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	05/31/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48295 Based on records review, and staff interviews, the facility failed clarify code status in the residents' record for 1 (Resident #59) of 23 residents reviewed for Advance Directives. Findings included: Resident #59 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included heart failure, coronary artery disease, and diabetes. Resident #59's physical chart was observed to contain a Full Code (cardiopulmonary resuscitation (CPR) would be performed if the resident stopped breathing and heart stopped beating) Agreement dated [DATE] signed by Resident #59's family member. The chart further contained a Do Not Resuscitate (DNR) document dated [DATE] with no expiration date, and a physician's order dated [DATE] that indicated Resident #59's code status was a full code. A review of Resident #59's electronic medical record (EMR) and an order dated [DATE] revealed Resident's #59's code status was a full code. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #59 was cognitively intact. A review of Resident #59's care plan dated [DATE] revealed that he had an advance directive of full code in place with a start date of [DATE]. The goal was that the advance directive would be honored by staff. In an interview with Nurse #5 on [DATE] at 12:48 pm she stated that she checked the electronic medical record (EMR) for code status when a resident's health declined. Nurse #5 accessed Resident # 59's EMR and the information indicated Resident #59 was a full code. She then checked Resident #59's physical chart under advance directives and it contained an advance directive for full code dated [DATE] and a DNR form with an effective date of [DATE] for Resident # 59. She stated that if he had experienced cardiopulmonary arrest (cessation of pulse and respirations) that she would have honored the DNR because it had the most current date. (continued on next page)

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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON on [DATE] at 12:50 pm she stated that the DNR form should not have been on the physical chart and should have been removed by Medical Records when Resident #59's advance directive changed to a full code. The ADON then removed the DNR form from the physical chart. During an interview with the Medical Records clerk on [DATE] at 12:54 pm she indicated that she filed Resident #59's advance directive of full code in his physical chart and should have removed the DNR document. During an interview with the Admissions Director on [DATE] at 1:08 pm revealed that she was responsible for intake paperwork when residents were admitted to the facility. She stated when Resident # 59 was readmitted to the facility on [DATE] after a hospital stay that he chose to be a full code. She further indicated that the unit nurses should have verified the code status with the resident and should have removed the Do Not Resuscitate document from the physical chart and given it to Medical Records to be filed. She stated that after Resident #59 was readmitted to the facility on [DATE] that she called his resident representative (RR) and made her aware of Resident 59's desire to be a Full Code. She further stated that she emailed the advance directive form to the RR to be signed but had not yet received the updated signed Full Code Agreement. The Full Code Agreement on the chart was from a previous advance directive update for Resident # 59. During an interview with the Administrator on [DATE] at 9:46 am he stated the DNR document should not have been on Resident 59's chart if he was a full code.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on record review and staff and Nurse Practitioner interviews the facility failed to protect a cognitively intact resident from verbal abuse by another cognitively intact resident that escalated into physical abuse when Resident #216 called Resident #51 a fat b**** and Resident #51 proceeded to purposefully run into Resident #216 with her electric motorized wheelchair (WC) resulting in an abrasion and bruising to Resident #216's right leg. This was for 2 of 4 residents reviewed for abuse. Findings included: Resident #51 was admitted to the facility on [DATE] with a diagnosis of stroke (disrupted blood flow to the brain). A review of Resident #51's care plan revealed in part a focus area initiated on 9/26/23 and last reviewed on 11/13/23 of verbally abusive behavior. The goal was for Resident #51 to decrease her instances of verbally abusive behaviors by 50 percent through the next review. Interventions included not to argue with Resident #51, and to reinforce the unacceptability of verbal abuse. A review of Resident #51's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. She had no behaviors in the assessment look-back period. She had functional limitation in range of motion of her upper and lower extremity on one side. She used a motorized WC and was independent with wheeling this 50 feet making 2 turns. Resident #216 was admitted to the facility on [DATE] with a diagnosis of stroke (disrupted blood flow to the brain). A review of Resident #216's care plan revealed in part a focus area initiated on 11/13/23 and last reviewed on 12/22/23 of physically aggressive behavior (pulled call bell out of wall and threw it in the Director of Nursing's (DON) office, wrote a letter to the Business Office Manager threatening to kill her). The goal was for aggressive behaviors to reduce by 50 percent. Interventions included reinforce unacceptability of verbal abuse, and one to one until further notice. A review of Resident #216's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. He had verbal behavioral symptoms directed towards others on 1 to 3 days of the assessment look-back period. He had functional limitation in range of motion of his upper and lower extremity on one side. He used a WC for mobility. Resident #216 was able to wheel this 50 feet making 2 turns with partial/moderate assistance. He received anti-psychotic medication on a routine basis. A review of a psychiatric progress note for Resident #216 dated 12/19/23 revealed in part Resident #216 had worsening mood lability (constantly undergoing change), increasing irritability, and restlessness. He had been placed on 24 hour 7 day per week supervision by nursing staff, with little improvement from redirection and/or behavioral intervention. In an effort to decrease his mood lability and paranoid behavior his antipsychotic medication dose was increased. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a nursing progress note for Resident #216 dated 1/13/24 at 4:11 PM written by Nurse #2 revealed in part Resident #216 was seated in his WC in the doorway of his room with his sitter (NA #4) in attendance. Resident #51 had stopped in her motorized WC and began talking with Resident #216. Resident #216 became upset and told Resident #51 Go back to your hall. You don't have any business over here. Resident #51 replied to Resident #216 that she wasn't going anywhere and Resident #216 did not own the hall. Resident #216 called Resident #51 names, Resident #51 turned her WC around and went back towards the nurses station while both residents continued shouting at each other. Resident #51 then propelled herself into Resident #216 as he continued to sit in his doorway. Resident #216 sustained 2 small skin tears to his right lower extremity that were cleaned with normal saline and a dressing was applied. Resident #216's vital signs were taken. Resident #216 was his own Responsible Party, and he called the police. Resident #51 no longer resided at the facility. Attempts at telephone interview with Resident #51's family member on 5/29/24 at 11:56 AM, and 5/30/24 at 8:08 AM and 3:29 PM were unsuccessful. On 5/29/24 at 5:21 PM a telephone interview with Nurse #2 indicated on 1/13/24 on the 3PM-11PM shift she was at the nurses station and could see Resident #51 go down Resident #216's hall in her motorized WC and stop at Resident #216's door where Resident #216 was seated in his WC. She reported she could not hear what was being said, but she could see the expressions on both residents' faces were angry and they were exchanging words. Nurse #2 stated she went down, separated the residents, asked Resident #51 to head back towards her room, and asked Resident #216 to head back into his room. She reported Resident #51 was headed down the hall towards her room, and then suddenly turned her motorized WC around, headed straight towards Resident #216 who was still seated in his WC in the doorway of his room, and ran her WC into his legs. Nurse #2 stated the two were separated again, and Resident #51 was escorted to her room. She went on to say Resident #216 had a scrape on his leg, she cleaned it, put a dry dressing on it, and offered to send Resident #216 to the hospital for evaluation but he refused. Nurse #2 reported Resident #216 called the police, and pressed charges against Resident #51 for assault. On 5/29/24 at 4:00 PM an interview with NA #1 indicated she was working on the hall where Resident #216 resided on 1/13/24 on the 3PM-11PM shift. She stated Resident #216 had a sitter (NA #4) with him and was receiving one to one supervision. NA #1 reported that while she was performing her rounds (inspection) of residents that shift, she saw Resident #51, who was in her motorized WC, come past Resident #216 while Resident #216 was sitting in his WC in the doorway of his room. NA #1 went on to say she heard Resident #216 call Resident #51 a fat b**** and tell Resident #51 not to come down his hall again. NA #1 further indicated when Resident #216 got angry, it took him a long time to stop being angry. She stated Resident #51 was returning insults to Resident #216, calling him a racist. NA #1 stated she spoke with Resident #216 and reinforced to Resident #216 that it was not okay for him to call people names. She reported Resident #51 turned around and went back towards her room. NA #1 stated a few minutes later, when she was in a room next to Resident #216's, she heard a commotion. She went on to say she came out into the hall, and Resident #51 had run into Resident #216 with her WC. NA #1 reported Resident #216 had a small open area on his leg and a bruise. