STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345449	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care/King	115 White Road King, NC 27021

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789 Based on record review and staff interviews, the facility failed to refer a resident with a newly identified serious mental illness for a Level II Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for PASRR (Resident #55). Findings included: Resident #55 was admitted to the facility on [DATE]. A Level I PASRR determination notification letter dated 3/9/20 indicated No further PASRR screening is required unless a significant change occurs with the individual's status which suggest a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. A review of Resident #55's medical record indicated on 6/25/24 the diagnosis of bipolar disorder was added and on 12/24/24 the diagnosis of major depressive and generalized anxiety disorders was added. There was no evidence indicating a Level II PASRR referral had been completed for Resident #55 after the new diagnoses of serious mental illnesses had been identified. An interview with the Social Worker (SW) on 4/14/25 at 11:25 a.m. revealed she was not aware Resident #55 had new serious mental illness diagnoses. She further stated it was her responsibility to complete a Level II PASRR screening for the residents. She revealed she would be notified by the Minimum Data Set (MDS) nurse or Director of Nursing (DON) of new identified mental health diagnosis. In an interview with the DON on 4/15/25 at 11:23 a.m. she revealed the medical record system was configured to alert the SW of new identified mental health diagnoses and was not sure why the SW did not receive an alert in the instance of Resident #55. During an interview with the Administrator on 4/16/25 at 9:09 a.m. he revealed he was not aware Resident #55's Level II PASRR referral had not been completed and explained this was a problem. He revealed the SW will be retrained and complete an audit of all residents who may require a PASRR referral.

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 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** 43222 Based on record review and staff interviews, the facility failed to develop a comprehensive care plan from 12/27/24 through 3/13/25 for 1 of 1 resident reviewed for urinary catheter (Resident #37). The facility also failed to update the care plan to reflect the change in the dialysis schedule for 1 of 2 residents reviewed for dialysis (Resident #48) and failed to update the care plan to reflect the change in dietary status for 1 of 2 residents reviewed for tube feeding (Resident #79). The findings included: Resident #37 was readmitted to the facility on [DATE] with diagnoses which included obstructive and reflux uropathy. She was hospitalized from 11/21/24 through12/4/24 and 3/11/25 through 3/13/25. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #37 was cognitively intact and was coded as frequently incontinent of bladder. The Admission/Readmission Nursing Collection Tool dated 12/4/24 and completed by Nurse #1 revealed that Resident #37 returned to the facility with an indwelling urinary catheter. A care plan for Resident #37's indwelling urinary catheter was originally created on 12/4/24 and resolved on 12/27/24 by MDS Coordinator #1. Interventions included: maintain catheter anchor, maintain catheter privacy bag, observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated, and provide catheter care each shift. The Provider Progress note dated 12/18/24 and completed by the Nurse Practitioner revealed that Resident #37 had an indwelling urinary catheter when genitourinary details were reviewed. The infection note dated 1/23/25 at 11:19 PM and completed by Nurse #3 revealed that Resident #37's indwelling urinary catheter was documented as patent and draining. In an interview with the Minimum Data Set (MDS) Coordinator #1 on 4/16/25 at 9:42 AM, they revealed that if a resident was readmitted with an indwelling urinary catheter, then the care plan should be updated within 14 days to include that focus. She stated she was normally notified in the morning clinical meeting of any changes in a resident's clinical status. Resident #37's care plan was updated on 12/4/24 to include the new indwelling urinary catheter from the hospital, but it was resolved on 12/27/24 because MDS Coordinator #1 did not see any orders in Resident #37's electronic medical record (EMR) or the hospital discharge summary on 12/4/24. MDS Coordinator #1 stated she could not provide a reason why she did not assess the resident visually and reconcile with the electronic medical record. She indicated that she saw so many residents, it was hard to keep track. The indwelling urinary catheter section in the care plan was readded on 3/13/24 when Resident #37 returned from another hospitalization . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan for Resident #37 updated on 3/13/25 revealed that the resident requires a urinary catheter related to: obstructive uropathy. Interventions included: change per physician order, empty as needed and record output, maintain catheter anchor, maintain catheter privacy bag, observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated, and provide catheter care each shift. A joint interview with the Director of Nursing (DON) and Assistant DON on 4/16/25 at 10:13 AM revealed that on 12/4/24, the admitting nurse should have entered urinary indwelling catheter orders. When entering documentation in the admission collection tool, the chosen answers automatically updated the care plan. They stated that the MDS nurses should have visually assessed Resident #37 and provided accurate support with record review. The Administrator was interviewed on 4/16/25 at 3:58 PM. He stated that MDS Coordinator #1, who resolved the catheter care plan on 12/27/24, should have completed a reassessment to see if the indwelling urinary catheter was still present or removed from Resident #37. 