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	345291	A. BUILDING _____ B. WING _____	C 05/18/2023

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UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/15/23 through 5/18/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #MS0Y11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/15/23 through 5/18/23. Event ID# MS0Y11. The following intakes were investigated: NC00193648; NC00194558; NC00196322; NC00197677; NC00197728; NC00198544; NC00201171 and NC00202113. Thirty-three (33) of the 33 complaint allegations did not result in deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to reflect the number of falls sustained for 1 of 6 residents (Resident #210) reviewed for accidents. The findings included: Resident #210 was admitted to the facility on 9/27/22 with a cumulative diagnoses which included a history of cerebrovascular accident (stroke) with hemiplegia/hemiparesis (complete paralysis to partial weakness on one side of the body).	F 641	F641: Accuracy of Assessment 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. MDS assessment for Resident #210 ARD 11/16/2022 Section J1900 corrected and transmitted on 6/7/2023 by the MDS Coordinator. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	6/13/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/09/2023

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F 641	Continued From page 1 Review of the resident's electronic medical record (EMR) revealed an admission Minimum Data Set (MDS) assessment was completed for Resident #210 on 10/3/22.. Documentation in Resident #210's EMR reported the resident sustained a fall without injury on 10/13/22 and 10/23/22. The resident was also reported to have one fall with injury on 10/26/22. Resident #210's most recent MDS was a quarterly assessment dated 11/16/22. The MDS section on Health Conditions reported the resident had only one fall with injury since her last MDS assessment dated 10/3/22. An interview was conducted on 5/17/23 at 11:55 AM with MDS Nurse #1. During the interview, the MDS nurse was asked to review the Health Conditions section from Resident #210's MDS dated 11/16/22. Upon review, MDS Nurse #1 confirmed the resident's quarterly MDS reported only one fall with injury. During a follow-up interview conducted on 5/17/23 at 12:27 PM, MDS Nurse #1 reported she reviewed Resident #210's EMR. She stated the resident's 11/16/22 quarterly MDS should have indicated the resident sustained two falls without injury and one fall with injury. An interview was conducted on 5/18/23 at 11:45 AM with the facility's Director of Nursing (DON). During the interview, the DON reported she would expect the MDS assessments to be accurately completed.	F 641	MDS assessments for the past 90 (ninety) days for current residents were audited for accuracy of coding of section J1900-Falls, with corrections as needed on 6/8/2023 and verified by Regional MDS Consultant. MDS coordinators were re-educated on section J1900, Falls and accurate coding on 6/8/2023 by the Regional MDS Consultant. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Audit of completed MDS assessments for current Residents will be audited weekly for 4 weeks, then ,mpnthly for 3 months, then quarterly by Regional MDS Consultant/DON or designee. 4. How the facility will monitor its performance to ensure the deficient practice does not recur. The Director of Nursing and/or facility MDS Coordinator will complete a summary of audit results and present monthly to the facility QAPI Committee to ensure continued compliance. 5. Compliance Date:6/13/2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		6/13/23

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F 656	Continued From page 2	F 656		

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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F 656	Continued From page 3 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan which addressed the use of an antipsychotic and antianxiety medication for 1 of 5 residents (Resident #21) reviewed for unnecessary medications. The findings included: Resident #21 was admitted to the facility on 2/15/23 with diagnoses which included manic depression (bipolar disorder) and anxiety disorder. The resident's admission orders dated 2/15/23 included the following medications, in part: 25 milligrams (mg) sertraline (an antidepressant) to be given as three tablets by mouth every day (for a total dose of 75 mg) and 0.5 mg risperidone (an antipsychotic medication) to be given as one tablet by mouth twice daily. Lorazepam (an antianxiety medication) was added to the resident's medication regimen on 2/20/23 as 2 mg / milliliter (ml) injected intramuscularly twice daily. Review of Resident #21's admission Minimum Data Set (MDS) assessment dated 2/20/23 indicated the resident had moderately impaired cognition. The MDS assessment also reported	F 656	F656 Develop/ Implement Comprehensive Care plan 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Electronic medical record for Resident #21, was reviewed by the Regional MDS Consultant and updated for use of antianxiety and antipsychotic psychoactive medication use 6/7/23 by MDS Coordinator. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. Care plans for current residents receiving antianxiety or antipsychotic medication use were audited and updated to reflect use of antianxiety and antipsychotic psychoactive medication use on 6-7-23 by MDS Coordinators. MDS Coordinators were re-educated on antipsychotic/ antianxiety care plans and all care plans and updates were reviewed on 6-8-23 by Regional MDS Consultant for accuracy.	