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 4:21 PM an interview with NA #2 indicated she was assigned to Resident #51 on 1/13/24 on the 3PM-11PM shift. NA #2 stated Resident #51 was independent with her motorized WC. NA #2 further indicated she had witnessed a verbal interaction between Resident #216 and Resident #51 prior to 1/13/24, where Resident #51 told Resident #216 he got his pastoral degree online, and Resident #216 replied to Resident #51 that she got her wigs online for two dollars. She reported on 1/13/24 she witnessed an exchange of words between Resident #216 and Resident #51 where Resident #51 was telling Resident #216 he couldn't tell her where she could go. NA #2 went on to say Nurse #2 went down to Resident #216 and Resident #51, separated them, and asked Resident #51 to try not to come down Resident #216's hall. She stated she then saw Resident #51 going towards her room in her WC, but Resident #51 suddenly turned her WC around, quickly drove back towards Resident #216, and hit him with her WC. NA #2 stated she had run after Resident #51, attempting to catch her before she got to Resident #216, but had she not been able to. She reported Resident #216's one to one sitter (NA #4) had been seated at a table just outside Resident #216's door and stood up when she saw Resident #51 coming towards them, but she had not been able to prevent the contact. NA #2 reported Resident #51 had never done anything physically like that before, and she didn't think anyone expected the verbal altercation to turn physical. She went on to say Resident #216 appeared shocked after the incident and had some open skin on his leg that needed to be cleaned and bandaged. NA #2 reported Resident #51 was visibly upset after the incident. She reported she escorted Resident #51 down the hall and took Resident #51's vital signs, which were normal, after Resident #51 got to her room. NA #2 stated Resident #51 normally got into bed at this time daily, so she was assisted into her bed. She went on to say Resident #51 was not able to get out of bed into her WC herself and remained in bed the rest of the evening. NA #2 indicated an investigation was conducted of the events, and everyone involved had to write witness statements. She went on to say the incident information was passed along in shift report. She stated she cared for Resident #51 multiple times after the incident and was not aware of any further interactions between Resident #51 and Resident #216. On 5/29/24 at 4:59 AM an interview with the Assistant Director of Nursing (ADON) indicated on 1/13/24 she was at the nurses station and observed Resident #51 and Resident #216 get into a verbal altercation. She stated she couldn't hear what they were saying, but they were getting loud. She went on to say the NA was trying to defuse the situation, but Resident #51 continued to yell. She reported she recalled Resident #216 was seated in his WC in the doorway of his room. The ADON went on to say she recalled Resident #216 had been wearing shoes and had his paralyzed leg on one footrest of his WC with his other leg resting on the floor as he used this leg when he wanted to propel his chair. She stated she did not see Resident #51 make impact with Resident #216. The ADON stated after the incident, she spoke with both residents. She reported Resident #216 had already called the police himself to press charges against Resident #51, and Resident #51 was tearful and reported the incident to her family. The ADON stated after the incident, efforts were made to keep the residents separated. She reported this was done by instructing Resident #216's one to one sitters to avoid situations where the two residents would meet and asking Resident #51 to avoid travelling down Resident #216's hall when she visited with other residents. Attempts for telephone interview with NA #4, who was Resident #216's one to one sitter on 1/13/24 on the 3PM-11PM shift, on 5/30/24 at 8:06 AM and 3:40 PM, and on 5/31/24 at 8:12 AM were unsuccessful. Resident #216 no longer resided at the facility. Attempts for telephone interview with Resident #216 on 5/30/24 at 10:08 AM and 3:42 AM, and on 5/31/24 at 9:07 AM were unsuccessful. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 8:41 AM in an interview the Social Worker (SW) reported although he did not witness the event on 1/13/24 between Resident #216 and Resident #51, he spoke with both residents afterwards. The SW stated Resident #126 admitted to calling Resident #51 names. The SW further indicated Resident #216 initially pressed assault charges against Resident #51, but Resident #216 later dropped the charges expressing remorse for insulting Resident #51. The SW stated initially, Resident #51 denied hitting Resident #216 with her WC, but when he interviewed the witnesses to the event, it was determined she had. He further indicated that both residents were angry after the incident. He went on to say Resident #216 had wanted to apologize to Resident #51, but Resident #51 had refused to accept. The SW reported he counseled both residents after the incident. He went on to say he asked the residents to stay away from each other, and if they did ever happen to cross paths in the hallway, for each to be the bigger person and walk away. The SW stated he asked Resident #51 to agree that if she needed to travel past Resident #216's room, she would have someone escort her. He went on to say he asked both residents about potentially moving rooms, so they weren't residing on the halls that were close to one another, but both refused. On 5/31/24 at 9:37 AM a telephone interview with the Nurse Practitioner (NP) indicated she was notified of the incident between Resident #51 and Resident #216 on 1/13/24. She stated she spoke with both residents after the incident. The NP reported Resident #51 indicated she had purposefully gone down Resident #216's hall even though Resident #51 was familiar with Resident #216, knew he could be antagonistic, and that Resident #51 did not care for Resident #216. She reported Resident #216's injury from the incident had been very minor and healed in a couple of days. The NP stated neither resident had any long term negative effects from the encounter. She reported multiple safety interventions were in place including psychiatry involvement, behavioral contracts, medication changes, and one to one staff supervision. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 12:31 PM in an interview the Administrator reported there had been some issues with Resident #216 threatening staff after his admission to the facility that resulted in Resident #216 being placed on one to one supervision with staff on 10/31/23 that continued until Resident #216's planned discharge from the facility on 2/5/24. He reported he was able to speak with Resident #216's family member when these issues started and discovered that although Resident #216 had some verbally abusive behaviors prior to his stroke, these had been made worse by the affect of the stroke disrupting his inhibitions. He indicated Resident #51 had some behavioral issues as well, but these had mostly been verbal abuse of staff members and false accusations. The Administrator stated previously, Resident #51 had been very courteous with other residents. He went on to say on 1/13/24, Resident #216 had been extremely verbally inappropriate with Resident #51 and even with staff members trying to intervene, Resident #51's personality just did not allow her to just turn and leave the situation. The Administrator stated Resident #51 told him she was insulted by what Resident #216 said to her that day, and that no one had ever spoken like that to her before. He went on to say initially when he spoke with Resident #51, she denied the incident. He stated after talking with Resident #51 and explaining to her that the potential consequences of her deliberately hitting another resident with her motorized WC would be her not being able to use a motorized WC in the facility, she became tearful, admitted to hitting Resident #216 with her WC on purpose. The Administrator reported Resident #51 expressed regret for doing it. He stated that even prior to the incident on 1/13/24, he had asked Resident #51 to visit residents on Resident #216's hall via an alternate route rather than going past Resident #216's room, because Resident #216 had made statements before that included Resident #51 thought she was a queen and did not belong on his hall. He reported just a couple of days prior to the incident, Resident #51 had confirmed to him that she was able to visit her friends via an alternate route that would not include her going past Resident #216's room. He went on to say on 1/13/24, Resident #51 had deliberately gone to Resident #216's room despite this. He stated after the incident on 1/13/24, Resident #51 remained true to her word and there had been no further incidents. The Administrator reported it had been very challenging managing Resident #216's behaviors. He stated at one point he had even involved a mobile crisis unit from the local hospital in an attempt to get Resident #216 some intervention that would stabilize him but was told there was nothing they could do.