STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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E 000	Initial Comments An unannounced onsite recertification and complaint investigation survey was conducted on 10/21/2024 through 10/25/2024. Additional information was obtained on 11/1/2024. Therefore, the exit date was changed to 11/1/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PGGG11.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted from 10/21/24 through 10/25/24. Additional information was obtained on 11/1/2024. Therefore, the exit date was changed to 11/1/2024. The following intakes were investigated NC00218901, NC00219660, NC00221329, NC00221972, NC00222555, NC00222416, NC00221816, NC00210550, NC00213818, NC00215176, NC00213130, NC00217333, NC00221257, NC00220708, NC00219285, NC00223495, NC00223357. 7 of the 42 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity K. Immediate Jeopardy began on 10/13/2024 and was removed on 10/25/2024.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that	F 554		11/27/24

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

Electronically Signed | 11/25/2024

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F 554	Continued From page 1 this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility's interdisciplinary team failed to assess and document the ability of a resident to self-administer medications for 2 of 2 residents (Resident #6 and Resident #12) who were reviewed for medication self-administration. Findings included: 1. A review of the electronic health record revealed Resident #6 was admitted to the facility on 05/20/24. A care plan dated 07/05/24 revealed Resident #6 did not have a care plan to address self-administration of medications. The quarterly Minimum Data Set assessment dated 08/26/24 revealed Resident #6 was cognitively intact. A review of physician orders dated 09/30/24 for Resident #6 revealed an order for Senna (a stool softener) Oral Tablet 8.6 milligrams (mg). Give 2 tablets by mouth at bedtime for constipation. There was no order discovered for Resident #6 to self-administer medications. Review of Resident #6's 10/20/24 Medication Administration Record (MAR) revealed Nurse #12 had signed off Senna 8.6 mg as having been administered at 9:00 PM. Attempts to interview Nurse #12 were unsuccessful.	F 554	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F554 Resident Self Administration of Medication 1. Resident #6 and #12 medications were removed and discarded upon noti¿cation the resident did not take them. The medical director and representative party was noti¿ed 10/22/2024. 2. On 11/4/2024 the Unit managers and Director of Nursing rounded current residents□ rooms to ensure no medications were left at the bedside for self-administration. Completed 11/4/2024. 3. Education for all licensed nurses was initiated by the sta¿ Development Coordinator on 10/24/24, all educated licensed nurses and medication aides, including agencies, on not leaving medications unattended at the bedside of the resident. Medications are to be given by the licensed nurse or medication aide however, if resident does not want to take medications at the appropriate time, sta¿ is to discard of the medication appropriately, notify the medical provider, the representative party, and document. This education was completed on	

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F 554	Continued From page 2 On 10/21/24 at 9:07 AM during an interview with Resident #6 a medicine cup with the resident's room number written on it was observed on the overbed table. The medicine cup contained two round orange-colored tablets. Resident #6 stated the tablets were stool softeners and she told the nurse to leave them in the cup because she did not want to take them at that time, the resident did not elaborate on when the nurse had given her the stool softener tablet. She stated the nurse usually brought her medications and stayed while she took all of them, but she told the nurse she would hold on to the stool softener until later and the nurse left it. On 10/21/24 at 2:22 PM an observation revealed the medicine cup with Resident #6's room number written on it was still observed on the overbed table. The medicine cup still contained two round orange-colored tablets. In an interview with Nurse #9, on 10/21/24 at 2:24 PM, which was conducted in conjunction with an observation of Resident #6's room, she stated there were no residents who currently resided in the facility who were authorized or assessed for self-administration of medications. Nurse #9 stated she was a night shift supervisor who had been called to come in on day shift to supervise. The nurse observed the medications on Resident #6's overbed table and removed the cup to discard them. The nurse stated they appeared to be stool softeners. Nurse #9 stated the nurse was expected to stay and observe the resident as medications were taken. She stated it was not standard practice to leave medications in a resident's room. She stated she was not the nurse who had administered the medication.	F 554	11/25/24. This new education will continue as a part of orientation with new hires and agency nurses. In-person and/or via phone. 4. The Director of Nursing and/or designee will round on 5 residents per unit to ensure no medications are left at the bedside unattended 5 times weekly for 4 weeks, 5 residents 3 times weekly for 4 weeks, and 5 residents weekly for 4 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identi¿ed are corrected. Compliance date 11/27/24.	

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F 554	Continued From page 3	F 554		

2. A review of the electronic health record revealed Resident #12 was admitted to the facility on 07/11/24.

A care plan dated 10/09/24 revealed Resident #12 did not have a care plan to address self-administration of medications.

The quarterly Minimum Data Set assessment dated 10/17/24 revealed Resident #12 was cognitively intact.

A review of physician orders for Resident #12, dated 09/27/24, revealed an order for Lactobacillus Capsule give 1 capsule by mouth two times a day for probiotic and an order for Gabapentin 100 milligrams capsule take 1 capsule by mouth every 12 hours for neuropathy. There was no discovered order for Resident #12 to self-administer medications.

Review of Resident #12's 10/21/24 Medication Administration Record (MAR) revealed Nurse #11 had signed off the probiotic was administered at 8:00 AM and the gabapentin was signed off as being administered at 9:00 AM.

Attempts to interview Nurse #11 were unsuccessful.

During an interview with Resident #12 on 10/22/24 at 8:45 AM, two orange tablets and one white capsule in were observed in a medication cup on the resident's overbed table. Resident #12 stated the medications in the cup were gabapentin and a probiotic. The resident stated the nurse usually stayed while she swallowed her medications, but she was on phone with her

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F 554	Continued From page 4 insurance company, so the nurse left the cup of medications for her to take on her own that morning, 10/22/24. She was unable to state the nurse's name. The resident stated the nurse left a total of 8 pills in the cup and she had already taken 5 of the pills. The resident was then observed to swallow the remaining medications in the cup. The resident stated the nurse was usually good about staying with her while she took her medications. The resident explained the nurse left the pills with her because she was on an important call, and she told the nurse she would take them on her own. On 10/25/24 at 11:32 AM an interview was conducted with Nurse #10, the Unit Manager, and she stated no residents in the facility were authorized to self-administer medications. She stated it was not the facility's policy to leave medications at the bedside unless a resident was assessed and authorized to self-administer medications. She stated the nurse should stay with the resident until all medications were taken. Nurse #10 added any medications not taken or refused should be disposed of and documented. An interview was conducted with the Director of Nursing on 10/25/24 at 12:02 PM and she stated no residents at the facility had been assessed and authorized to self-administer medications. She stated the nurse was expected to stay with the resident while a resident swallowed their medications, and no medications should be left at bedside.	F 554		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		11/27/24

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F 584	Continued From page 5	F 584		

The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.

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F 584	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the walls in the residents' rooms in good repair for 8 of 11 sampled residents' rooms: 3206, 3217, 3222, 3251, 3242, 3243, 3214 and 3225. The findings included: a. An observation on 10/21/24 at 08:16 AM of room 3206 revealed the wall behind the bed was excoriated (measuring approximately 24 inches). b. An observation on 10/21/24 at 08:30 AM of room 3217 revealed the wall behind the bed had stripped paint. c. An observation on 10/21/24 at 08:38 AM of room 3222 revealed that the wall behind the bed was extremely excoriated (measuring approximately 24 inches). d. An observation on 10/21/24 at 09:05 AM of room 3251 revealed excoriation of walls behind the table located near the middle of the room. e. An observation on 10/21/24 at 09:40 AM of room 3242 revealed wall next to bed in front of table with excoriation. f. An observation on 10/21/24 at 09:49 AM of room 3243 revealed excoriated walls behind the bed (measuring approximately 18 inches). g. An observation on 10/21/24 at 09:59 AM of room 3214 revealed several areas on the walls in the room with paint missing from walls. h. An observation on 10/22/24 at 08:30 AM of room 3225 revealed excoriation of walls behind the bed (measuring approximately 12 inches) An interview conducted on 10/25/24 at 05:44 PM with the Maintenance Director revealed that she was aware that the walls in the rooms need to be	F 584	F584 Safe/Clean/Comfortable/Homelike Environment 1. Rooms 3206, 3217, 3222, 3251, 3242, 3243, 3314, and 3225 walls were repaired. Completed by 11/25/24. 2. On 11/1/24, Administrator/ designees inspected residents□ rooms to ensure rooms were in good condition. If rooms were found in need of repairs, it was placed on the maintenance log. This process is on- going. 3. The Staff Development Coordinator completed education for all current sta¿ on placing a work order for repairs for the maintenance director to address. Administrator in-serviced the maintenance director on repairing the rooms timely. New hires will receive education on placing a work order for repairs for the maintenance director to address in orientation. In-person and/or via phone. 4. Administrator and designee will audit 5 rooms per hall to ensure rooms are good repair weekly x 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identi¿ed are corrected. Compliance Date: 11/27/24	

