STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care/Greenville	2578 West Fifth Street Greenville, NC 27834

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48230 Based on record review and staff interviews, the facility failed to maintain documentation of grievances and evidence of the result of all grievances for 7 of 7 months reviewed. Findings included: Review of the facility policy dated 1/23/2020 titled Grievances read in part: (4) The Administrator will maintain a file for tracking and referencing grievances received and responses provided for a period of 3 years. A review of the grievance logs from June 2024 to January 2025 revealed all logs from June 2024 to January 2025 were unavailable. In a telephone interview with previous Administrator #2 on 1/28/25 at 2:40 PM he stated when he left employment at the facility two weeks ago the grievance log binder was on the shelf behind the desk in the Administration office. In an interview with current Administrator #1 on 1/28/25 at 3:30 PM she stated she had been unable to locate the grievance log binder for the time period of June 2024 to January 2025. She stated she would continue to search for it. In a follow-up interview with Administrator #1 on 1/30/25 at 11:00 AM she stated she still had not located the missing grievance log binder covering the time frame of June 2024 to January 2025. She was aware complete grievance logs including the result of the grievance investigation were to be maintained for three years or longer.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48295 Based on record review, and staff interviews and Pharmacist interviews, the facility failed to provide care according to professional standards when Nurse #1 borrowed medication from Resident #6 to administer to Resident #5. The findings included: Resident #6 was admitted to the facility on [DATE] with diagnoses that included diabetes with neuropathy (nerve pain). Physician orders dated 10/19/24 for Resident #6 revealed an order for gabapentin (a medication used to treat nerve pain) 100 milligrams (mg) to be administered once a day. The admission Minimum Data Set (MDS) assessment for Resident #6 dated 10/22/24 revealed she was cognitively intact. Resident #6 was no longer at the facility and was not available for interview. Resident #5 was admitted to the facility on [DATE] with diagnoses that included pain of lower extremities. Physician orders dated 10/19/24 for Resident #5 revealed an order for gabapentin 100 mg to be administered 3 times a day for pain. The admission Minimum Data Set (MDS) assessment for Resident #5 dated 10/22/24 revealed he was moderately cognitively impaired. Review of the Medication Administration Record (MAR) for Resident #5 for the month of October 2024 revealed the ordered gabapentin 100mg had been signed off as administered by Nurse #1 on 10/19/24 at 9:00 am and 2:00 pm. Resident #5 was no longer at the facility and was not available for interview. During an interview with Administrator #2 on 1/29/25 at 11:43 am he stated he was the Administrator in October of 2024 and recalled that Resident #5's family member had a concern that Nurse #1 borrowed 2 pills of gabapentin (not sure of the dosage) from Resident #6 and administered them to Resident #5. He stated Nurse #1 told the facility she borrowed the gabapentin from Resident #6 to administer to Resident #5 because gabapentin was not in the ADS. Administrator #2 stated Nurse #1 should not have borrowed the gabapentin and should have called the on-call pharmacist if the gabapentin was not available. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview with Nurse #1 on 1/29/25 at 7:25 pm she stated she borrowed 2 capsules of gabapentin 100 mg from Resident #6 and administered the capsules to Resident #5 on 10/19/24, one capsule at 9:00 am and one capsule at 2:00 pm, for a total of 2 capsules borrowed and administered. Nurse #1 stated she borrowed the gabapentin because Resident #5 was a new admission, his medication supply had not yet come in, and the gabapentin was not available in the automated dispensing system (a pharmacy device designed to provide secure surplus medication storage on patient care units). She further stated that she should have called the on-call pharmacist to have the gabapentin called into the back-up pharmacy but did not. Nurse #1 stated she did not know she could not borrow medications from one resident to give to another resident. An interview was conducted with the Director of Nursing (DON) on 1/30/25 at 9:55 am. The DON stated Administrator #2 told her on 10/21/24 that Nurse #1 borrowed 2 gabapentin 100 mg capsules from Resident #6 and administered them to Resident #5 on 10/19/24. The DON further indicated she completed an investigation that revealed Nurse #1 borrowed 2 gabapentin 100 mg capsules for Resident #5 on 10/19/24 because he was newly admitted , and his medication supply had not yet arrived from the pharmacy. The DON stated the facility had a process in place to ensure residents did not miss any doses of prescribed medications while they waited for the pharmacy to deliver their medications. She stated Nurse #1 should not have borrowed medications from Resident #6 but should have first attempted to obtain the needed medication from the on-site automated dispensing system and if it was not available to call the on-call pharmacist to have the medication called in to a local pharmacy for delivery to the facility. During an interview with the Regional Director Clinical Consultant on 1/29/25 at 10:15 am she stated she was contacted by Administrator #2 on 1/22/24 and asked to assist with an investigation where Nurse #1 borrowed gabapentin from Resident #6 and administered it to Resident #5. The Regional Director Clinical Consultant stated she assisted the DON in the completion of the investigation and formulated a plan of correction on borrowing medications and the use of the back-up medication system. She further indicated that the nurse had borrowed the gabapentin for Resident #5 because a family member had demanded that it be administered right away, and the medication was not available in the automated dispensing system. During an interview with the Pharmacist on 1/30/25 at 10:00 am he stated Resident #5 was admitted to the facility on the evening of 10/18/24 and his order for gabapentin 100 mg was received in the pharmacy on 10/19/24 at 12:31 am, was filled and sent out to the facility for the next night's delivery on 10/20/24. The interview revealed Nurse #1 should not have borrowed medications from Resident #6 to administer to Resident #5. The Pharmacist went on to explain Nurse #1 should have obtained the medication from the automated dispensing system and if it was not available, she should have called the on-call pharmacist, and the medication would have been called into a local back-up pharmacy for the medication to be delivered to the facility. The facility provided the following corrective action plan with a completion date of 10/24/2024: Address how the facility will correct the deficiency as it relates to the individual. Nurse #1 was suspended by the Administrator on 10/21/2024 pending investigation. The Administrator submitted a report to North Carolina Department of Health and Human Services (NCDHHS). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medications for Resident #5 were delivered on 10/19/2024. Medications were replaced for Resident #6 by the facility at the facility's cost. Address how the facility will act to protect residents in similar situations. A 100% admissions audit for the last 14 days (October 8-22) was performed by the Regional Director of Clinical Services on 10/22/2024 for medication delivery within 24 hours of admission. All residents admitted in the last 14 days had all ordered medications on the medication cart. Address what measures will be put into place or systemic changes made to ensure that the problem does not recur. All licensed nurses and medication aides were educated by the Staff Development Coordinator and DON on using the automated dispensing system (a pharmacy device designed to provide secure surplus medication storage on patient care units) for medications and never borrowing medications from one resident to give to another resident on 10/22/2024 and 10/23/2024. The DON ensured all licensed nurses had access to the automated dispensing system on 10/21/2024. Indicate how the facility will monitor its performance to make sure that solutions are sustained. The DON or Unit Manager will audit all new admissions to verify that medications were received within 24 hours of admission as they are admitted to the facility. These audits will occur 5 times a week for 2 weeks then 3 times a week for 2 weeks to ensure compliance has been achieved. The plan of correction must provide dates when corrective action will be completed: Compliance date: 10/24/2024 The facility's corrective action plans date of compliance of 10/24/24 was verified on 1/30/2025 by review of the following: Interviews and record review verified Resident #6's gabapentin was replaced on 10/25/24 by the facility at the facility's expense. Record review revealed a 100% admissions audit was completed 10/8/24 through 10/22/24 to ensure new admission medications were received. Interviews with Nurses revealed they were educated on how to obtain medications for new admissions and not to borrow medications from one resident to administer to another. Record reviews and interviews confirmed audits were performed 5 times a week for 2 weeks and then 3 times a week for 2 weeks to ensure compliance was achieved. The compliance date of 10/24/2024 was validated.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 Based on record review and staff interviews, the facility failed to have a complete and accurate Medication Administration Record (MAR) for 1 of 3 residents (Resident #11) reviewed for record accuracy. Findings included: Resident #11 was admitted to the facility on [DATE]. Resident #11's Physician's orders included: - Administer enteral feed Jevity 1.5, 237 milliliters (mls) (1 carton) twice a day at 5:00 AM and 11:00 PM with an order date of 10/23/24. - Flush feeding tube every 6 hours at midnight, 6:00 AM, noon and 6:00 PM with 150 mls of free water with an order date of 10/23/24. Resident #11's December 2024 MAR revealed the enteral feed had not been documented as given or refused on: -12/10/24 at 5:00 AM by Nurse #2 -12/19/24 at 5:00 AM by Nurse #3 -12/24/24 at 5:00 AM by Nurse #4 -12/26/24 at 6:00 AM by Nurse #2 The December 2024 MAR further revealed the 150 mls of free water was not documented as given or refused on: -12/10/24 at 6:00 AM by Nurse #2 -12/12/24 at 6:00 AM by Nurse #4 -12/19/24 at 6:00 AM by Nurse #3 -12/24/24 at 6:00 AM by Nurse #4 -12/26/24 at 6:00 AM by Nurse #2 (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	In a telephone interview on 1/28/25 at 3:10 PM with Nurse #3 she stated she forgot to sign the MAR after giving the enteral feed and 150 ml free water flush to Resident #11 on 12/19/24. She further stated she was aware all medications should have been signed off in the MAR as soon as they were given. In a telephone interview on 1/28/25 at 6:40 PM with Nurse #4 she stated she must have forgotten to sign the MAR after giving the 150 ml free water flush on 12/12/24 and the enteral feed and free water flush to Resident #11 on 12/24/24. Nurse #1 revealed she was aware all medications were to be signed off in the MAR as soon as they were given. In a telephone interview on 1/29/25 at 9:27 AM with Nurse #2 she stated she must have forgotten to sign the MAR on 12/10/24 and 12/26/24 after giving the enteral feed and 150 ml free water flush as well as after giving the free water flush on 12/12/24 to Resident #11. Nurse #2 revealed she was aware all medications needed to be signed off in the MAR as soon as they were given. An interview with the Director of Nursing (DON) was conducted on 1/29/25 at 9:40 AM. The DON stated all medications were to be signed off in the MAR as soon as they were given. She further stated that if a medication was not given, the Nurse was to use one of the codes available in the MAR to indicate why it was not given. There should not have been empty spaces in the MAR where it should have been signed off by the Nurse. In an interview with Administrator #1 on 1/29/25 at 9:50 AM she revealed all medications were to be signed off in the MAR as soon as possible, and available coding was to be used if medication was not given. The signature space for the medication should never be left empty. She stated all new hires including agency staff are educated regarding signing the MAR.