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on staff, nurse practitioner, and resident interviews and record review the facility failed to protect a resident's right to be free from misappropriation of a narcotic medication (oxycodone) for 2 of 2 residents reviewed for misappropriation of property. (Resident #84, Resident #72) Findings included: a. Resident #84's Minimum Data Set assessment dated [DATE] revealed he was assessed as cognitively intact. He was assessed to have rare pain which rarely or never affected his sleep, therapy activities, and day to day activities. Review of Resident #84's orders revealed on 2/14/23 he was ordered oxycodone 10 milligrams (mg) tablet by mouth at bedtime daily. Review of Resident #84's Medication Administration Record (MAR) for July 2023 revealed on 7/10/23 he was documented to have been administered oxycodone 10 mg at 9 PM by Medication Aide #1. Review of Resident #84's controlled drug reconciliation form for July 2023, used to keep track of the doses of oxycodone for Resident #84, revealed on 7/10/23 at 8 PM Resident #84's oxycodone 10 mg was signed out by Medication Aide #1. b. Resident #72's Minimum Data Set assessment dated [DATE] revealed she was assessed as cognitively intact. She denied pain presence at the time of the assessment. Review of Resident #72's orders revealed on 7/4/23 she was ordered oxycodone 5 mg one tablet daily by mouth every eight hours as needed for pain. Review of Resident #72's Medication Administration Record (MAR) for July 2023 revealed on 7/10/23 she was documented to have been administered oxycodone 5 mg at 8 PM by Medication Aide #1. Review of Resident #72's controlled drug reconciliation form for July 2023, used to keep track of the doses of oxycodone for Resident #72, revealed on 7/10/23 at 6 PM Resident #72's oxycodone 5 mg was signed out by Medication Aide #1. Review of Resident #72's progress notes for 7/10/23 revealed no progress note indicated Resident #72 had requested her as needed oxycodone 5 mg or indicated she had pain. Review of a written statement dated 7/11/23 revealed Patient Care Aide #1 wrote on 7/10/23 after he clocked out from work, he was walking behind Medication Aide #1 and saw a packet fall out of Medication Aide #1's bag by the breakroom door. There were two pills in the packet. One white and one pink. He called Medication Aide #2 to ask her about them to find out what type of pills they were. Medication Aide #2 told him to go take a picture but when he returned the packet was not there. Patient Care Aide #1 was not available for interview. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Aide #2 was not available for interview. Review of a written statement dated 7/10/23 revealed Nurse Aide #7 wrote as she was walking to clock into her shift, she noticed the pills in a pill crushing sleeve on the floor. There was a male resident up who was sitting in his doorway. She picked up the pill crushing sleeve with the medications because she did not want the resident to pick up the pills. She then clocked in and went straight to the 500 hall where Nurse #6 was located. She handed Nurse #6 the pill crushing sleeve with the medications in it and explained to her where the medications were found. She documented the time she found the medications to the time handing them to Nurse #6 was about 5 to 6 minutes. There were two pills in the pill crushing sleeve. During an interview on 5/29/24 at 5:24 PM Nurse Aide #7 stated she was starting her shift around 11 PM on 7/10/24 and saw a pill crush sleeve containing two pills on the floor near the timeclock. She picked the pill crush sleeve up with the two medications in it, clocked in, and took the pills to her supervisor, Nurse #6, and explained where she found them. During an interview on 5/29/24 at 7:31 PM, Nurse #6 stated Nurse Aide #7 came to the facility at 11 PM on 7/10/24 and gave her (Nurse #6) a pill crushing sleeve which contained two pills, one pink and one white. She asked Nurse Aide #7 where she found the pills and Nurse Aide #7 stated between room [ROOM NUMBER] and the housekeeping doors to the room where staff clock in and out. She stated upon looking at the pills they appeared to be oxycodone. She used a pill identification application to confirm that the two pills were oxycodone 5mg and oxycodone 10mg. Nurse #4 was working another hall and she (Nurse #6) asked her to come to the 500 hall nursing station to verify what she believed at that point to be oxycodone 5mg and oxycodone 10mg. Nurse #4 also identified the pills were oxycodone 5 mg and oxycodone 10 mg. She then took the pill crushing sleeve with both medications still inside, wrote a note that the medications were found by Nurse Aide #7 and where they were found and that they were both in the same pill crushing sleeve. Then she took another piece of paper and stapled it to make an envelope for the note as well as the medications and pushed this package under the Director of Nursing's locked office door and notified the Director of Nursing. During an interview on 5/29/24 at 3:47 PM Nurse #4 stated she went to Nurse #6's nursing station at the start of 11P-7A shift on 7/10/23 at the 500 hall. Nurse #6 had two pills in a medicine cup and said she needed Nurse #4 to confirm the identity of the pills. Nurse #4 stated she identified them as oxycodone 5 mg and 10 mg respectively and used a drug identification application. Nurse #6 then told Nurse #4 the pills were found on the floor by the time clock in a single pill crushing sleeve. She stated they put the medications in the crush sleeve the way they were found, secured them by pushing them under the locked Director of Nursing's door in a sealed envelope, and notified the Director of Nursing. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an investigational summary dated 7/15/23, written by the Administrator, revealed at approximately 11 PM on 7/10/23 Patient Care Aide #1 observed a small clear plastic bag (pill crushing sleeve) fall to the floor from the carry bag that was being carried by Medication Aide #1. Medication Aide #1 was in the process of leaving her shift as she walked down the 700 hall towards the time clock Patient Care Aide #1 went to look at the plastic sleeve and noted there were two small round pills in the sleeve, one pink and one white. He indicated in his interview that he was concerned and did not want to touch the bag and instead walked around the nursing station and called Medication Aide #2, who was off duty, to ask her how he should handle it. Medication Aide #2 told Patient Care Aide #1 to take the sleeve to Nurse #6. Patient Care Aide #1 returned to where the sleeve was and noted that it was gone. Patient Care Aide #1 then went to Nurse #6 to tell her what he had seen. When he approached her with the story, he learned that Nurse #6 already had the sleeve and pills. A few minutes earlier, as Patient Care Aide #1 was walking away from the sleeve, Nurse Aide #7 was walking down the same hall and observed the sleeve on the floor with two pills in it. She picked it up and brought it to Nurse #6. Nurse #6 used a pill identification application and determined that one pill was oxycodone 5 mg (white pill), and one pill was oxycodone 10 mg (pink pill). Nurse #4 also examined the two pills in the sleeve and confirmed they were both oxycodone 5 mg and 10 mg respectively. The morning of 7/11/23 the Director of Nursing began an investigation and determined that the two oxycodone tablets that fell from Medication Aide #1 were consistent with medication that was located on the medication cart that Medication Aide #1 had on her 200 hall assignment that evening. There were two residents with Physician's orders for oxycodone. One was Resident #84 with an order for oxycodone 10 mg and the other was Resident #72 with an order for oxycodone 5 mg. Documentation on the MAR reflected that both residents were given oxycodone during the shift that Medication Aide #1 was working the medication cart and electronically noted as given by Medication Aide #1. During interviews with each resident (Residents #84 and #72) by the Staff Development Coordinator, both Resident #84 and Resident #72 indicated they did not receive their oxycodone medication from Medication Aide #1 during the shift. Both residents were alert and oriented. Furthermore, Resident #72's order for 5 mg oxycodone was an as needed order and she did not ask for her oxycodone during that shift. The Administrator interviewed Medication Aide #1 at approximately 3 PM on 7/11/23 with the Director of Nursing and Staff Development Coordinator present. Medication Aide #1 denied taking the oxycodone pills or having any intent to take the oxycodone with her out of the facility. Medication Aide #1 was asked to take a drug urine test. She agreed to do so and produced a urine sample, which tested positive for oxycodone. Medication Aide #1 was then asked to explain the positive test results. Medication Aide #1 stated she took some gummies on Sunday before the 4th of July. She stated someone must have put something in them. She denied ever taking oxycodone and confirmed she did not have a prescription for oxycodone. At this point she was asked to write her statement in which she denied any allegation that she had done anything to divert medications. Medication Aide #1 was placed on suspension and a final disciplinary action of termination of employment resulted following a review from the facility's corporate Human Resource Director. Review of a written statement by the Staff Development Coordinator dated 7/11/23 revealed Resident #84 was interviewed by the Staff Development Coordinator, and he stated he did not get his pain medication on 7/10/23 at bedtime. He denied pain or discomfort. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/24 at 11:09 AM Resident #84 stated he remembered a nurse or medication aide had documented he had taken a pain medication last year and he did not take it. He stated he did not remember which staff member he told he did not take the medication, but he told someone. Resident #84 stated he found out from someone that a staff member had documented he had taken the medication when he had not. He concluded he did not have pain as a result that evening and was able to sleep. Review of a written statement by the Staff Development Coordinator dated 7/11/23 revealed Resident #72 was interviewed by the Staff Development Coordinator. Resident #72 stated she did not have pain and did not request her as needed pain pill the evening of 7/10/23. During an interview on 5/30/24 at 10:18 AM Resident #72 stated the Staff Development Coordinator asked her sometime in July 2023 if she had asked for an as needed oxycodone 5 mg tablet the evening before. Resident #72 told the Staff Development Coordinator no; she had not asked for it and did not take any oxycodone the evening in question, but that was all she could really remember from the incident and did not believe she had any pain, or she would have asked for the medication. During an interview on 5/29/24 at 4:08 PM the Staff Development Coordinator stated it was a while ago so she would have a hard time remembering the details, but she was notified either on 7/10/23 or 7/11/23 via phone by Medication Aide #2 that Patient Care Aide #1 had witnessed a pill crush sleeve fall from Medication Aide #1's bag near the timeclock. She stated she notified the Director of Nursing and Administrator. The morning of 7/11/23 when she arrived at the facility, she was notified by someone that two pills, a 5 mg and a 10 mg oxycodone were found on the floor in a pill crush sleeve. The pills in question were secured and pushed under the Director of Nursing's locked door. The Administrator took over the investigation of drug diversion at that point. She was asked to interview Resident #84 and Resident #72 about their pain medications and if they had pain. Both residents denied pain and denied taking pain medication the evening of 7/10/23. She reviewed Resident #84's record to find that at 7/10/23 at 9 PM he was documented 0 for pain, at 7/11/23 at 2:19 AM he was documented 0 for pain, and at 10 AM on 7/11/23 his pain remained a 0. Review of a written statement dated 7/11/23 revealed Medication Aide #1 wrote on 7/10/23 she was on 200 hall and was pulling Resident #84's medications. The only medication she pulled was a narcotic and put it in a crush pack. She then left the cart with the pill and sat it down to try and control a resident on another hall. After handling the situation, she went to handle another situation and clocked out after grabbing her things from the cart. She wrote she did not intentionally take the meds with her. She did not know the medications were somehow still attached to her when she left. Medication Aide #1 was not available for interview. During an interview on 5/30/24 at 3:13 PM, the Director of Nursing verified the information in the investigational summary. She stated that although Medication Aide #1 did test positive for oxycodone, she (the Director of Nursing) was unable to prove other medications were diverted from Resident #84 and Resident #72, but common sense would indicate she had diverted other medications as well which resulted in her positive urine test and the facility terminating her employment and implemented a plan of correction. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/31/24 at 10:02 AM the Nurse Practitioner stated she was notified of the concern of drug diversion on 7/10/23 because she was required to be made aware of the situation. No one suffered any ill outcome due to the drug diversion and residents affected denied pain due to the drug diversions. The facility provided and implemented the following corrective action plan with a completion date of 7/20/23. Problem Identified: The medication aide was clocking out on 7/10/23 when a pouch containing 2 pills, one pink and one white, fell from her personal bag. This was witnessed by another employee. Upon investigation, these medications (Oxycodone 5mg and Oxycodone 10mg) belonged to two residents on 200 hall where the medication aide had been assigned on 2nd shift. Address how corrective action will be accomplished for resident(s) found to have been affected: On the morning of 7/11/23 100% of the resident narcotic count sheets were reviewed, and residents identified with Oxycodone 5mg and 10mg were interviewed to determine if they requested pain medicine and if so, did they receive it. Pain assessments were completed on the identified residents, and both were found to be in no pain at the time assessed. [Medication Aide #1] arrived at the facility at approximately 3 PM on 7/11/23 and was brought into the Administrator's office and was interviewed and terminated prior to her shift. An initial and 5 day report was submitted to DHSR on 7/11/23 at 7:16 PM and 7/15/23 at 6:24 PM respectively. The Greenville City Police were notified on 7/11/23 at 3:00 PM. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: All narcotic count sheets were reviewed by the Regional Nurse for accuracy and possible discrepancies. This was completed on 7/11/23. All alert and oriented residents with Brief Interview for Mental Status (BIMS) score greater than 13 were interviewed by Nursing Management Team to determine whether they were receiving their medications as ordered and requested. This was completed on 7/11/23. Address what measures will be put in place and systemic changes made to ensure that the identified issue does not occur in the future: All licensed nurses and medication aides were educated by the Director of Nursing regarding the abuse policy as it relates to misappropriation and the consequences of diversion. All new licensed employees will receive this education in orientation prior to taking the assignment. This was completed on 7/12/23. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Starting 7/12/24, Narcotic count sheets will be reviewed by DON or designee weekly for discrepancies. Corresponding residents will be interviewed weekly to determine if they are receiving medications as ordered. The audit will consist of 5 residents every week x 12 weeks. The DON or unit manager will present the audits to the Interdisciplinary Team during the facility Quality Assurance and Performance Improvement meeting monthly until compliance is achieved starting 7/12/23. The corrective action plan was reviewed on 5/31/24. Interviews confirmed all staff responsible for medication administration and storage were educated about the facility's abuse policy regarding misappropriation of resident property. Monitoring tools, staff education, and Performance Improvement Plan were reviewed. The corrective action was verified as completed on 7/20/23.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of medications and diagnoses. This was for 2 of 5 residents reviewed for unnecessary medication (Resident #98 and Resident #262). Findings included: 1. Resident #98 was admitted to the facility on [DATE] with a diagnosis of stroke (disrupted blood flow to the brain). A review of Resident #98's quarterly MDS assessment dated [DATE] revealed she received injections on 5 days of the look back period of the assessment and insulin orders and insulin injections on 4 days of the look back period of the assessment. A review of Resident #98's physician orders and Medication Administration Record (MAR) for March 2024 did not reveal any physician's orders for injections, insulin or insulin injections, or documentation injections or insulin injections were administered to Resident #98 in March 2024. On 5/30/24 at 10:14 PM an interview with MDS Nurse #2 indicated she completed the medication section of Resident #98's MDS assessment dated [DATE]. She stated looking at Resident #98's physician orders and MAR for March 2024, she could not see where Resident #98 had any injections, insulin injections, or insulin orders. She reported she coded the medication section of Resident #98's 3/7/24 MDS incorrectly. MDS Nurse #2 stated Resident #98's MDS assessments should be an accurate. On 5/30/24 at 10:26 AM an interview with the Director of Nursing indicated Resident #98's MDS assessment should accurately reflect what medications she was receiving. On 5/31/24 at 12:51 PM an interview with the Administrator indicated Resident #98's MDS assessments should be accurate. 2. Resident #262 was admitted to the facility on [DATE] with a diagnosis of debility. A review of Resident #262's discharge summary dated 5/21/24 did not reveal diagnoses of anxiety, depression, or schizophrenia. A review of Resident #262's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was coded for diagnoses of anxiety, depression, and schizophrenia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 12:10 AM an interview with MDS Nurse #1 indicated she coded the diagnoses section of Resident #262's MDS assessment dated [DATE]. She stated she was not sure where she got the information that Resident #262 had diagnoses of anxiety, depression, and schizophrenia. She reported she had thought it was strange when she coded these diagnoses on his MDS assessment but saw that he wasn't taking any medication for these diagnoses. MDS Nurse #1 indicated she would normally get a resident's diagnoses by looking at their discharge summary, but when she looked at Resident #262's now, she didn't see these diagnoses listed. She reported she must have coded these diagnoses on Resident #262's MDS assessment dated [DATE] in error. On 5/30/24 at 2:04 PM an interview with the Director of Nursing (DON) indicated Resident #262's MDS assessment should be accurate. She stated if MDS Nurse #1 had any concerns related to Resident #262's diagnoses, she should have clarified this before coding his MDS assessment. On 5/31/24 at 12:51 PM an interview with the Administrator indicated Resident #262's MDS assessment should be accurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on record review and staff interviews the facility failed to develop the comprehensive care plan in the area of anticoagulant (blood thinning) medication for 1 of 5 residents (Resident #98) reviewed for unnecessary medications. Findings included: Resident #98 was admitted to the facility on [DATE] with a diagnosis of atrial fibrillation (an irregular heartbeat which can lead to blood clots). A review of Resident #98's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she received anticoagulant medication. A review of Resident #98's physician's orders revealed a current active order for apixaban (an anticoagulant medication) 5 milligrams (mg) twice daily for atrial fibrillation with a start date of 12/6/23. A review of Resident #98's March 2024, April 2024, and May 2024 Medication Administration Records revealed documentation apixaban 5 mg was administered to her twice daily as prescribed by her physician. A review of Resident #98's current comprehensive care plan dated last reviewed on 4/10/24 did not reveal a care plan focus area or interventions related to receiving anticoagulant medication. On 5/30/24 at 10:14 AM an interview with MDS Nurse #2 indicated she coded Resident #98's MDS assessment dated [DATE] that indicated Resident #98 was receiving anticoagulant medication. She stated she would have been responsible for ensuring that Resident #98 had a care plan focus area that addressed this. She reported this was an oversight on her part. On 5/30/24 at 10:26 AM an interview with the Director of Nursing indicated Resident #98's comprehensive care plan should accurately reflect the whole picture of Resident #98, including addressing that Resident #98 was receiving anticoagulant medication.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 Based on record review, resident, family and staff interviews, the facility failed to ensure residents rights and invite residents/resident representatives to participate in care plan meetings 3 of 7 residents reviewed for care plan meetings (Residents #31, Resident #53 and Resident #362). The findings included: 48295 1. Resident #362 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease and diabetes type 2. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #2 was moderately cognitively impaired. Review of care plan dated 4/23/24 revealed that a care plan had been developed on 4/11/24 and reviewed and revised on 4/18/24, and 4/23/24. Interviews with Resident #362 on 05/29/24 at 8:46 am and on 5/30/24 at 1:48 PM revealed she had not been invited to a care plan meeting since she was admitted to the facility on [DATE]. She indicated that no one had talked to her about her care. She further stated she could not say whether or not a family member had been invited to a care plan meeting. In an interview with Resident #362's resident representative on 5/30/24 at 2:26 pm, it was revealed that he had not been invited to a care plan meeting since Resident #362 had been admitted to the facility. Review of the electronic medical record (EMR) for Resident #362 revealed there was no documentation of a care plan meeting being held with the resident or family. In an interview with the Social Worker (SW) on 5/29/24 at 2:02 pm it was revealed that he was unaware of when Resident #362's last care plan meeting was held. He further indicated that he had held his position since November of 2023 and that he did not have a formal system to track care plan meetings and kept notes in spiral notebooks. He stated he was in the process of transcribing care plan meeting documentation into the EMR from the notebooks. He further indicated that he could not find any handwritten notes for Resident # 362 in his notebooks that indicated that she had a care plan meeting. The SW indicated that he typically mailed a written invitation to the resident representative and hand delivered an invitation to the resident for care plan meetings. He stated he had not prepared or delivered an invitation to Resident # 362 or her representative. An interview with MDS Nurse #1 on 5/30/24 at 12:58 pm revealed that Resident # 362 was admitted on [DATE] and the 48-hour care plan was completed by nursing on admission. She accessed the EMR and stated she could see where Nurse #4 completed the baseline care plan. She further indicated that the resident and the family should have been invited to participate in the care plan meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Nurse #4 on 5/30/24 at 8:26 am she stated she did not recall attending a care plan meeting for Resident # 362 or completing the paperwork, but that she attended many care plan meetings. She further indicated that she often attended care plan meetings with a team that included the Social Worker, a Nurse, Activities Director, Dietary Manager, and the resident, and/or the resident representative. She stated that care plan meetings were typically held in the resident's room with family present but sometimes the family member would attend by phone during the care plan meeting. She further stated that when a care plan meeting was completed, that was documented in the EMR by the Social Worker and all attendees signed an attendance roster. In an interview with the Administrator on 05/30/24 at 9:25 am he stated that he was unaware that Resident # 362 was not invited to a care plan meeting. He added that 48-hour baseline care plans were completed on admission within 48 hours then quarterly at a minimum. He further indicated that if there was a change in condition a care plan meeting was held, and the care plan revised as necessary. He stated that he had a systemic problem related to staff turnover of the MDS position and he hired a new Social Worker in November of 2023. The Administrator stated that care plan meetings should have been held on admission and quarterly and that the resident and/or the resident representative should have been invited. 2. Resident #53 was admitted to the facility on [DATE] with diagnoses which included fracture of the right femur, neurogenic bladder, and osteoarthritis. The Quarterly Minimum Data Set assessment dated [DATE] indicated that Resident #53 was cognitively intact. Review of Resident 53's care plan revealed that the care plan had been revised on 11/15/23, 12/18/23, 12/21/23 and had a last review date of 2/18/24. An interview with Resident #53 on 05/28/24 at 3:35 pm revealed he had not been invited to a care plan meeting recently and could not remember when he last attended a care plan meeting. He stated that no one had come to his room to discuss his care with him. Review of the care conference meeting documented in the electronic medical record (EMR) revealed that the last quarterly care plan meeting held for Resident #53 was 6/16/23 and that Resident # 53 attended the meeting along with the interdisciplinary team participants that included the Activities Director, Social Worker and MDS Nurse #2. The next care conference was scheduled for 9/15/23. In an interview with the Social Worker (SW) on 5/29/24 2:07 pm he stated that Resident #53 had one care plan meeting since he took the position in November of 2023 and that was a grievance meeting, but he could not recall the date. He further indicated that a grievance meeting did not take the place of the required quarterly care plan meeting. The SW stated that he had not held a quarterly care plan meeting for Resident #53 since he was hired in November of 2023 because he met with Resident #53 one on one many times about grievances. He indicated that he just made notes in a spiral notebook when he met with residents and did not document it in the resident's chart. The SW indicated that he hand delivered care plan invitations to residents. He further indicated that he had not invited Resident #53 to a care plan meeting since he was hired. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing on 5/31/24 at 11:08 am she stated that she did not know when a care plan meeting was held for Resident #53 or who was invited. She further indicated that Resident #53 should have had quarterly care plan meetings, and the resident should have been invited to attend. She stated that there had been turnover in the social work department that could have contributed to the care plan meetings not being done. Interview with the Administrator on 05/30/24 at 9:25 am he stated that he was unaware that Resident #53 had not been invited to or had a care plan meeting since 6/16/23 and that baseline care plans were done on admission within 48 hours, then quarterly at a minimum. He further indicated that if there was a change in condition that a care plan meeting was held, and the care plan was revised as necessary. He stated that he had a systemic problem related to staff turnover of the MDS position and he hired a new MDS nurse a month ago and he had previously hired a new Social Worker as well. The Administrator stated that care plan meetings should be held quarterly. 40200 3. Resident #31 was admitted to the facility on [DATE] with diagnoses which included hypertension and hip fracture. Resident #31's admission Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact. An interview on 5/28/24 at 1:29 PM with Resident #31 revealed she did not remember being invited to or attending any care plan meetings. An interview on 5/29/24 at 3:24 PM with the Social Worker (SW) revealed that he scheduled care plan meetings based on the MDS calendar. He stated that he looked at the upcoming month and sent out letters to the Responsible Party about 3 weeks in advance. He stated that Resident #31 had not had a care plan meeting. He also stated that he had had many different conversations with the resident's family about concerns and had gotten that confused with the care plan meetings. An interview on 5/30/24 at 10:02 AM with the Administrator revealed that he was aware of the requirement for care plan meetings to be held. He was also aware that care plan meetings were not being held. He stated there was a breakdown in the process and the SW had not established a tracking system to ensure timelines were met.