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F 584	Continued From page 7 fixed. She reported that the facility was in the process of fixing the walls and renovating the rooms. The Maintenance Director reported that the challenge was doing the work while residents were in the rooms. She confirmed that there was an electronic reporting system, but the current process was that the housekeepers told her which room, and she goes there. The Maintenance Director stated most of the beds now have a bump stop (at the head of the bed) to prevent further damage to the walls.	F 584		
F 585 SS=B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		11/27/24

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F 585	Continued From page 8	F 585		

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

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F 585	Continued From page 9 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews with the responsible party (RP) and Administrator, the facility failed to maintain documentation of the results of grievances reported by the RP for 1 of 1 sampled resident (Resident #190). Findings included: Resident #190 was admitted to the facility on 10/24/19.	F 585	F585 Grievances 1. Residents #190 no longer reside in the facility. 2. Current residents are potentially a¿ected by this de¿ciency. 3. On November 7,2024, the Regional Director of Clinical Services educated the leadership team on when the sta¿ member receives a grievance, they will record the nature and speci¿cs of the	

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F 585	Continued From page 10 Review of the clinical records indicated Resident #190 discharged from the facility on 3/24/24. On 10/25/24 at 9:54 a.m., a telephone interview was conducted with the RP of Resident #190. The RP revealed she had filed multiple grievances with the facility throughout the resident's stay at the facility concerning Resident #190's inadequate ADL (activities of daily living) care. She was unable to provide dates of any of the grievances' submissions. A review of the facility's grievance records revealed no grievance documentation available concerning Resident #190. During an interview on 10/25/24 at 11:33 a.m., the Administrator stated he searched every storage area in the facility but was unable to locate any of the facility's grievances dated prior to June 2024. He stated he was not familiar with Resident #190 or the resident's family. The Administrator revealed the facility was purchased by the current owners effective June 2024. He also revealed the previous owners removed boxes of documents from the facility in August 2024 which they claimed as belonging to them. He stated he had no knowledge of what the contents of the boxes were, only knew boxes contained paper files.	F 585	grievance on the designated grievance form or assist the resident or family member to complete the form. Take any immediate actions needed to prevent further potential violations of any resident□s right. Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation of resident property immediately to the administrator and follow procedures for those allegations. The Grievance O¿cer will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. All sta¿ involved in the grievance investigation or resolution should make prompt e¿orts to resolve the grievance and return the grievance form to the Grievance O¿cer. Prompt e¿orts include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance. All sta¿ involved in grievance investigation or resolution will take steps to preserve the con¿dentiality of ¿les and records relating to grievances and will share them only with those who have a need to know. 4. The administrator will interview 5 alert and oriented residents per unit with a Brief Interview for Mental Status of 13 and above weekly x 12 weeks to ensure residents have no grievances or grievances have been resolved promptly. To address the cause of this deficiency, the Administrator will call all of the	

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F 585	Continued From page 11	F 585	residents representative party that submit grievances on a residents behalf for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identi¿ed are corrected. 5. Compliance date 11/27/24.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment for 1 of 2 residents (Residents #15) reviewed for hospice services. Findings included: Resident #15 was admitted to the facility on 2/7/24 with diagnosis which included malignant	F 637	F637 Comprehensive Assessment after signi¿cant change 1. Resident #15 significant change was completed on 11/25/2024. 2. All current residents on hospice will be reviewed Regional Minimum Date Set Nurse Consultant by 11/25/2024 to ensure the significant change was completed within the required timeframe. 3. Regional Minimum Data Set Nurse	11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 637	Continued From page 12 neoplasm of the right lung. Resident #15 was admitted to Hospice Services on 4/16/24. A review of the MDS assessments revealed a Significant Change in Status MDS Assessment was not completed after Resident #15 was admitted to hospice services. During an interview on 10/24/24 at 10:35 a.m., the MDS Coordinator revealed she began working at the facility two months ago. She stated she was informed by the Regional MDS Consultant that the facility did not have a MDS Coordinator for over a year; instead, the facility utilized traveling MDS Nurses to complete the MDS' and different facility staff to conduct onsite interviews and observations. After a review of Resident #15's medical record, the MDS Coordinator acknowledged that a Significant Change in Status MDS should have been completed within fourteen days of Resident #15's admission to hospice services.	F 637	Coordinator will educate Minimum Data Set Nurses on completing the significant change MDS within 14 calendar days after the determination that a significant change has occurred. This was completed 11/25/24. 4. The Minimum Data set nurse will review the hospice resident list weekly for 12 weeks to ensure significant changes were set and completed timely per RAI guidelines for. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date: 11/27/24.	
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 observations, record reviews and staff interviews, the facility failed to accurately code the minimum data set (MDS) assessments in the areas of falls (Resident #42), range of motion (Resident # 59) and failed to assess (Resident #69) and code the MDS assessment for	F 641	F641 Accuracy MDS 1. Resident #42 falls were correctly coded on the MDS admission on 6/20/24. 6/20/24 assessment was modified to include PTSD on 11/25/24. The	11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

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UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 641	Continued From page 13 cognition, mood, behavior, functional abilities, bowel and bladder continence, and oral/dental status. This was for 3 of 30 sampled residents reviewed for MDS accuracy. Findings included: 1. Resident #59 was admitted to the facility on 3/10/20 with the diagnosis which included: hemiplegia and hemiparesis following a cerebrovascular accident affecting the right dominant side and a right-hand contracture. Review of the annual minimum data set (MDS) assessment dated 8/3/24 indicated Resident #59 was severely, cognitively impaired and had no range of motion impairments of his upper or lower extremities. The review of the Occupational Therapy (OT) Discharge Summary dated 12/29/23 recommended Resident #59 receive a Functional Maintenance Program for right wrist/hand/finger orthosis in place-using a right grip splint. Nursing education was provided. The prognosis to maintain CLOF (current level of function) was excellent with consistent staff support. On 10/21/24 at 2:03 p.m., Resident #59 was observed in his room in his wheelchair. The resident's right hand was fisted. When asked if he was able to open the hand, the resident nodded his head "no". There was no splinting device observed in the room. During an interview on 10/23/24 at 1:53 p.m., the Rehabilitative Director revealed he had worked at the facility since 8/26/24. The Rehabilitative Director stated that after speaking with this	F 641	assessment already had Schizophrenia coded. Resident #59 range of motion was corrected on the 8/3/24 minimal data set on 11/25/24. Resident #69 cognition, mood, behavior, Functional abilities, bowel and bladder continence, oral and dental can no longer be assessed for the 6/12/, however a 9/12/24 assessment was completed with full, appropriate assessment of cognition, mood, behavior, functional abilities, bowel and bladder, and oral and dental status. 2. Regional MDS reviewed 30 days of falls, range of motion, cognition, mood, behavior, functional abilities, bowel and bladder continence, oral, and dental to ensured areas were not dashed as not assessed. Completed on 11/25/24. 3. The Regional MDS Consultant educated MDS nurses on coding MDS assessment appropriately regarding range of motion, cognition, mood, behavior, functional abilities, bowel and bladder continence, oral, and dental, ROM, psychiatric diagnoses such as schizophrenia and PTSD. Completed 11/25/24. 4. Administrator and/or designee will audit 3 MDS assessments to ensure the falls, range of motion, cognition, mood, behavior, functional abilities, bowel and bladder continence, oral, and dental is not dashed weekly x 6 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

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UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 641	Continued From page 14 Surveyor earlier and visiting with Resident #59, he was able to locate a right-hand grip splint in the nightstand of the resident's room. He stated the resident allowed him to apply the splint and it continued to fit comfortably, indicating Resident #59's range of motion had been maintained. He stated Resident #59's most recent rehabilitative services received dated from 12/19/23 to 12/29/23 for splinting/contracture management. During an interview on 10/24/24 at 10:35 a.m., MDS Director stated she had been employed at the facility for two months but, was informed by the Regional MDS Consultant the facility did not have a MDS Coordinator in over a year. She stated she was informed that the facility used traveling MDS nurses to code the MDS assessments and different facility staff would conduct the onsite interviews and observations during that period of time. The MDS Director was unable to explain why the previous MDS nurse did not accurately complete the range of motion section of the MDS assessment. 2. Resident #69 was admitted to the facility on 6/2/20 with diagnosis of Alzheimer's disease. Review of the quarterly MDS assessment dated 6/12/24 indicated Resident #69 was not assessed for cognition, mood, behavior, functional abilities, bowel and bladder continence, and oral/dental status. During an interview on 10/24/24 at 10:35 a.m., the MDS Director stated she had been employed at the facility for two months but was informed by the Regional MDS Consultant the facility did not have a MDS Coordinator in over a year. She revealed she was informed the facility used	F 641	5. Date of compliance: 11/27/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

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UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 641	Continued From page 15	F 641		

traveling MDS nurses and different facility staff would conduct the onsite interviews and observations during that period of time. The MDS Director was unable to explain why the previous MDS nurse did not complete the sections of the MDS assessment for the resident's cognition, mood, behavior, functional abilities, bowel and bladder continence, and oral/dental status.

