when she came to work on					
	6/19/21, an agency nurse working the 300 hall told her there was a problem with ants in						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345523	B. WING			C		
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/RAMSEUR				STREET ADDRESS, CITY, STATE, ZIP CODE 7166 JORDON ROAD RAMSEUR, NC 27316				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTIVE ACTI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 925	Resident #3's room (i room 305 and the RF upset and he said the #1 stated she observ window seal, the floo on the nightstand ner said she called the property with the said she called the said she called the said she called the said she said	305). She stated she went to was there. He was very ere were ants all over. Nurse ed small black ants on the rand there were some ants at to the resident's bed. She revious DON and let her ts. The previous DON told ray was and to go spray the e only called the previous he knew that the ants were ministrator and the ron 7/28/21 at 2:30 PM, live black ants were observed in	F	925				