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on observations, staff, Podiatrist, and resident interviews and record review the facility failed to ensure a resident was free from injury while being loaded into the transportation van for 1 of 6 residents reviewed for accidents. Resident #72's right foot became caught between the van ramp and hydraulic lift platform and she sustained an avulsion to her right great toe (forcible tearing off of skin), the skin was unable to be sewn together, x-ray results showed the toe had a minimally displaced fracture (Resident #72). Findings included: Resident #72 was admitted to the facility on [DATE]. Her active diagnoses included coronary artery disease, heart failure, end stage renal disease, and diabetes. Resident #72's minimum data set assessment dated [DATE] revealed she was assessed as cognitively intact. She was independent with sit to stand function and chair/bed to chair transfers. She was documented to receive dialysis. Review of a nursing note dated [DATE] noted as late entry for [DATE] revealed Resident #72 was being loaded to be transported to dialysis by the Transport Driver and Resident #72 moved her foot up too far while the lift was in motion. Resident #72's right great toe was caught on the lift gate as she was being lifted into the transport vehicle. She sustained a laceration on her right great toe. Wound care was provided by this nurse (Staff Development Coordinator) and the Corporate Nurse Consultant. There was minimal bleeding at that time, pressure bandage applied so resident could go to dialysis, and Resident #72 stated the toe was not hurting anymore. Review of a nursing note dated [DATE] noted as late entry for [DATE] revealed Resident #72 returned from dialysis. The dressing to her right great toe was noted to be bloody. The wound was cleansed, and a pressure dressing applied. Resident #72 complained of pain from touch. As needed pain medication was offered, and on a follow-up assessment it was noted the bandage was soaked with blood. The physician was notified, 911 called, and the transfer was paperwork completed. Report was given to Emergency Medical Services on arrival and then transported to the hospital for further evaluation. Review of the hospital discharge summary dated [DATE] for Resident #72 revealed the physician documented upon initial examination; Resident #72 did appear to have a laceration but upon further inspection there was no large area to sew however there was avulsed (forcible tearing off of skin) skin removed to the toe. X-ray showed a minimally displaced fracture to the right great toe metatarsal. Due to the open fracture, Resident #72 was given Keflex (a type of cephalosporin antibiotic that treats bacterial infections) in the emergency department and sent back to the facility with a prescription for 5 days. The laceration was repaired after washing with soap and water and irrigation. Steri-Strips were used. The right great toe was wrapped in sterile gauze and Coban (a self-adhering, elastic bandage). Resident #72 was advised to follow up with her regular doctor in the next couple of days for wound check and resident was agreeable to the plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Universal Health Care/Greenville		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:57 PM Resident #72 stated in [DATE] the Transport Driver was taking her to dialysis and she was in the van lift as he began to operate the lift. She stated he had placed her feet flat on the lift instead of on the wheelchair footrests. As the lift went up, she screamed out in pain. Her right great toe had been caught in the lift as she was going up. She shouted, put it down, put it down, and he heard her and let the lift down. The Corporate Nurse Consultant must have heard her yell from inside and she came out and asked what was wrong. Resident #72 told her that her toe got caught in the lift of the van. The Corporate Nurse Consultant got down on her knees to check Resident #72's toe and got someone to bring her ointment and gauze. The Corporate Nurse Consultant treated the toe and got her fixed up so she could go to dialysis. Resident #72 went to dialysis because she told them she still wished to go, and she was not hurting. When she got up to leave dialysis the toe started to bleed again. The dialysis nurse treated the toe and she returned to the facility. The toe started to bleed when she returned, and the nurse was concerned and sent Resident #72 to the hospital for evaluation of the toe. She stated at the hospital she discovered her right great toe was broken, and the toenail was damaged and killed the toenail. She concluded her toe had healed but the toenail died . She stated she had been unable to wear shoes for some time which was why she did not have any on during the incident. During an interview on [DATE] at 10:15 AM the Podiatrist stated he had seen Resident #72 today for an exam and reviewed her right great toe as well. She was seen last by podiatry in [DATE] and since then she had several missed appointments due to resident refusals and today was the first she had been seen by podiatry since 2022. He stated upon review of her right great toe, the toenail looked dystrophic (thick and crumbly and discolored due to past trauma). The toe itself had proper alignment with no obvious signs of injury. He stated based on his review this morning the toenail probably would not regrow. It is likely to remain dystrophic, however the toe itself was healed and did not impact her daily life. During an interview on [DATE] at 12:16 PM the Transport Driver stated he remembered the incident with Resident #72 in [DATE]. He further stated he was taking Resident #72 to dialysis, and he placed her on the lift for the transport van. He then positioned the resident on the lift and one step he had to perform each transport was looking to see if the resident's feet were on the wheelchair footrests. He stated everything was good and she was positioned correctly with her feet on the footrests of the wheelchair. He stated he was standing on her right side, by the lift where he was supposed to stand and had the lift control in his hand and began to raise her up as he watched the lift. He stated he was responsible for observing the closing back ramp which would prevent the resident from rolling back and off the ramp as he was trained. Because of this and the resident's size, he did not see that she removed her right foot from her footrest and placed it on the lift with her right great toe under the yellow ramp which folds down to the van entrance as the lift elevated to the floor of the van. As the ramp made it to the highest elevation, Resident #72 said, Oh, my feet! He stopped the lift immediately and then lowered the lift. Resident #72 then told him her foot was in pain, so he called for nursing assistance and two nurses came and checked Resident #72. Following their treatment of the resident's right great toe he was told she could go to dialysis. He raised the lift fully without the resident to ensure the lift was working properly and no issues were found. With the two nurses observing him, he again put the resident on the same lift, and he had no issues as the resident was placed on the van and taken to dialysis. Later he was informed Resident #72 had to go to the hospital for her right great toe. He then had to watch a training video regarding the van and the lift. Training was also given by a staff member after the video training. He was then monitored for multiple weeks after the incident by a staff member and there were no issues with any of his transports. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

During an interview on [DATE] at 11:37 AM the Corporate Nurse Consultant stated she was one of the first staff to respond from the facility to Resident #72's incident in the van. She further stated there was a call overhead for nursing assistance at the front of the building. She was in the building that day and she went to respond. Resident #72 was at the front of the building in her wheelchair with the Transport Driver. Resident #72's right great toe was bleeding. She had yellow non-skid socks on with no shoes and she removed the sock as the Staff Development Coordinator came to her and then went to collect wound supplies. At the time she did not complain of pain, and the Corporate Nurse Consultant did not know how much the resident could feel her feet due to her diabetic history. She held pressure at the tip of her toe, cleaned the wound, and dressed it. Resident #72 said she wanted to proceed to dialysis and have the doctor look at it there. They then had the Transport Driver do a return demonstration for the Staff Development Coordinator and herself. He did everything as he should and used the correct process. When they interviewed the resident, Resident #72 stated she had moved her foot as the lift was going up and felt a pinch. Resident #72 could not wear shoes before the incident due to edema. The Corporate Nurse Consultant stated at no time did she recall Resident #72 say to her that the transport driver had put her feet on the lift floor instead of the wheelchair footrests or had issues with the lift. Even though they did not find any issues with the Transport Driver's return demonstration, he was monitored afterword, given education as well as watching the van driver training in order to complete a plan of correction since there was an injury. Resident #72 often preferred to not use her wheelchair footrests and would slide down in her wheelchair with her feet on the floor to feel more comfortable.