3. Resident 42 was admitted to the facility 6/14/24 following a fractured pelvis and septic shock resulting in generalized muscle weakness.

Resident #42's hospital discharge summary dated 6/14/24 included diagnoses of schizophrenia and Post-Traumatic Stress Disorder (PTSD).

The diagnoses on Resident #42's EMR face sheet did not include schizophrenia or PTSD.

Record reviewed showed schizophrenia and PTSD were listed on the Medical Doctor's admission note dated 6/15/24 which stated he was being followed by psychiatry. The psychiatry notes had both diagnoses listed, and psychiatric diagnoses were listed on the medication administration record.

Resident #42's admission Minimum Data Set assessment dated 6/20/24 did not include any psychiatric diagnoses.

During an interview with the MDS coordinator on 10/24/24 at 10:31 a.m. she stated she had been in this role for two months and had been aware that some MDS assessments had errors which she was correcting. She stated Resident #42's admission MDS assessment should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 641	Continued From page 16 included the diagnoses of schizophrenia and PTSD. During an interview with the Director of Nursing on 10/24/24 at 11:25 a.m., she stated that all residents should have complete and accurate diagnoses in their charts. She stated the MDS Coordinators will be working close with the nursing staff to make sure all charts contain accurate and complete information going forward.	F 641		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to apply the right-hand grip splinting device as recommended by the occupational therapist for 1 of 1 sampled resident (Resident #59) with a contracture of his	F 688	F688 Splints 1. Resident #59 splint was applied to the right on 10/23/2024 by the Director of Rehabilitation. 2. On November 7, 2024, current	11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 688	Continued From page 17 right hand. Findings included: Resident #59 was admitted to the facility on 3/10/20 with the diagnosis which included: hemiplegia and hemiparesis following a cerebrovascular accident affecting the right dominant side and a right-hand contracture. Review of the annual Minimum Data Set assessment dated 8/3/24 indicated Resident #59 was severely cognitively impaired and had no impairments of his upper or lower extremities. The care plan did not include Resident #59's right-hand contracture and the application of a splinting device. The review of the Occupational Therapy (OT) Discharge Summary dated 12/29/23 recommended Resident #59 receive a Functional Maintenance Program for right wrist/hand/finger orthosis in place-using a right grip splint. Nursing education was provided. The prognosis to maintain CLOF (current level of function) was excellent with consistent staff support. There was no physician order in the medical record for the application of the grip splint for Resident #59's right hand. On 10/21/24 at 2:03 p.m., Resident #59 was observed in his room in his wheelchair. The resident's right hand was fisted. When asked if he was able to open the hand, the resident nodded his head "no". There was no splinting device observed out in the open in the room.	F 688	residents with splints orders were veri¿ed with occupational therapy and the Director of Nursing. The splints were veri¿ed and accounted for. Completed 11/7/2024. 3. On 10/25/24 the Sta¿ Development Coordinator and/or designee educated licensed nurses and certi¿ed nursing aides on where to locate the splints and how to know what resident has a splint order. This was completed on 11/25/24. Education will continue in orientation with new hire. In-person and/or via phone. 4. Director of Nursing and/or designee will audit 5 residents with splints or 100% of resident with splints if less than 5 available, 3 times weekly x 4 weeks, 2 times weekly for 4 weeks and weekly the 4 weeks to ensure orders are in the electronic medical record and that the splints were applied as ordered. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identi¿ed are corrected. 5. Compliance Date: 11/27/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

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F 688	Continued From page 18	F 688		

During an interview on 10/24/24 at 3:25 p.m., Nurse Aide (NA) #8 revealed she worked with Resident #59 since his admission but had been on leave of absence for one month and returned on 10/22/24. She stated the resident has had the splint applied since 10/22/24. NA #8 stated the nurses and nursing assistants were able to apply the splint to the resident's hand. NA #8 revealed she was unsure where the resident's splinting device was stored.

During an interview on 10/23/24 at 1:53 p.m., the Rehabilitation Director revealed he had worked at the facility since 8/26/24. The Rehabilitation Director stated that after speaking with this Surveyor earlier and visiting with Resident #59, he was able to locate a right-hand grip splint in the nightstand of the resident's room. He stated the resident allowed him to apply the splint and it continued to fit comfortably, indicating Resident #59's range of motion had been maintained. He stated Resident #59's most recent rehabilitative services received dated from 12/19/23 to 12/29/23 for splinting/contracture management. He revealed the Occupational Therapist would be re-evaluating Resident #59 the next day as part of his quarterly evaluation. The Rehabilitation Director revealed he did not know who was responsible for applying the splint to the resident's right hand because he was unable to locate Resident #59's previous therapy records due to facility ownership change.

On 10/24/24 at 3:05 p.m., Resident #59 was observed in his room with a visitor who revealed she was the resident's POA (power of attorney). A blue colored hand splint was observed on the resident's right hand. The visitor/POA indicated she frequently visited the resident she had not

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UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 688	Continued From page 19 observed the splint on the resident's hand in two years.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Nurse Practitioner interviews, the facility failed to administer oxygen at the physician prescribed rate for 1 of 1 resident sampled for respiratory care (Resident #14). The findings included: Resident #14 was admitted to the facility on 01/22/24 with diagnoses which included hypoxemia (a low level of oxygen in the blood) and congestive heart failure. A review of Resident #14's quarterly Minimum Data Set (MDS), dated 09/15/24, revealed she was moderately cognitively impaired and was on oxygen therapy. A review of Resident #14's Physician Orders read, "oxygen at 2 liters per minute via nasal cannula" and was written on 09/25/24.	F 695	F695 Respiratory/Tracheostomy Care and Suctioning 1. Resident #14 oxygen was set to the amount as prescribed by the prescribing physician immediately upon noti¿cation. 2. On November 7, 2024, the Director of Nursing reviewed current residents that receive oxygen to ensure they on the current settings as ordered by the prescribing physician. Completed 11/7/2024. 3. On 10/24/24 the Sta¿ Development Coordinator initiated education to all licensed nurses on assessing residents that are on oxygen to ensure residents are being administered the appropriate amount of oxygen as ordered by the prescribing physician. Completed on 11/25/24. Education will continue in orientation with new hire. In-person and/or via phone. 4. The Director of Nursing will monitor 5	11/27/24

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	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

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UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 695	Continued From page 20 A review of Resident #14's Care Plan, last revised on 10/14/24, indicated she was at risk for respiratory complications secondary to her supplemental oxygen requirement. Interventions included to administer oxygen as ordered. A review of Resident #14's vital signs revealed an oxygen saturation of 96% on 10/19/24 and 98% on 10/01/24. There were no other documented oxygen saturation values in the record. An observation of Resident #14 was made on 10/21/24 at 11:48 A.M. Resident #14 was lying in her bed with her eyes closed with no shortness of breath noted. She had oxygen in her nose via nasal cannula. The oxygen concentrator was placed next to her bed and was set to deliver 3.5 liters per minute of oxygen. A second observation of Resident #14 was made on 10/21/24 at 3:54 P.M. Resident #14 was lying in her bed with her eyes closed with no shortness of breath noted. She had oxygen in her nose via nasal cannula. The oxygen concentrator was placed next to her bed and was set to deliver 3.5 liters per minute of oxygen. An interview was conducted with Nurse #4 on 10/23/24 at 12.53 P.M. The nurse confirmed she worked on 10/21/24 from 7:00 A.M. until 7:00 P.M. and had been assigned to care for Resident #14. Nurse #4 stated one of Resident #14's visitors informed her that she was moaning. She was unsure of the time of day. Nurse #4 stated she immediately went to the resident's room to assess her. Nurse #4 indicated she took Resident #14's vital signs which included her oxygen saturation rate. The nurse stated she remembered the oxygen saturation rate being in	F 695	residents with oxygen to validate the oxygen is administered as ordered by the prescribing physician 3 times a week for 4 weeks, 2 times a week for 4 weeks, and 1 time a week for 4 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identi¿ed are corrected. Compliance Date: 11/27/24.	