41772 2. Resident #48 was admitted to the facility on [DATE] with diagnoses that included kidney transplant failure, end stage renal disease (ESRD) and dependence on renal dialysis. The quarterly minimum data set (MDS) assessment dated [DATE] indicated Resident #48 had severe cognitive impairment. Resident #48 was coded as receiving dialysis. The comprehensive care plan for Resident #48 was initiated 10/23/24 and last reviewed 2/10/25. The care plan included in part the focus area of Resident #48 was at increased risk for complications secondary to requiring hemodialysis secondary to ESRD. The interventions included Resident goes to dialysis Tuesday, Thursday, and Saturday with an 11:00 AM chair time at the Dialysis Center. Review of a physician's order dated 2/19/25 revealed Resident #48's dialysis days were Monday, Wednesday, Friday with an 11:00 AM chair time at the Dialysis Center. An interview was conducted with MDS Coordinator #1 on 4/16/25 at 1:13 PM. She indicated changes to residents' care was communicated each morning during the clinical meeting. MDS Coordinator #1 stated the care plans were usually updated in the clinical meeting. She further stated the care plan was not updated because the information probably did not get communicated. An interview was conducted with the Director of Nursing (DON) on 4/15/25 at 3:11 PM. The DON stated information was pulled from the 24-hour report and reviewed each morning during the clinical meeting. She stated the nurse who entered the dialysis order was responsible for making sure changes to Resident #57's dialysis schedule was communicated in the 24-hour report. The DON stated the MDS nurse should have updated the care plan to reflect the change in resident's dialysis scheduled days. 3. Resident # 79 was admitted to the facility on [DATE] with diagnoses that included oropharyngeal phase dysphagia and adult failure to thrive. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly minimum data set (MDS) assessment dated [DATE] indicated Resident #79 had severe cognitive impairment with disorganized thinking and inattention. Resident #79 was coded for feeding tube and received more than 51% of her calories from feeding. The comprehensive care plan for Resident #79 was initiated 12/23/24 and last updated 3/18/25. The care plan included in part a focus area of Resident #79 was at risk for complications related to the need for an enteral tube feeding and for possible malnutrition with tube feeding. The interventions included Resident # 79 received a meal tray. Review of a physician's order dated 3/19/25 revealed Resident #79 had a diet order for nothing by mouth (NPO), NPO texture, NPO consistency. An interview was conducted with MDS Coordinator #1 on 4/16/25 at 1:13 PM. She indicated changes to residents' care was communicated each morning during the clinical meeting. MDS Coordinator #1 stated Resident #79 had two different care plans for tube feeding. She indicated the care plan should have been updated to reflect Resident #79's updated diet status of NPO. An interview was conducted with the Director of Nursing (DON) on 4/15/25 at 3:11 PM. The DON stated information was pulled from the 24-hour report and reviewed each morning during the clinical meeting. She stated the nurse who entered the NPO order was responsible for making sure changes to Resident #79's diet was communicated in the 24-hour report. The DON stated the MDS nurse should have updated the care plan to reflect the change in resident's diet to NPO.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on observation, record review, and staff interviews, the facility failed to obtain physician orders for the management of an indwelling urinary catheter for 1 of 1 resident reviewed for urinary catheter (Resident #37). The findings included: Resident #37 was readmitted to the facility on [DATE] with diagnoses which included obstructive and reflux uropathy. She was hospitalized from 11/21/24 through 12/4/24 and 3/11/25 through 3/13/25. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #37 was cognitively intact and was coded as frequently incontinent of bladder. The care plan for Resident #37 was created on 12/4/24 and resolved on 12/27/24 revealed that the resident requires a urinary catheter. Interventions included: maintain catheter anchor, maintain catheter privacy bag, observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated, and provide catheter care each shift. The Admission/Readmission Nursing Collection Tool dated 12/4/24 and completed by Nurse #1 revealed that Resident #37 returned to the facility with an indwelling urinary catheter. The Provider Progress note dated 12/18/24 and completed by the Nurse Practitioner revealed that Resident #37 had an indwelling urinary catheter when genitourinary details were reviewed. Review of Resident #37's electronic medical record from 12/4/24 until 3/11/25 revealed no physician orders regarding the care of her indwelling urinary catheter. The skilled note dated 1/14/25 at 3:50 PM and completed by Nurse #2 revealed that urine was obtained from Resident #37 for diagnostic testing. The infection note dated 1/23/25 at 11:19 PM and completed by Nurse #3 revealed that Resident #37's indwelling urinary catheter was documented as patent and draining. The care plan for Resident #37 created on 3/13/25 revealed that the resident requires a urinary catheter related to: obstructive uropathy. Interventions included: change per physician order, empty as needed and record output, maintain catheter anchor, maintain