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F 656	Continued From page 4 the resident received an antidepressant, antipsychotic, and antianxiety medication during the 7-day look back period. On 2/21/23, the resident's lorazepam was discontinued and replaced with 1 mg clonazepam (also an antianxiety medication) initiated as one tablet to be given by mouth twice daily. Resident #21's current medications (as of the date of review on 5/17/23) continued to include 25 mg sertraline to be given as three tablets by mouth every day, 0.5 mg risperidone to be given as one tablet by mouth twice daily, and 1 mg clonazepam to be given as one tablet by mouth twice daily. A review of Resident #21's current care plan revealed it included an area of focus (dated 2/20/23) which indicated the resident was at risk for side effects from the use of an antidepressant medication. Further review of the resident's comprehensive care plan revealed it was last revised on 5/1/23. However, the care plan did not address Resident #21's use of an antipsychotic or antianxiety medication as of 5/17/23. An interview was conducted on 5/17/23 at 11:55 AM with MDS Nurse #1. Upon request, the nurse reviewed Resident #21's current care plan. When asked, the MDS nurse confirmed the resident's current care plan only addressed her use of an antidepressant medication (not an antipsychotic or antianxiety medication). MDS Nurse #1 reported the facility usually implemented a care plan to address "psychotropic" medications (any drug capable of affecting the mind, emotions, and/or behavior), which would have included the antidepressant,	F 656	3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Audit of care plans for current residents receiving antianxiety or antipsychotic medications will be audited weekly for four weeks, then every two weeks times two, then every month at QAPI meeting by Regional MDS Consultant/DON and/or designee. 4. How the facility will monitor its performance to ensure the deficient practice does not recur. Any identified issues will be reviewed during the monthly QAPI meetings by Administrator and Interdisciplinary team and changes will be made as indicated. These changes will be reviewed/re-evaluated during the monthly QAPI meetings with any revisions made as indicated to assure continued compliance. 5. Compliance Date: 6/13/23	

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F 656	Continued From page 5 antipsychotic, and antianxiety medications. An interview was conducted on 5/18/23 at 11:45 AM with the facility's Director of Nursing (DON). During the interview, the DON reported all of Resident #21's psychotropic medications should have been addressed in the resident's care plan.	F 656		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and	F 761	F761 Label/Store Drugs and Biologicals:	6/13/23

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F 761	Continued From page 6 record review, the facility failed to: 1) Discard expired medications and/or medications without a legible expiration date on 3 of 3 medication (med) carts observed (the 200 Hall Med Cart, the 400 Hall Med Cart and the 500 Hall Med Cart); 2) Label medications with the minimum information required, including the name of the resident, on 1 of 3 med carts observed (the 400 Hall Med Cart); 3) Store medications in accordance with the manufacturer's storage instructions in 1 of 3 Medication Storage Rooms (230-300 Hall Med Cart); and 4) Secure a medication cart when not in use for 1 of 6 med carts observed to be unlocked and unattended by nursing staff (300 Hall Med Cart). The findings included: 1. An observation was conducted on 5/17/23 at 2:12 PM of the 200 Hall medication cart in the presence of Medication (Med) Aide #1. The observation revealed 6 - 12.5 milligram (mg) promethazine (an antinausea medication) suppositories with an expiration date of February 2023, and 1 - 650 mg acetaminophen suppository with an expiration date of March 2023 were stored on the med cart. Upon review of the suppositories, Med Aide #1 confirmed the suppositories were past their expiration date. An interview was conducted on 5/18/23 at 12:05 PM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated third shift nursing staff were typically responsible to check the expiration dates on the medications stored on the med carts to be sure none were expired. However, she also reported she would expect a nurse (or Med Aide) to review	F 761	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All expired, illegible or undated medications were discarded appropriately by the assigned charge nurses on each cart on 5/18/2023. All medications on each cart and refrigerator were checked and stored per pharmacy/manufacturer protocol by ADON/supervisors and designees. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. DON/ADON and designees audit all carts and med rooms for proper storage, labeling, and ensuring carts were locked on 5/19/23. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. In- service held by ADON and/or designee on 5/17/2023- 5/19/2023 with all licensed nurses and medication aides, including agency on medication storage, labeling, securing cart and privacy. All new hires (nurses and med aides, including agency) will be educated during orientation, on expectations on labeling, storage and securing drugs on the cart, ADON or	