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	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

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UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 695	Continued From page 21	F 695		

the high 90s and thought it might have been 97%; however, she did not document the resident's vital signs in her medical record. She indicated that she repositioned Resident #14 which seemed to alleviate her discomfort and then she left the room. When asked why she had not documented the resident's vital signs and oxygen saturation in the medical record, Nurse #4 explained that she only documented vital signs on a resident if they had been scheduled as a task, or if the results were abnormal. Nurse #4 clarified that because the resident had not appeared to be in respiratory distress at that time, she had not checked the settings on the oxygen concentrator. The nurse added that because there were a lot of visitors in the room at that time, she did not want to appear rude by asking them to move around in order for her to get to the concentrator to check the settings. Nurse #4 stated that if Resident #14's oxygen saturation values had been abnormal, she would have checked the settings on the oxygen concentrator regardless of how many visitors were in the room at the time.

An interview was conducted with Nurse Practitioner (NP) #1 on 10/23/24 at 11:25 A.M. NP #1 stated he had been asked to assess Resident #14 after her oxygen concentrator had been discovered to have been set to deliver her oxygen therapy at 3.5 liters per minute on 10/21/24. He stated that obtaining her oxygen saturation rate was difficult due to her wearing gel nail polish on her nails but confirmed she had no signs and symptoms of dyspnea (shortness of breath) or air hunger, and that she had good capillary refill. He explained Resident #14 does not have a diagnosis of chronic obstructive pulmonary disease and had been receiving

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UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 695	Continued From page 22 oxygen therapy due to her diagnosis of hypoxemia. He further explained that while no harm came to the resident on 10/21/24, he stated he had instructed the staff to continue her oxygen therapy at the prescribed rate of 2 liters per minute and encouraged them to monitor the settings on the concentrator. NP #1 stated it was his expectation that nursing staff follow the physician's orders for oxygen therapy and to also monitor the settings on the oxygen concentrators. An interview was conducted with the Director of Nursing (DON) on 10/23/24 at 2:06 P.M. The DON stated that after she had been informed of Resident #14's oxygen concentrator having been set to deliver her oxygen therapy at 3.5 liters per minute on 10/21/24, she had asked NP #1 to assess the resident. She explained she had also spoken to nursing staff who informed her they felt Resident #14's visitors often "fiddled" with the settings during their visits with her. The DON indicated there were no new orders after NP #1's assessment, however he had stated that he did not want her oxygen therapy to be delivered at 3.5 liters per minute. The DON stated it was her expectation that nursing staff observe all aspects of a resident's care when they are in a resident's room. An interview was conducted with the Administrator on 10/23/24 at 12:44 P.M. The Administrator stated it was his expectation that nurses follow physician's orders and monitor residents receiving oxygen therapy as per the facility's policy and procedure.	F 695		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

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F 725	Continued From page 23 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to have licensed nursing coverage 24 hours/day in the facility for 17 out of 120 days reviewed for staffing. The failure to have a licensed nurse in the facility at all times had a high likelihood of impacting every resident in the facility. The findings included:	F 725	F725 Su¿cient Nursing Sta¿ 1. Sta¿ schedules were adjusted immediately to ensure the appropriate number of licensed nurses are scheduled to work. 2. Current residents are a¿ected by this current de¿ciency. 3. Regional Director of Clinical Services educated the Director of Nursing, scheduler and Administrator on November	

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F 725	Continued From page 24 Review of the staffing data submitted by the facility through the CMS (Centers for Medicare and Medicaid Services) Payroll-Based Journal (PBJ) system for quarter 3 (April 1, 2024 through June 30, 2024) indicated there was no licensed nurse coverage 24 hours/day in the facility on 4/6/24, 4/5/24, 4/13/24, 4/14/24, 4/20/24, 4/21/24, 4/27/24, 4/28/24, 5/4/24, 5/5/24, 5/11/24, 5/12/24, 5/18/24, 5/19/24, 5/25/24, 5/26/24 and 5/27/24. The facility was unable to locate the Staff Schedule/Assignment Sheets, timecard reports or payroll reports to review for licensed nursing staff for April through June of 2024. During an interview with the Staff Development Coordinator (SDC) on 10/23/24, she stated she had been in the role of SDC, Infection Preventionist and the Assistant Director of Nursing since the new company took over in June 2024. The SDC indicated they had been using a lot of agency staff prior to the new company taking over and was unable to provide any information to confirm or deny whether facility actually had licensed nurses (registered nurses or licensed practical nurses) in the building 24 hours a day on those specific days. During an interview with the Facility Scheduler on 10/23/24, she stated, she had been in her role since June 2024. She stated was aware of the regulation that stated the facility must have licensed nurse coverage 24 hours/day. The Facility Scheduler was unable to speak to any scheduling issues that occurred prior to June 2024 and did not know who handled that job prior to her.	F 725	7, 2024, on providing the appropriate amount of licensed nurses in the facility based on the amount of residents 24 hours a day 7 days a week. 4. Director of Nursing and/or designee will audit schedule daily to ensure licensed nurses are scheduled to work in the facility for 7 days a week weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identi¿ed are corrected. Compliance Date:11/27/24	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON	F 727		11/27/24

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F 727	Continued From page 25 CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide Registered Nurse (RN) coverage at least 8 consecutive hours per day, 7 days per week for 17 out of 120 days reviewed for staffing. The findings included: Review of the staffing data submitted by the facility through the CMS (Centers for Medicare and Medicaid Services) Payroll-Based Journal (PBJ) system for quarter 3 (April 1, 2024 through June 30, 2024) indicated indicated there was no RN coverage for eight consecutive hours on 4/5/24, 4/6/24, 4/13/24, 4/14/24, 4/20/24, 4/21/24, 4/27/24, 4/28/24, 5/4/24, 5/5/24, 5/11/24, 5/12/24, 5/18/24, 5/19/24, 5/25/24, 5/26/24 and 5/27/24. The facility was unable to locate the Staff Schedule/Assignment Sheets, RN timecard reports, or payroll reports to review for the time	F 727	F727 RN 8 hrs/7 days/week, Fulltime DON 1. Sta¿ schedules were adjusted immediately to ensure proper RN coverage is in place. 2. Current residents are a¿ected by this current de¿ciency. 3. Regional Director of Clinical Services educated the Director of Nursing, Scheduler and Administrator on November 7, 2024, on providing a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week. 4. Director of Nursing and/or designee will audit schedule to ensure a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution	

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F 727	Continued From page 26 period of April 1, 2024 through June 30, 2024. During an interview with the Staff Development Coordinator (SDC) on 10/23/24 at 11:14 AM, she stated she has been in the role of SDC, infection preventionist and the assistant director of nursing since the new company took over in June 2024. She stated they currently had four RNs on staff and had been using a lot of agency staff prior to the new company taking over. The SDC was unable to provide any information to confirm or deny whether facility actually had RN coverage at least 8 consecutive hours per day in the building on those specific days. The SDC indicated she was not currently assist with scheduling. During an interview with the Facility Scheduler on 10/23/24 at 11:20 AM, she stated she had been in her role since June 2024. She stated she was aware of the regulation that stated the facility must have RN coverage for 8 consecutive hours. The Facility Scheduler was unable to speak to any scheduling issues that occurred prior to June 2024 and did not know who handled that job prior to her. During an interview with the facility Administrator on 10/23/24 at 1:00 PM, he stated he began working at the facility in June 2024 when the new company took over. He stated he had searched everywhere he could think of and was unable to locate any timecard reports, staffing sheets, or daily postings prior to June 2024.	F 727	if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identi¿ed are corrected. Compliance Date:11/27/24	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		11/27/24

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F 760	Continued From page 27 medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to prevent a significant medication error when a nurse failed to administer insulin before a meal as scheduled as specified in the physician's order. This occurred for 1 of 1 sampled resident (Resident #25). The findings included: Resident #25 was admitted to the facility on 04/19/2021. Her diagnoses included, in part, diabetes mellitus and dementia. A review of the resident's physician's orders included the following: - Humalog Insulin Solution (Insulin Lispro) Inject as per sliding scale (where the dose of insulin administered was dependent on the resident's current blood glucose level): The sliding scale insulin was ordered to be administered before meals and at bedtime as follows: -If the blood glucose was 101 - 150 milligrams (mg)/deciliter (dL), give 2 unit of insulin. -If the blood glucose was 151 - 200 mg/dL, give 3 units of insulin. -If the blood glucose was 201 - 250 mg/dL, give 5 units of insulin. -If the blood glucose was 251 - 300 mg/dL, give 7 units of insulin. -If the blood glucose was 301 - 350 mg/dL, give 9 units of insulin. -If the blood glucose was 351 - 400 mg/dL, give 11 units of insulin. Call MD for blood sugar < or >400. Humalog insulin is a rapid-acting insulin with peak serum blood levels typically seen 30 to 90	F 760	F760 Signi¿cant Med Error 1. On 10/25/24 the Director of Nursing and/or designees noti¿ed the medical director and the resident representative party regarding the medication error for resident #25. 2. On 11/16/24 the Director of Nursing and/or designee initiated an audit of orders for all residents receiving Insulin to validate the that all orders were timed correctly per physician order. This was completed on 11/18/24. 3. On 10/25/24 the Sta¿ Development Coordinator initiated education for all licensed nurses on ensuring the residents receive their medications as scheduled. This was completed on 11/25/24. Education will continue in orientation with new hire. In-person and/or via phone. 4. The Director of Nursing and/or designee will audit at least 5 residents 2x/week for 4 weeks, then 1x/week for 4 weeks, then 10 residents monthly x1. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identi¿ed are corrected. Compliance date 11/27/24.	