During an interview on [DATE] at 12:01 AM the Staff Development Coordinator stated she was the unit manager for Resident #72's hall at the time of the incident in [DATE]. She further stated a page for nursing to come to the front was heard overhead and she and the Corporate Nurse Consultant responded to the page. She saw that Resident #72's sock had blood on it, so she went to get supplies while the Corporate Nurse Consultant remained with Resident #72. She returned and the Corporate Nurse Consultant and herself dressed Resident #72's wound. At the time the wound was barely bleeding, and Resident #72 showed no signs of pain and denied pain as well. Resident #72 was given the option to not go to dialysis, but she stated she wanted to go and was not in discomfort. They asked Resident #72 how her foot became injured, and she told them that the yellow flap which flipped down hit her toe as she was going up. She did not say she was positioned incorrectly or that she moved as far as the Staff Development Coordinator could recall. She stated the Transport Driver indicated to them that she would often move her feet after he had correctly positioned her and would move her feet out of the wheelchair footrests onto the lift gate. She stated because Resident #72 wanted to go to dialysis, the Corporate Nurse Consultant and herself observed him operating the lift and he did it correctly. Resident #72 did not remove her feet from the wheelchair footrests. The Staff Development Coordinator stated they then monitored the Transport Driver loading residents on the lift for several weeks following the incident for a plan of correction, and each time she was assigned to observe him operating the lift on the van, he did it correctly. She stated she could not remember what they found in the hospital once the resident agreed to go to the hospital following her toe being injured on the lift as it was a long time ago.

During observation on [DATE] at 12:40 PM the Transport Driver was observed demonstrating the lift of the van used during the incident in [DATE] and the lift operated correctly.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 7:27 AM the Director of Nursing stated she was notified of the incident with the van on the evening of [DATE]. She stated upon investigation, it came to her attention that Resident #72 did not wish to use the leg rests on her wheelchair and the van driver was unable to visualize her entire body during the lift process. Because Resident #72 could move her legs herself, she was able to remove her feet from the leg rest on her wheelchair during the lift process with the hydraulic lift. This resulted in her putting her foot down on the lift with her toe under the yellow ramp which folds down to the van entrance as the lift goes up. Because he could not visualize her entire body during the lift process, Resident #72 sustained a cut to her right great toe and a fracture to her right great toe. In response to this incident the Transport Driver was asked to provide a demonstration of how he had lifted Resident #72, and this was when she discovered the space where the resident could place her foot and the van driver could not see it. She stated they reeducated the Transport Driver to no longer utilize the hydraulic lift with Resident #72. She stated Resident #72 was then transported by a different transport service with a platform ramp. Due to her weight they had to send two staff members everywhere she was transported, and she went to dialysis three days a week. Because of the requirement of multiple staff, they then changed to a different transport company who could transport her via bariatric stretcher. The transport driver was given education regarding safe transportation as well as in-house training. The Transport Driver was then monitored for approximately 6 weeks and the results were reported to QAPI monthly. During an interview on [DATE] at 8:35 AM the Administrator stated on [DATE] Resident #72 was being transported to dialysis. The Transport Driver placed her on the lift and had given her instructions about the placement of her feet during the lift operation. As the lift was going up to the height of the van entrance, she moved her foot, and her right great toe was far enough forward to get pinched by the yellow ramp which folds down to the van entrance. The Transport Driver responded immediately and lowered the lift. He stated he did not know if the Transport Driver could see Resident #72's toe or not during the lift process but because she moved her foot right as the lift was reaching the van height, her toe was pinched by the lift against the van ramp causing a laceration and toe fracture to her right great toe. He stated they reevaluated how she would go on future transports and identified that the Transport Driver had had issues with Resident #72 maintaining safe positioning during lift operation and Resident #72 had acknowledged to the Administrator that the Transport Driver had given her instructions for safe positioning prior to the incident but that she moved her foot which resulted in the facture on [DATE]. Due to this information, it was decided the resident would transport via either platform ramp or stretcher only and no longer use the hydraulic lift. The facility provided and implemented the following corrective action plan with a completion date of [DATE]. Problem Identified: On [DATE], [Resident #72] was being loaded onto the facility van by the facility's van driver when she moved her foot sustaining a laceration to the great toe. Address how corrective action will be accomplished for resident(s) found to have been affected: [Resident #72]'s foot was assessed, cleaned and dressed by the nurse consultant and unit manager. [Resident #72] requested to proceed to her scheduled dialysis appointment following wound care. This was completed on [DATE]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed: A review of facility transports for the last 30 days revealed no other injuries during the unloading or loading process by the van driver were found. This was completed on [DATE]. On [DATE] a return demonstration by the van driver revealed the correct procedure was followed. Address what measures will be put in place and systemic changes made to ensure that the identified issue does not occur in the future: The van driver was educated by the [Maintenance Director] on [DATE] regarding safe loading and unloading of passengers. The van driver completed Transportation in Healthcare/Van driver training in Relias on [DATE]. On [DATE], transportation mode changed from hydraulic lift to a manual ramp. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Starting [DATE] the DON or unit manager will observe the loading or unloading of 1 resident daily Monday through Friday x 2 weeks, then one resident 3x/week x 2 weeks and 1 resident weekly x 4 weeks to ensure the correct procedure is followed. Results of the DON's transportation audits will be reviewed in the facility Quality Assurance and Performance Improvement meeting monthly until compliance is achieved starting [DATE]. The corrective action plan was validated on [DATE]. Interviews and observations confirmed the transport driver was educated about the safe loading and unloading of passengers and van safety. Monitoring tools, staff education, and Performance Improvement Plan were reviewed. The corrective action was verified as completed on [DATE].

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on observation, record review, staff interviews, and Pharmacist interview, the facility failed to maintain a medication error rate of less than 5%. Two (2) medication errors were observed out of 25 opportunities which resulted in a medication error rate of 8%. This occurred for 1 of 3 residents reviewed during a medication pass observation (Resident #7). The findings included: Resident #7 was admitted to the facility on [DATE] with diagnoses which included asthma. The Minimum Data Set (MDS) quarterly assessment revealed Resident #7 had severe cognitive impairment. a. An active physician order was in place for ultra-lubricating eye drops to instill 2 drops in each eye daily for dry eyes. During a medication administration observation on 5/30/24 at 8:30 am, Nurse #1 was observed administering ultra-lubricating eye drops to Resident #7. The bottle of ultra-lubricating eye drops had a blue label attached which read shake well before use. An interview was conducted on 5/30/24 at 8:44 am with Nurse #1 who confirmed the blue label attached to the ultra-lubricating eye drops stated to shake well before use. Nurse #1 stated he was aware of the instructions for the eye drops to shake well before use, but stated he forgot to shake the medication. A telephone interview was conducted on 5/30/24 2:02 pm with the Pharmacist who revealed the pharmacy placed the blue labels on the ultra-lubricating eye drops medication to ensure the nurse knew to follow the manufacturer's recommendations. During an interview on 5/30/24 at 10:47 am the Director of Nursing (DON) stated Nurse #1 should have read the label and administered the medication to Resident #7 as directed on the label. The DON stated the ultra-lubricating eye drops were to be shaken prior to being administered to Resident #7. b. An active physician order was in place for budesonide formoterol fumarate inhalation aerosol (a steroid inhaler used to reduce inflammation in the lungs) 1 puff twice a day for asthma. During a medication administration observation on 5/30/24 at 8:30 am, Nurse #1 was observed to administer budesonide formoterol fumarate inhalation aerosol two puffs to Resident #7. The inhaler had a blue label attached which read shake well before use; and rinse mouth with water and spit afterwards. Nurse #1 did not shake the inhaler prior to administration and failed to have Resident #7 rinse her mouth and spit after the inhaler was administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/30/24 at 8:44 am with Nurse #1 who confirmed the blue label attached to the budesonide formoterol fumarate inhalation aerosol read to shake well before use and rinse mouth with water and spit afterwards. Nurse #1 stated he was aware of the instructions for the inhaler to shake well before use, but stated he forgot to shake the medication. He stated he did