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F 761	Continued From page 7 the labeling of a medication prior to administering it to a resident. 2-a. An observation was conducted on 5/17/23 at 1:45 PM of the 400 Hall medication cart in the presence of Nurse #1. The observation revealed 1 - expired vial of 25 milligrams (mg) / milliliter (ml) promethazine dispensed for Resident #360 was stored on the med cart. The vial had the manufacturer's expiration date of April 2023 imprinted on its label. Upon review of the vial, Nurse #1 confirmed the promethazine was expired. A review of Resident #360's medication orders revealed the resident had a current order for 25 mg/ml promethazine to be injected as 25 mg intramuscularly every 6 hours as needed for nausea/vomiting. 2-b. An observation was conducted on 5/17/23 at 1:45 PM of the 400 Hall medication cart in the presence of Nurse #1. The observation revealed a stock bottle of 81 milligram (mg) delayed release aspirin with approximately 30 tablets remaining in the bottle was stored on the med cart. The expiration date of the stock bottle of aspirin was not legible. 2-c. An observation was conducted on 5/17/23 at 1:45 PM of the 400 Hall medication cart in the presence of Nurse #1. The observation revealed 3 - unlabeled vials of 25 mg/ml promethazine were stored on the med cart. The vials were not labeled with the minimum required information, including a resident's name. During an interview conducted on 5/17/23 at 1:50 PM with Nurse #1, the nurse confirmed the	F 761	designee. Licensed nurses, medication aides, including agency will not be allowed to work if they have not had this training by 6/13/23 by ADON/SDC or designee. 4. How the facility will monitor its performance to ensure the deficient practice does not recur. DON/ADON and/ or designee will complete an audit of medication carts and medication rooms daily, 5 days/weekly, then weekly for 4 weeks, to ensure proper labeling and storage of meds and biologicals. Pharmacy Consultant will do monthly review of med rooms and carts for compliance with storage and labeling of meds and biologicals. DON/ administrative and/or designee nurses will complete a summary of audit results and present at the monthly QAPI meeting, monthly to ensure continued compliance. 5. Compliance Date: 6/13/2023	

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F 761	Continued From page 8	F 761		

promethazine vials were not labeled with a resident identifier. She reported both the unlabeled vials of promethazine and the expired promethazine vial needed to be sent back to the pharmacy. The nurse also acknowledged the expiration date on the label of the aspirin tablets could no longer be read. Nurse #1 reported the stock bottle of aspirin needed to be removed from the med cart.

An interview was conducted on 5/18/23 at 12:05 PM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated third shift nursing staff were typically responsible to check the expiration dates on the medications stored on the med carts to be sure none were expired. However, she also reported she would expect a nurse (or Med Aide) to review the labeling of a medication prior to administering it to a resident.

3. An observation was conducted on 5/17/23 at 2:05 PM of the 500 Hall medication cart in the presence of Nurse #1. The observation revealed a stock bottle of 81 milligram (mg) delayed release aspirin with 4 tablets remaining in the bottle was stored on the med cart. The expiration date of the stock bottle of aspirin was not legible.

During an interview conducted on 5/17/23 at 2:10 PM with Nurse #1, the nurse confirmed the expiration date on the label of the stock bottle of aspirin could no longer be read. She reported the stock bottle of aspirin needed to be removed from the med cart and added, "I'm going to tell them to take this out of the stock room."

An interview was conducted on 5/18/23 at 12:05

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PM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated third shift nursing staff were typically responsible to check the expiration dates on the medications stored on the med carts to be sure none were expired. However, she also reported she would expect a nurse (or Med Aide) to review the labeling of a medication prior to administering it to a resident.

4. Accompanied by Nurse #2, an observation was conducted on 5/17/23 at 2:30 PM of the 230/300 Hall Medication (Med) Storage Room. The observation revealed one - unopened bottle of 0.2% brimonidine / 0.5% timolol eye drops (a combination medication used to treat glaucoma) dispensed for Resident #87 was stored in the Med Storage Room's refrigerator. A thermometer placed in the refrigerator indicated the refrigerator's temperature was 36 degrees Fahrenheit. The thermometer reading was confirmed by Nurse #2 at the time of the observation.

The manufacturer's storage instructions for 0.2% brimonidine / 0.5% timolol eye drops indicated the bottle should be stored at 59 - 77 degrees Fahrenheit.

An interview was conducted with Nurse #2 on 5/17/23 at 2:50 PM. During the interview, the nurse stated she thought the eye drops were likely put in the refrigerator because another type of eye drop was supposed to be refrigerated until opened. Upon inquiry, the nurse reported she was not sure if the brimonidine / timolol eye drops should have been stored in the refrigerator.

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An interview was conducted on 5/18/23 at 12:05 PM with the facility's Director of Nursing (DON) to discuss the findings of the medication storage observations. During the interview, the DON stated she would expect medications to be stored in accordance with the manufacturer's instructions.

5. On 5/17/23 at 10:28 AM an observation was made of a medication cart parked outside of room 310. The lock mechanism was observed in the unlocked position. No staff were observed in the hall. Resident #14 was sitting in a wheelchair near the cart. A few moments later Nurse #1 exited room 312 and walked to the nurses' station and used the phone before returning to the medication cart.

An interview was conducted with Nurse #2 on 5/17/23 at 10:32 AM. She explained she had been in room 312 and out of view of the medication cart. She demonstrated the lock was not engaged by opening a top drawer. She stated the cart should have been locked when she stepped away.

On 5/18/23 at 2:40 PM an interview with the Director of Nursing (DON) was conducted. She stated the medication cart should be secured when out of the nurse's line of sight.