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F 760	Continued From page 28	F 760		

minutes after its administration. Humalog insulin is injected subcutaneously (A subcutaneous injection is a method of administering medication by injecting it into the fatty layer of skin, or subcutis, just below the dermis and epidermis).

A review of Resident #25's October 2024 Medication Administration Record (MAR) revealed Humalog Insulin was transcribed to the MAR to be administered at 7:30 AM, 11:00AM, and 4:00 PM.

A review of the facility's meal delivery times revealed breakfast meal trays were scheduled for delivery to Resident #25's hall between 7:15 AM - 7:30 AM daily. Resident #25's mealtime Humalog insulin coverage for the morning meal was scheduled for administration at 7:30 AM (prior to the meal).

On 10/24/24 at 9:50 AM, Nurse #4 was observed as she checked Resident #25's blood glucose level. The resident's blood glucose result was 252 mg/dL. Nurse #4 returned to the medication cart, reviewed the physician's orders to determine the dose of insulin needed, then drew up 7 units of Humalog insulin for administration to the resident. Nurse #4 explained Resident #25 needed to be given 7 units of Humalog based on her orders for sliding scale insulin.

On 10/24/24 at 9:55 AM, Nurse #4 was observed as she injected 7 units of Humalog insulin subcutaneously (under the skin) into Resident #25's left arm via the Resident's Humalog KwikPen. The Humalog KwikPen is a disposable single-patient-use prefilled pen containing Humalog insulin.

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F 760	Continued From page 29 An interview was conducted on 10/24/24 at 9:55 AM with Nurse #4. At that time, the nurse was asked why Resident #25's Humalog insulin was administered more than 2.5 hours late. The sliding scale Humalog insulin (7 units) was scheduled for administration at 7:30 AM but was not administered to the resident until 9:55 AM. Nurse #4 responded by stating the late administration was due to the heavy medication pass workload and the time it was taking to test and transfer COVID positive residents to other rooms. An interview was conducted on 10/25/24 at 1:50 PM with the facility's Director of Nursing (DON). During the interview, the concern regarding the late administration of Resident #25's Humalog insulin was discussed. The DON stated the nurses on the halls have enough time to pass medications within the timeframes. She stated if a nurse needed assistance with getting a medication pass completed within the timeframe the administrative nurses (e.g., Unit Manager, Infection Preventionist, or she herself) could assist as needed. The DON stated education would need to be provided to Nurse #4. The DON stated if Resident #25's Humalog insulin was ordered to be given at 7:30 AM, Nurse #4 should have given the insulin within one hour before its scheduled time for administration.	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

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UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 842	Continued From page 30	F 842		

accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 842	Continued From page 31 §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to maintain a complete medical record in the area of diagnoses for 1 of 5 residents (Resident #42) reviewed for unnecessary medications. The findings included: Resident #42 was admitted to the facility 6/14/24 following a fractured pelvis and septic shock resulting in generalized muscle weakness. Review of Resident #42's hospital discharge summary 5/22/24 showed diagnoses schizophrenia and post-traumatic stress disorder (PTSD).	F 842	F842 Resident Record-Identi¿able Information 1. Resident #42 medical record was updated to re¿ect the diagnosis of post tramatic stress syndrome and schizophrenia 10/15/24 2. On 11/22/24 the Minimal Data Set Nurse, Director of Nursing and designee reviewed the diagnoses for all current resident□s medical records to ensure the medical diagnosis were updated to re¿ect the diagnosis of post trimitic stress syndrome and schizophrenia. This was completed on 11/26/24. 3. On 11/25/26, The Regional Director of Clinical Services educated the Minimal Data Set Nurse, Director of Nursing, and	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 842	Continued From page 32 Review of Resident #42's electronic medical record cumulative diagnosis face sheet did not include schizophrenia or PTSD. During an interview with the Director of Nursing on 10/24/24 at 11:25 AM, she stated that all residents should have complete and accurate diagnoses in their charts. She stated the MDS Coordinators will be working close with the nursing staff to make sure all charts contain accurate and complete information going forward.	F 842	Unit Managers on ensuring the residents medical diagnosis is accurate in the residents medical record. 4. The Minimal Data Set Nurse/DON will audit 5 residents chart to ensure the medical diagnosis is current and updated weekly for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identi¿ed are corrected. Compliance Date: 11/27/24	
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880		11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

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F 880	Continued From page 33 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 34 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to implement a broad-based approach COVID-19 testing for staff and residents on 10/13/24 when residents tested positive for COVID-19 on two resident halls. The facility had been in outbreak status since 10/08/24 when a staff member tested positive and only residents/staff with symptoms, roommates of residents that tested positive and staff that requested or were symptomatic tested for COVID-19. Broad-based COVID-19 testing per the Centers for Disease Control and Prevention (CDC) guidance was not implemented until 10/23/24. Before broad-based testing was implemented on 10/23/24, a total of 4 staff members and 22 residents had tested positive for COVID-19. Results of the broad-based testing from 10/23/24 through 10/25/24 yielded one (1) staff member and 6 additional residents positive for COVID-19. In addition, 11of 14 staff members failed to wear surgical masks covering both their mouth and nose for source control to help prevent transmission while working in the facility during the COVID-19 outbreak and one staff member (Nurse Aide #6) entered a resident room under transmission-based precautions for COVID-19 without wearing eye protection. The facility's infection control policy and procedures for outbreak testing did not conform with CDC guidance. had not initiated the administration of any 2024-2025 COVID-19 vaccinations for residents. The resident census at the time of the	F 880	F880 Infection Prevention and Control 1. On 10/23/24, the Director of Nursing and Infection Preventionist completed broad-based testing on all sta¿ and residents within the facility. The facility will complete testing on all residents and sta¿ twice per week until there is a 14-day interval of no new positive cases. On 10/23/2024 the Director of Nursing, Sta¿ Development Coordinator, and the Unit Managers initiated education with current sta¿ and providers, including the medical director and nurse practitioners, regarding source control to include wearing face mask throughout the building during outbreak status regardless of if they are in a covid positive room or not. On 10/24/24 the corporate education department reviewed and updated the policy related to COVID-19 to assure that it re¿ected the CDC□s recommendations for broad based testing and appropriate source control during an identi¿ed outbreak. 2. Current residents are a¿ected by this current de¿ciency. 3. On 10/23/2024 the Director of Nursing, Sta¿ Development Coordinator, and the Unit Managers initiated education regarding how to properly Don and Do¿ Personal Protective Equipment with current sta¿. On 10/23/2024 the Director of Nursing, Sta¿ Development Coordinator, and the Unit Managers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 35	F 880		

survey was 129. The facility had their first 2024-2025 COVID-19 vaccination clinic on 10/16/24 through10/18/24. These cumulative practices and system failures occurred during a COVID-19 outbreak and had the high likelihood for continued transmission of COVID-19 to residents and staff and a serious adverse outcome.

Immediate Jeopardy began on 10/13/24 when COVID positive residents were identified on the 200-hall and 400-hall and broad-based testing of staff and residents was not initiated. Immediate jeopardy was removed on 10/25/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of E (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective.