catheter privacy bag, observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated, and provide catheter care each shift. Resident #37 had the following physician orders related to an indwelling catheter dated 3/14/25: - Check indwelling urinary catheter anchor placement each shift (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Check indwelling urinary catheter anchor each week and as needed every day shift every 7 days for catheter care - Indwelling urinary catheter care each shift - Change indwelling urinary catheter as needed for clinical indications such as infection, obstruction, or when the closed system is compromised Multiple telephone attempts were made to contact Nurse #1, but she did not return the call. A telephone interview was conducted with Nurse #3 on 4/14/25 at 1:52 PM. She revealed if a resident had an indwelling urinary catheter, then catheter care must be provided each shift or if they are incontinent, whenever they had a bowel movement. Also, it was important to make sure the bag was anchored and positioned correctly, and output was monitored. All catheter instructions should be included in the medication administration record (MAR), or treatment administration record (TAR). Nurse #3 stated that Resident #37 had a catheter when she was readmitted to her assigned hall on 12/4/24. She could not remember if the orders were entered at that time or not. Nurse #3 indicated that she knew how to care for an indwelling urinary catheter, even if there were no orders. During a telephone interview with Nurse #2 on 4/14/25 at 2:16 PM, she revealed that indwelling urinary catheters were monitored to make sure it was draining or had discoloration or sediment present. If the indwelling urinary catheter needed to be changed, then she would do so if it became clogged, not draining, or leakage/comes out. Indwelling urinary catheter care was mainly performed by the nurse aides. If she was helping with incontinence care, then she would assist with catheter care at the end. Nurse #2 stated that Resident #37 was readmitted from the hospital (12/4/24) with the indwelling urinary catheter. Catheter instructions/care were sometimes included on the TAR or on the MAR. Nurse #2 stated that there should always be an order for catheter care and when changing the indwelling urinary catheter. She indicated she had been a nurse for [AGE] years and if there were not any orders for an indwelling urinary catheter, then she would do what she normally does with catheters. She did not realize there was a lack of indwelling urinary catheter orders for Resident #37, but if she did, she should have notified her supervisor. An interview was conducted with the Director of Nursing (DON) on 4/15/25 at 8:06 AM. She revealed that she could not find any catheter care/changing orders for Resident #37 prior to 3/14/25, and she could not say the exact date when the indwelling urinary catheter was inserted for Resident #37. The DON stated that when the facility received Resident #37 on 12/4/24 with a newly inserted indwelling urinary catheter, orders for catheter care and changing of the catheter should have been entered immediately by the admitting nurse (Nurse #1). The DON indicated that the orders were not put in for Resident #37's catheter perhaps because nursing staff just assumed that catheter care/changing would be completed, even if the orders were not entered. The Administrator was interviewed on 4/16/25 at 3:56 PM. He stated that none of the nursing staff followed up on Resident #37's hospital discharge summary dated 12/4/24 missing indwelling urinary catheter care orders. Regardless, Nurse #1 should have contacted the Medical Director for clarification orders.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on observations, record review, and staff interviews, the facility failed to label a new tube feeding formula bottle when it was hung for 1 of 2 residents with a feeding tube (Resident #245). The findings included: Resident #245 was admitted to the facility on [DATE] with diagnoses which included failure to thrive, dysphagia, and gastrostomy status (surgical procedure for inserting a tube through the abdomen wall and into the stomach. The tube is used for feeding or drainage). Gastrostomy, feeding tube, and enteral tube feeding are interchangeable descriptions. Review of Resident #245's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and was dependent on staff with most activities of daily living (ADL). Resident #245 received all nutrition and hydration through the feeding tube. Review of Resident #245's care plan dated 4/3/25 revealed she was at risk for complications related to the need for a feeding tube. Interventions included: administer tube feedings and flushes per order, head of bed elevated during feedings per order, pause feedings during personal care as indicated, residual checks per order, and tube insertion site care per order. Review of a physician order dated 4/11/25 revealed an order for Resident #245 to receive Glucerna 1.5 at 65 milliliters (ml) per hour (hr) administered continuously over 12 hours (6:00 PM - 6:00 AM) with all shifts required to document in the medication administration record (MAR). Check tube placement prior to administration. Review of the April 2025 MAR revealed that Nurse #2 signed off Resident #245's enteral tube feeding of Glucerna 1.5 at 65 ml/hr was started at 6:00 PM on 4/12/25. An observation of Resident #245's tube feeding formula bottle was conducted on 4/13/25 at 11:52 AM. There were no date, time, or flow rate on the tube feeding bottle. An observation and interview with the Assistant Director of Nursing (ADON) was conducted on 4/13/25 at 11:53 AM. She stated that when nurses hang a new tube feeding formula bottle, they needed to label it with the resident's name, date, time, and flow rate per hour. The ADON stated that Resident #245's tube feeding was started at 6:00 PM on 4/12/25 and completed at 6:00 AM this morning. Nurse #2 was interviewed via telephone on 4/14/25 at 2:25 PM. She revealed that when hanging a new tube feeding bottle, she was supposed to label it with the resident's name, date and time of administration, and the flow rate per hour. Nurse #2 was not sure why she had not labeled Resident #245's tube feeding formula bottle at 6:00 PM on 4/12/25. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 4/15/25 at 12:01 PM, she revealed that when a new tube feeding bottle was hung, the nurses should label the bottle with their name, the resident's name, the date and time of administration, and the rate of the tube feeding formula administration. The DON stated that the tube feeding bottle in Resident #245's room should have been properly labeled when hung at 6:00 PM on 4/12/25 by Nurse #2. The Administrator was interviewed on 4/16/25 at 3:59 PM. He stated that Resident #245's tube feeding bottle hung on 4/12/25 by Nurse #2 should have been properly labeled.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41772 Based on observation, record review, staff interview, and the facility policy, the facility failed to ensure a staff member followed facility policy to sign off a controlled medication immediately after administering on the controlled medication count sheet. This occurred for 1 of 4 staff observed during medication administration (Nurse #1). The findings included: Review of the facility policy entitled: Pharmacy Preparation and General Guidelines: IIA6 -Controlled Substances Policy read in part: When a controlled substance is administered, the licensed nurse immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration 2) Amount administered 3) Remaining quantity 4) Initials of the nurse administering the dose, completed after the medication is actually administered. During an observation of medication pass on 4/15/25 at 8:40 AM, Nurse #1 was observed administering one controlled medication to Resident #57: Oxycodone 10mg - Give 1 tablet by mouth every 12 hours as needed for pain. Nurse #1 removed the Oxycodone medication from the bubble pack and administered it to Resident #57. Nurse #1 did not document (sign out) the medication on the controlled medication count sheet. An interview was conducted with Nurse #1 with the Assistant Director of Nursing present on 04/15/25 at 10:22 AM. Nurse #1 confirmed she had not completed the narcotic medication count sheet immediately for the controlled medication she administered to Resident #57. Nurse #1 acknowledged she should have pulled the narcotic medication, administered, and signed out the medication as soon as she administered it. An interview was conducted with the DON on 4/15/25 at 3:30 PM. The DON stated Nurse #1 should have pulled the narcotic medication, administered, and immediately signed the medication out on the controlled medication count sheet.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41772 Based on observations and staff interviews, the facility failed to discard expired medications 2 of 3 medication carts (D Hall Medication Cart and E Hall Medication Cart) reviewed for medication storage. The findings included: a. An observation of the D Hall medication cart with Medication Aide #1 on 04/16/25 3:55 PM revealed an opened box of Bisacodyl Suppositories (medication used to cause a bowel movement) with an expiration date of 3/31/25. An interview with Medication Aide #1 on 4/16/25 at 4:01 PM revealed she thought the nurses were responsible for checking the medication carts for expired medications. b. An observation of the E Hall medication cart with Nurse #2 on 4/16/25 at 4:06 PM revealed: an opened bottle of CoQ10 (a dietary supplement used in some people with certain conditions)100 with an expiration date of 2/2025 and an opened bottle of Antacid Antigas liquid (medication used to help sooth or relieve heartburn, acid indigestion and sour stomach) with an expiration date of 2/2025. An interview with Nurse #2 on 4/16/25 at 4:09 PM revealed the nurse assigned to the medication cart was responsible for checking the cart for expired medication. Nurse #2 stated she had missed the medications during her cart check. An interview was conducted with the Assistant Director of Nursing (ADON) on 4/16/24 at 4:13PM. The ADON stated the nurses assigned to the medication cart were responsible for checking the cart. The ADON further stated nurses on the management team check the medication carts as well as the pharmacist comes in monthly and does a thorough check of the medication carts.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 20710 Based on observations, policy review and staff interviews, the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean under the shelf of 1 of 1 steam tables observed. This practice had the potential to affect residents. The findings included: A review of the Live Well Healthcare Solutions Food Service Closing Checklist read as: All plate warmers, pellet warmers, tray racks and steam tables cleaned and turned off. During the kitchen observation on 04/15/25 at 3:09 PM the steam table was observed. The 5-foot steamtable shelf was observed with dark brown dried food debris. On 4/16/25 at 10:18 AM the 5-foot steamtable shelf was observed with dark brown dried food debris and was sticky to touch. In an interview on 4/16/25 at 10:20 AM the Corporate Dietary Supervisor stated staff should clean the steamtable shelf. In an interview on 4/16/25 at 12:10 PM the Administrator stated the kitchen staff would scrub the steamtable shelf clean. He reported they would add the shelf to the daily sanitation checklist and inspection.