know he was supposed to have Resident #7 rinse mouth and spit after the budesonide formoterol fumarate inhalation aerosol was administered but he forgot. A telephone interview was conducted on 5/30/24 2:02 pm with the Pharmacist who revealed the pharmacy placed the blue labels on the budesonide formoterol fumarate inhalation aerosol medication to ensure the nurse knew to follow the manufacturer's recommendations. The Pharmacist stated the budesonide formoterol fumarate inhalation aerosol should have been shaken to ensure the medication was mixed well before administration and Resident #7's mouth should have been rinsed and the water and spit out after the administration to prevent oral thrush (an infection in the mouth common with use of steroid sprays/inhalers for asthma). During an interview on 5/30/24 at 10:47 am the Director of Nursing (DON) stated Nurse #1 should have read the label and administered the medication to Resident #7 as directed on the label. The DON stated the budesonide formoterol fumarate inhalation aerosol was to be shaken prior to use and Nurse #1 was required to have Resident #7 rinse her mouth and spit after the inhaler was administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45045 Based on observations, record review, and staff interviews, the facility failed to remove an open and expired medication from 1 of 2 medication storage rooms observed (Hall 300/400) and failed to ensure 1 of 5 medication carts (Hall 300) and 1 of 1 wound treatment carts were secured while unattended. The findings included: 1. An observation of the Hall 300/400 medication storage room was conducted on 5/30/24 at 10:24 am with the Assistant Director of Nursing (ADON) and the following was observed. The ADON confirmed the findings before removal of the item. One open vial of tuberculin purified protein derivative solution (PPD solution/TB solution) with an open date of 4/25/24 noted on the box was observed in the medication refrigerator in the Hall 300/400 medication storage room. The manufacturer's recommendation for the tuberculin purified protein derivative noted on the package was once opened vial should be discarded after 30 days. An interview was conducted on 5/30/24 at 10:25 am with the ADON who reported she was not sure how long the open vial of the PPD solution was able to be used for. The ADON reviewed the PPD solution box and confirmed the manufacturer's recommendation was to discard after 30 days of opening. The ADON stated the PPD solution should have been removed and discarded from the Hall 300/400 medication storage room refrigerator and she was unable to state why the PPD solution was still there. During an interview on 5/31/24 at 9:51 am the Director of Nursing (DON) stated the Hall 300/400 medication storage room was checked for expired medications before the observation and she was unable to state how the expired vial of tuberculin purified protein derivative solution was missed when it was checked. 2. A continuous observation on 5/30/24 at 8:06 am through 8:10 am revealed the Hall 300 medication cart was observed with the key hanging from the narcotic drawer lock in the inward (pushed in) position. The medication cart was located in Hall 300 between the nursing station and beginning of the resident rooms on Hall 300 without staff present. At 8:10 am Nurse #1 was observed to exit a resident room at the end of Hall 300 and walk towards the Hall 300 medication cart. An interview was conducted on 5/30/24 at 8:10 am with Nurse #1 who reported he got distracted and he left the keys in the Hall 300 medication cart when we went down the hall to administer medication. Nurse #1 stated he realized he forgot to take the keys when he left the resident room to return to the medication cart and did not have the keys with him. An interview was conducted on 5/30/24 at 10:49 am with the Director of Nursing (DON) who stated Nurse #1 was expected to lock the medication cart and take the keys with him when he left the Hall 300 medication cart to pass medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48230 3. The facility treatment cart was observed on 5/31/24 at 8:07 AM with the lock not engaged as evidenced by the red dot on the lock being visible. The cart was parked at the end of 500 hall in front of a resident's room whose door was closed. There was no staff member at the treatment cart. Several staff members were observed walking near the treatment cart. At 8:19 AM, Nurse #5 came out of the resident room the cart was parked in front of. The surveyor asked Nurse #5 to open the top drawer. She then realized she had left the cart unlocked when she left it earlier. Nurse #5 stated she usually locks her cart. She further stated the cart should be always locked when she was not directly using it. Nurse #5 revealed there were medicated treatments inside the cart such as wound cleanser and medicated creams and ointments. An interview with the Director of Nursing (DON) on 5/31/24 at 8:58 AM was completed. The DON stated the treatment cart should have been secured and locked unless the nurse was present at the cart. The DON further stated that the nurse assigned to the treatment cart was responsible for it and ensuring that it was secured. An interview with the Administrator on 5/31/24 at 9:05 AM revealed treatment carts should not be unlocked unless the Nurse is standing in front of it. The Nurse assigned to that medication cart is responsible for it for their entire shift.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 48230 Based on record review and staff interviews the facility failed to have a documented water management program for Legionella. The facility further failed to ensure hand hygiene was performed during medication administration for 1 of 2 nurses observed (Nurse #1). Findings included: 1. In an interview with the facility Assistant Maintenance Manager on 5/30/24 at 8:06 AM he stated the Director of Maintenance left the position a couple of months ago and he had been responsible for water management, including an assessment to identify where water borne pathogens could grow and spread. He further stated he had no knowledge of what the water management system entails, how they were to assess for or prevent Legionella or who should have been notified should there be a concern with Legionella in the building. An interview with the Administrator on 05/30/24 8:59 AM revealed he did not know what measures were in place to assess the growth or spread of Legionella in the facility water system. He was able to provide the water management system binder for review. A review of the water management system binder revealed there was no plan in place to assess and identify the growth and spread of Legionella or to assess areas of the water system where growth may accumulate. A water management policy was not found in the binder. In a follow up interview with the Administrator on 05/30/24 at 3:38 PM he reviewed the water management plan and stated that the plan was not up to date or complete. The Administrator further stated there was no water management policy in place. He revealed that the previous Director of Maintenance took the correct documentation with him when he left in March of 2024. 45045 2. The facility policy titled Handwashing/Hand Hygiene last revised in August 2023, revealed that the purpose of the policy was to provide guidelines for staff, patients, and visitors in utilizing hand hygiene and it stated that appropriate hand hygiene was essential in preventing transmission of infectious agents. The policy further stated that staff were to perform hand hygiene before and after contact with residents, after contact with objects in residents' room, and after removing personal protection equipment such as gloves. The facility policy titled Oral Inhalation Administration, no date, revealed after the administration of the oral inhalation medication, gloves (if worn) were to be removed and discarded and hand hygiene was to be completed with soap and water or facility-approved hand sanitizer. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a continuous observation on 5/30/24 at 8:30 am through 8:40 am of Resident #7's medication administration, Nurse #1 was observed to prepare Resident #7's medications, enter Resident #7's room and administer the oral medications. Nurse #1 was then observed to perform hand hygiene with soap and water, don (put on) clean gloves, and administer eye drops to Resident #7. Nurse #1 removed his gloves, and without performing hand hygiene with soap and water or hand sanitizer, donned clean gloves. Resident #7 was observed to blow her nose with a tissue and hand the used tissue to Nurse #1. Nurse #1 threw the used tissue in the trash, removed his gloves, and without performing hand hygiene with soap and water or hand sanitizer, donned clean gloves. He then administered the nasal spray to Resident #7, removed the gloves, and donned clean gloves without performing hand hygiene. Nurse #1 was observed to remove the cap of the oral inhaler with gloved hands, place the inhaler tip into Resident #7's mouth, administer the medication, and replace the cap on the oral inhaler. Nurse #1 then removed his gloves, retrieved the medications from the overbed table, exited Resident #7's room, and returned Resident #7's medications to the cart. Nurse #1 was not observed to perform hand hygiene with soap and water or hand sanitizer after he administered Resident #7's medications. During an interview on 5/30/24 at 8:55 am Nurse #1 stated he performed hand hygiene with soap and water before putting on his gloves the first time and he did not think he needed to do it again. Nurse #1 stated he normally would not perform hand hygiene again during medication administration. Nurse #1 stated he did use hand sanitizer after he returned Resident #7's medications to the cart before pulling the next resident's medication, but not when he left the room. An interview was conducted with the Director of Nursing (DON) on 5/30/24 at 10:47 am who revealed Nurse #1 should have performed hand hygiene between glove changes, and when he exited Resident #7's room after the medication administration. The DON stated she spoke with Nurse #1 who reported he was nervous and just forgot to perform hand hygiene during the medication administration observation.