The findings included:

A. The facility policy titled "Policies and Procedures" [Infection Prevention and Control], Section Emerging Infectious Disease(s), Policy Name COVID-19 Effective date 03/11/24 revealed the center followed the Centers for Disease Control and Prevention (CDC) and standards of practice for prevention of COVID-19 to protect employees and patients. Section 4 revealed Infection Prevention and Control measures may include, but were not limited to:

i. Employee and patient testing according to current standards

Per the CDC guidelines dated 6/24/24, "The

initiated education with current sta¿ and providers, including the medical director and nurse practitioners, regarding Special Droplet Contact Precautions when a resident test positive for COVID-19. On 10/23/2024 the Director of Nursing, Sta¿ Development Coordinator, and the Unit Managers initiated education with current sta¿ and providers, including the medical director and nurse practitioners, regarding source control to include wearing face mask throughout the building during outbreak status regardless of if they are in a covid positive room or not. On 10/24/24 the policy related to COVID-19 was updated to assure that it re¿ected the CDC□s recommendations for broad based testing and appropriate source control during an identi¿ed outbreak and the Regional Director of Clinical Services educated the Director of Nursing, Sta¿ Development Coordinator, Administrator, and Unit Managers on the updated on the new policy. Completed 10/23/2024.
4. The Director of Nursing and/designee will monitor 5 sta¿ members to ensure that they Don and Do¿ the PPE appropriately 3 times weekly x 4 weeks, 2 times weekly x 4 weeks, and weekly x 4 weeks. The Director of Nursing will interview 5 sta¿ members to ensure they understand what Special Droplet Contact Precautions require 3 times weekly x 4 weeks, 2 times weekly x 4 weeks, and weekly x 4 weeks. Not sure what to put for the policy. (How is this going to be monitored?) Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 36 approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based approach is preferred if all potential contacts cannot be event identified or managed with contact tracing or if contact tracing fails to halt transmission. If additional cases are identified, strong consideration should be given to shifting to broad based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach testing should continue on affected units or facility wide every 3-7days until there are no new cases for 14 days. If antigen testing is used more frequent testing (every three days) should be considered. A review of the facility document titled COVID-19 Contact Tracing Investigation revealed the following: - The COVID outbreak started on 10/08/24 when the facility Social Worker tested positive for COVID. - The Receptionist tested positive on 10/10/09/24. - On 10/13/24 four residents on the 200-hall (Resident #98, Resident #126, Resident #442, and Resident #443) and 1 resident on the 400-hall (Resident #5) tested positive for COVID. - On 10/14/24 two residents on the 400-hall (Resident #90 and Resident#92) and 1 resident on the 700 hall (Resident #67) tested positive for COVID. - On 10/15/24 one resident on the 200-hall (Resident #68) and one resident on the 700-hall (Resident #3) tested positive for COVID. - On 10/17/24 one resident on the 200-hall (Resident #29), one resident on the 300-hall (Resident #55), one resident on the 400-hall (Resident #111), and two residents on the	F 880	problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identi¿ed are corrected. 5. Compliance Date: 11/27/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 37	F 880		

700-hall (Resident #107 and Resident #116).
- On 10/18/24 one resident on the 300-hall (Resident #39) and two residents on the 700-hall (Resident #4 and Resident #119) tested positive.
- On 10/21/24 one resident on the 300-hall (Resident #13) tested positive.
- On Tuesday, 10/22/24, two more residents and one staff member tested positive.
- On Wednesday, 10/23/24, one additional resident and one staff member tested positive.

On 10/23/24 at 11:09 AM an interview was conducted with the Infection Preventionist (IP)/Assistant Director of Nursing /Staff Development Coordinator, and she stated residents were tested when they were symptomatic or the roommate of a COVID positive resident. She further stated staff were tested when they requested or if they were symptomatic. The IP stated the facility Social Worker tested positive for COVID on 10/8/24 and on 10/09/24 the Receptionist tested positive for COVID. She stated on 10/13/24 five residents on the 200 hall and one resident on the 400-hall tested positive. On 10/14/24 there were 2 more residents on the 400-hall who tested positive for COVID and 1 resident on the 700-hall. On 10/15/24 another resident on the 700-hall and 1 resident on the 200-hall tested positive. On 10/17/24 a total of 5 more residents tested positive - 1 on the 200-hall, 1 on the 300- hall, 1 on the 400-hall and 2 on the 700-hall. On 10/18/24 another resident on the 300-hall and 2 residents on the 700-hall tested positive. She stated on Monday, 10-21-24, there were19 COVID+ residents and zero COVID+ staff. On Tuesday, 10/22/24 two more residents and 1 staff tested COVID+. On Wednesday, 10/23/24, 1 additional resident and 1 staff tested positive. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 38	F 880		

IP stated residents were tested only when they were symptomatic or if they were roommates of a resident who tested positive. She stated a COVID "outbreak" was when 6 or more residents and/or staff were positive. The Infection Preventionist stated she had spoken with her corporate clinical nurse consultant who had informed her that she did not have to report the COVID outbreak to the Health Department as they had in the past because the facility reported to National Healthcare Safety Network (NHSN). She said she reported this outbreak to the health department on 10/18/24 when the number of COVID+ residents reached 18. The IP stated she felt the spread of COVID throughout the building was largely due to noncompliant residents and the agency staff working at different facilities and getting exposed from numerous sources. The IP stated she felt they did all the protocols they should have initiated. The IP stated COVID+ residents were quarantined for 10 days and then they're off of quarantine and they do not re-test those residents after the 10-day quarantine. The interview further revealed the facility had a COVID-19 vaccine clinic

In an interview with Nurse Aide (NA) #6 on 10/22/24 at 12:43 PM she stated she had not been tested for COVID by the facility.

On 10/23/24 at 11:09AM the IP stated the facility had a COVID vaccine clinic from 10/16/24 through 10/18/24 and had one scheduled for that week (the week of 10/21/24) but cancelled it due to the survey.

An interview was conducted with the Director of Nursing (DON) on 10/23/24 at 2:06 PM and she stated she expected all nurses (staff and agency)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 39	F 880		

to follow the standards of nursing and to follow the infection prevention/infection control practices. The DON deferred questions regarding testing and education to the IP.

A follow up interview with the DON was conducted on 10/25/24 5:00 PM revealed all residents in the facility and all staff members entering the facility were tested for COVID beginning on 10/23/24. The facility identified 6 more COVID+ residents on Wednesday, 10/23/24 and one staff member on Friday, 10/25/24. No positive cases were identified on Thursday 10/24/24.

B. The facility policy titled "Infection Prevention and Control Committee", updated 08/02/2024, revealed the Infection Prevention and Control Committee was responsible for implementing established program plans and standards of practice that promoted, monitored, and maintained an environment that reduced the risk of transmission and acquisition of center-acquired infections.

The facility policy titled "Policies and Procedures" [Infection Prevention and Control], Section Emerging Infectious Disease(s), Policy Name COVID-19 Effective date 03/11/24 revealed the center followed the Centers for Disease Control and Prevention (CDC) and standards of practice for prevention of COVID-19 to protect employees and patients. Section 4 revealed Infection Prevention and Control measures may include, but were not limited to:

a. Source control (well-fitting face mask/face covering):
- For those with suspected or confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 40	F 880		

respiratory infection
- For those who have had close contact with someone with COVID-19 for 10 days after contact
- For those who reside or work in an area of the facility experiencing COVID-19 outbreak with uncontrolled transmission, or
- When otherwise recommended by public health authorities
- Even if not otherwise required by the facility, individuals should always be allowed to wear source control based on personal preference.
c. Respiratory Hygiene/cough etiquette
d. Visual alerts posted to inform current infection control practices
f. Appropriate staff use of PPE, when indicated

On 10/21/24 at 7:45 AM an interview and observation was conducted upon entry with Receptionist #1, and she informed the survey team masks were in use due to COVID-19 infection in the facility. Receptionist #1 was wearing mask during the interview. A box of yellow surgical masks and a box of black N-95 masks were available on the reception desk. There was no signage at the entrance to alert staff and visitors of a COVID outbreak, visual alerts for infection control practices or instructions about when to use personal protective equipment and hand hygiene.

On 10/22/24 at 12:26 PM in an interview with Receptionist #2 she stated the front door was kept locked, so all visitors had to ring the bell to enter. She was wearing a mask covering her nose and mouth during the interview. She further stated visitors were directed to sign-in at the digital kiosk. Receptionist #2 stated that while she did not talk about the COVID status in the facility, she did talk to visitors about protecting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 41	F 880		

themselves and also helping to protect the residents. She stated and offered the visitors a mask, either a surgical, KN95 or N95. Receptionist #2 stated it was not mandatory for visitors to wear masks while in facility. Receptionist #2 added she was unsure of what the mask policy was for staff working in the facility.

On 10/21/24 at 3:08 PM an observation revealed Nurse Aide (NA) #2 walking down the 700-hall without wearing a mask.

An interview was conducted with the Director of Nursing (DON) on 10/21/24 at 3:19 PM after she was observed removing her mask to speak to a resident in the Unit 2 common area. The DON stated she removed her mask to talk to the resident because he was hard of hearing. She further stated the purpose of the masks was to stop the spread of COVID.

An observation on 10/22/24 at 10:38 AM revealed a housekeeper enter and exit 2 rooms on the 600-hall with a mask worn under his chin not covering his mouth and nose.

An observation on 10/22/24 at 10:41 AM revealed Nurse #5 was reviewing medication administration records while seated in the Unit 2 common area. Nurse #5 was wearing a surgical mask tucked under her chin and the other nurse had on an N95 mask as well as a face shield.

On 10/22/24 at 1:42 PM an observation and interview were conducted with Nurse #6 while she prepared to pass medications on the 600-hall. There were no COVID positive residents on the 600-hall. She was observed wearing a surgical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 42	F 880		

mask below her nose. Nurse #6 stated when working on a COVID hall staff wore masks and the facility preferred for staff to wear N95 masks during the COVID outbreak.

An interview was conducted with NA#3 on 10/22/24 at 1:45 PM as she entered the 600-hall from the therapy department hall. She was not wearing a face mask. NA #3 stated she was assigned to obtain weights on residents throughout the facility who were due weights. NA #3 added she was not assigned to weigh any residents with COVID. She said since the COVID outbreak masks were to be worn by staff and staff could wear the mask of their preference.

On 10/22/24 at 1:52 PM an observation and interview were conducted with NA #4 on the 600 Hall. Her mask was under her nose. NA #4 stated she did not think the facility had an outbreak. NA #4 further stated an outbreak was when 50 or more residents were positive for COVID. She added the type of mask staff wore was an individual preference.

On 10/23/24 at 10:04 AM Nurse #8 was observed as she prepared to administer medications on the 200-hall (a hall where there were COVID positive residents). Her surgical mask did not cover her mouth or nose.

On 10/23/24 at 10:43 AM Nurse #8 was observed as she stood at a medication cart across from a room with droplet precaution signage on the 200-hall. Nurse #8 was wearing her surgical mask below her chin, not covering her mouth or nose.

On 10/23/24 at 10:49 AM the Medical Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 43	F 880		

was observed walking down the 200-hall to the 400- hall then to 600-hall with his surgical mask under his nose.

On 10/23/24 at 5:20 PM the IP brought staff folders to the conference room with no mask on.

On 10/22/24 at 1:59 PM an observation and interview were conducted with Nurse #7 while she was walking through the Unit 2 common area. Nurse #7 was wearing a surgical mask, which covered her nose and mouth, and she stated the facility was considered in a COVID outbreak. She further stated masks were required, either surgical or N95. Nurse #7 added masks should be worn for the duration of the shift and should cover both the nose and mouth to keep from breathing in or out droplets.

The facility policy titled "Policies and Procedures" [Infection Prevention and Control], Section Precautionary Measures Policy Name Transmission Based Precautions- General Practice Effective date 12/01/21 revealed the facility initiates transmission-based precautions to protect other patients, employees and visitors from the spread of a confirmed or suspected infection or contagious disease. The TBPs will be based on the type of pathogens, knowledge of the natural history of certain diseases and studies of epidemiology. The TBP measures will be the least restrictive possible for the patient under the circumstances. Measures included:

19. If protective attire is determined necessary, when donning the protective attire follow these steps:
a. Wash hands or perform hand hygiene with alcohol-based hand rub

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 44	F 880		

b. Put on gown
c. Apply mask over mouth and nose,
(1) Pinch the metal band above the nose to make the mask fit to the contour of the face.
(2) The mask must be replaced if it becomes moist or after 20 minutes
(3) Do not touch the mask once it is positioned until it is removed
(4) Remove the mask when leaving the room and discard immediately,
(5) Do not reuse the mask.
d. Put on goggles or face shield if required. Place over eyes and adjust to fit.
e. Put on gloves.

An observation on 10/22/24 at 12:43 PM was conducted of NA #6 as she passed lunch trays to residents on the 200-hall. Prior to entering a COVID+ resident's room (room 211), she sanitized her hands and then donned PPE which consisted of an N95 mask, gown and gloves. She did not wear eye protection as she entered the room. When NA #6 exited the room, she was asked why she had not donned eye protection. NA #6 pointed towards the top of her head and patted a pair of goggles. NA #6 explained that she had been busy, moving fast to get the lunch trays passed out and had forgotten to put them on. NA #6 stated she was an agency NA, and it was her first time working in the facility. When asked if she had been made aware of the COVID outbreak in the facility, she confirmed the DON told her that morning.

An interview was conducted on 10/23/24 at 11:09 AM with the Infection Preventionist (IP) and she stated she educated staff in all departments related to COVID protocol. The IP stated masks were mandatory during COVID outbreaks. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 45	F 880		

stated education for donning and doffing personal protection equipment (PPE) was provided during orientation, during yearly competencies, and in-services as needed. When informed of observations of staff not wearing their masks over both their nose and mouth, she stated she tried to make rounds periodically throughout the day to check to make sure staff were using PPE correctly. She stated when she saw staff not wearing their masks correctly, she reminded them to cover both their nose and mouth with the mask. She stated all staff were fit-tested for N95 masks and had been instructed on the proper application of masks and PPE.
An interview was conducted with the Director of Nursing (DON) on 10/23/24 at 2:06 PM and she stated she expected all nurses (staff and agency) to follow the standards of nursing and to follow the infection prevention/infection control practices. The DON deferred questions regarding testing and education to the IP.

In an interview with the Nurse Practitioner (NP) on 10/23/24 at 3:53 PM she stated staff not wearing masks properly can increase the transmission of COVID from staff to staff and from staff to resident. She stated none of her residents who tested COVID+ had been hospitalized.

On 10/22/24 at 2:14 PM an interview was conducted with the Administrator, and he stated it was his expectation that any staff member caring for a COVID+ resident wear an N95 mask.

C. The facility policy titled "Infection Prevention and Control Committee", updated 08/02/2024, revealed the Infection Prevention and Control Committee was responsible for implementing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 46	F 880		

established program plans and standards of practice that promoted, monitored, and maintained an environment that reduced the risk of transmission and acquisition of center-acquired infections.
The facility policy titled "Policies and Procedures" [Infection Prevention and Control], Section Emerging Infectious Disease(s), Policy Name COVID-19 Effective date 03/11/24 revealed the center followed the Centers for Disease Control and Prevention (CDC) and standards of practice for prevention of COVID-19 to protect employees and patients. Section 4 revealed Infection Prevention and Control measures may include, but were not limited to:

i. Employee and patient testing according to current standards

A review of the CDC's policy for COVID testing dated June 2024 revealed the following guidance for nursing homes:
- The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
- Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 47	F 880		

1 (where day of exposure is day 0), day 3, and day 5.
- Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- Empiric use of Transmission-Based Precautions for residents and work restriction for HCP are not generally necessary unless residents meet the criteria described in Section 2 or HCP meet criteria in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively. However, source control should be worn by all individuals being tested.
-In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric use of Transmission-Based Precautions for residents and work restriction of HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.
- If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 48	F 880		

Exposure to SARS-CoV-2, respectively.
- If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.
- If antigen testing is used, more frequent testing (every 3 days), should be considered.

An interview was conducted with the IP on 10/23/24 at 11:09 AM and she stated there was a lot of "back and forth" about the infection control policy with the new facility ownership. She stated all staff receive PPE and infection control training during orientation, yearly during competency training and in-services as needed.

The Administrator was notified of immediate jeopardy on 10/23/24 at 5:47 PM.

The facility provided the following credible allegation of IJ removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of noncompliance.
On 10/23/2024, during the annual certification survey for Blumenthal Health and Rehabilitation, it was noted that the facility had multiple residents affected by COVID. These residents were noted to be located on more than one hallway throughout the facility. During the survey it was noted that multiple staff did not employ appropriate source control throughout the facility. The facility did not initiate broad-based testing on all staff and residents with the increase in COVID

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 49	F 880		

cases throughout the facility. It is also noted that the facilities policy did not meet the CDC's guidance related to testing.

On 10/23/24, the Director of Nursing and Infection Preventionist completed broad-based testing on all staff and residents within the facility. The facility will complete testing on all residents and staff twice per week until there is a 14-day interval of no new positive cases. The Infection Preventionist was notified on 10/24/24 and will be responsible for continuing testing until resolution of the outbreak.

Specify action the entity will take to alter the process or system to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed.
On 10/23/2024 the Regional Nurse Consultant educated the Director of Nursing, Staff Development Coordinator/Infection Preventionist, and the Unit Managers regarding Special Droplet Contact Precautions when a resident tested positive for COVID-19. All staff, including medical director and Nurse Practitioner, will perform hand hygiene using soap and water and/or alcohol-based hand rub before entering and before exiting the room. All staff, including medical director and nurse practitioner will wear a gown when entering the room, remove before exiting the room. All staff, including medical director and nurse practitioners, will wear an N95 when entering the room and remove before exiting the room. All staff, including the medical director and nurse practitioner will wear eye protection such as a face shield or goggles when entering the room and remove them before exiting the room. All staff, including the medical director and nurse practitioner will wear gloves

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 50	F 880		

when entering the room and remove them before leaving the room. Education completed 10/23/2024.

On 10/23/2024 the Director of Nursing, Staff Development Coordinator, and the Unit Managers initiated education with current staff and providers, including the medical director and nurse practitioners, regarding source control to include wearing face mask throughout the building during outbreak status regardless of if they are in a covid positive room or not.

On 10/23/2024 the Director of Nursing, Staff Development Coordinator, and the Unit Managers initiated education with current staff and providers, including the medical director and nurse practitioners, regarding Special Droplet Contact Precautions when a resident test positive for COVID-19. All staff, including the medical director and nurse practitioners, will perform hand hygiene using soap and water and/or alcohol-based hand rub before entering and before exiting the room. All staff, including the medical director and nurse practitioner, will wear a gown when entering the room, remove before exiting the room. All staff including the medical director and nurse practitioner will wear an N95 when entering the room and remove before exiting the room. All staff, including the medical director and nurse practitioners will wear eye protection such as a face shield or goggles when entering the room and remove them before exiting the room. All staff, including the medical director and nurse practitioners, will wear gloves when entering the room and remove them before leaving the room. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 51	F 880		

agency staff, will receive education prior to the start of their shift in person. This education will be by 10/24/24.

On 10/23/2024 the Regional Nurse Consultant educated the Director of Nursing, Staff Development Coordinator, and the Unit Managers regarding how to properly Don Personal Protective Equipment. The gown will fully cover the torso from neck to knees, arms to end of wrists, and wrap around the back. Then fasten behind neck and waist. Once the gown is fastened, the mask or respirator will be secure with ties or elastic bands at middle of head and neck and ensure the flexible band to nose bridge fits properly. The fit of the mask should be snug to the face and below chin. All staff, including the medical director and nurse practitioners will then Fit-check respirator by gently exhaling while blocking any paths for air to escape. If air is escaping, reposition the respirator and check again until you feel no air escaping. All staff, including the medical director and nurse practitioners will then place goggles or face shield over their face or eyes and adjust to fit. Then the staff will don the glove and extend to cover wrist of isolation gown. Education completed 10/23/2024.

On 10/23/2024 the Regional Nurse Consultant educated the Director of Nursing, Staff Development Coordinator, and the Unit Managers regarding how to properly Doff Personal Protective Equipment. All staff, including the medical director and nurse practitioners will use a gloved hand, grasp the palm area of the other gloved hand and peel off the first glove, hold removed glove in gloved hand, slide fingers of ungloved hand under remaining glove at wrist and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 52	F 880		

peel off second glove over first glove. All staff, including the medical director and nurse practitioners will then discard gloves in a waste container. All staff, including the medical director and nurse practitioners will then remove goggles or face shield from the back by lifting head band or earpieces. Otherwise, discard in a waste container. All staff, including the medical director and nurse practitioners will unfasten the gown ties and take the gown off by taking care that sleeves don't contact your body when reaching for ties. The gown will then need to be pulled away from neck and shoulders, touching inside of gown only. All staff, including the medical director and nurse practitioners, will then remove the mask or respirator by grasping the bottom ties or elastics, then the ones at the top, and remove without touching the front and discarding in a waste container. All staff, including the medical director and nurse practitioners, will then wash their hands or use an alcohol-based hand sanitizer immediately after removing all personal protective equipment. Education completed 10/23/2024.

On 10/23/2024 the Director of Nursing, Staff Development Coordinator, and the Unit Managers initiated education regarding how to properly Don Personal Protective Equipment with current staff. The gown will fully cover the torso from neck to knees, arms to end of wrists, and wrap around the back. Then fasten behind neck and waist. Once the gown is fastened, the mask or respirator will be secure with ties or elastic bands at middle of head and neck and ensure the flexible band to nose bridge fits properly. The fit of the mask should be snug to the face and below chin. All staff, including the medical director and nurse practitioners will then Fit-check respirator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 53	F 880		

by gently exhale while blocking any paths for air to escape. If air is escaping, reposition the respirator and check again until you feel no air escaping. All staff, including the medical director and nurse practitioners will then place goggles or face shield over their face or eyes and adjust to fit. All staff, including the medical director and nurse practitioners will don the glove and extend to cover wrist of isolation gown. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift in person. Education will be completed by the Staff Development Coordinator or Director of Nursing.

On 10/23/2024 the Director of Nursing, Staff Development Coordinator, and the Unit Managers initiated education regarding how to properly Doff Personal Protective Equipment with current staff. All staff, including the medical director and nurse practitioners will use a gloved hand, grasp the palm area of the other gloved hand and peel off the first glove, hold removed glove in gloved hand, slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove. All staff, including the medical director and nurse practitioners will then discard gloves in a waste container. The staff will then remove goggles or face shield from the back by lifting head band or earpieces. Otherwise, discard in a waste container. All staff, including the medical director and nurse practitioners will unfasten the gown ties and take the gown off by taking care that sleeves don't contact your body when reaching for ties. The gown will then need to be pulled away from neck and shoulders, touching inside of gown only. All staff, including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 54	F 880		

the medical director and nurse practitioners will then remove the mask or respirator by grasping the bottom ties or elastics, then the ones at the top, and remove without touching the front and discarding in a waste container. All staff, including the medical director and nurse practitioners, will then wash their hands or use an alcohol-based hand sanitizer immediately after removing all personal protective equipment. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift in person. Education will be completed by the Staff Development Coordinator or Director of Nursing.
Any staff that did not receive education on 10/23/24 will receive education by the beginning of the next scheduled shift by the Staff Development Coordinator. The Staff Development Coordinator will be responsible for tracking staff that still require education. The education will be added to the orientation process. Staff Development Coordinator was notified of this responsibility on 10/24/24.

On 10/24/24 the corporate education department reviewed and updated the policy related to COVID-19 to assure that it reflected the CDC's recommendations for broad based testing and appropriate source control during an identified outbreak. Regional Nurse educated the Director of Nursing, Administrator, Medical Director, and Staff Development Coordinator/Infection Prevention on the updated policy for Infection control prevention on 10/24/2024.

On 10/24/24 the infection preventionist placed a call to the local health department for guidance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 55	F 880		

There were no additional recommendations from the health department regarding the COVID-19 outbreak. The facility will continue to provide updates to the local health department as new cases arrive.

The Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 10/25/24

The facility's credible allegation of IJ removal was validated on 10/25/24 by the following:
An interview with the DON was conducted on 10/25/24 revealed all residents in the facility and all staff members entering the facility were tested for COVID. The facility identified 6 more COVID+ residents on Wednesday, 10/23/24 and one staff member on Friday, 10/25/24. No positive cases were identified on Thursday 10/24/24.

The IP began in-servicing of all staff on donning of PPE, including an N95 mask for all who enter a COVID+ room. All staff on-site were fit-tested for N95 masks and all staff who enter the building in the following days will be fit-tested prior to being allowed to work. Signed rosters reviewed. All staff completed hand hygiene competency including nursing, dietary, housekeeping, and laundry.
All staff on multiple hallways were observed on 10/24/24 and 10/25/24 wearing masks, donning proper PPE before entering COVID+ rooms and performing hand hygiene prior to going into a resident's room and after performing care.

In an interview with Nurse #1 on 10/25/24 at 5:59 PM she stated PPE and handwashing in-services were completed on Wednesday, 10/23/24. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/BLUMENTHAL	3724 WIRELESS DRIVE GREENSBORO, NC 27455

(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
F 880	Continued From page 56	F 880		

was wearing an N95 mask appropriately.
An interview was conducted with the Medical Records Clerk on 10/25/24 at 6:00 PM. She stated she completed handwashing and COVID in-services Wednesday, 10/23/24. She was wearing an N95 mask appropriately.

On 10/25/24 at 6:02 PM an interview was conducted with Nurse Aide #7 and they stated they received education on PPE and handwashing in the past few days. She was wearing an N95 mask appropriately.

An interview was conducted with Nurse Aide #8 on 10/25/24 at 6:03 PM. She stated she received education on handwashing and PPE past few days. She was wearing an N95 mask appropriately.

On 10/25/24 at 6:06 PM an interview was conducted with Nurse Aide #9 and she stated she received education on PPE and handwashing on10/25/24. She was wearing an N95 mask appropriately.

On 10/25/24 at 6:07 PM an interview was conducted with Med Aide #1 and she stated she received abuse, handwashing, and PPE education over the last few days.

The IJ removal date of 10/25/24 was validated.