STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER: Universal Healthcare/Ramseur		STREET ADDRESS, CITY, STATE, ZIP CODE: 7166 Jordon Road Ramseur, NC 27316	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 38904 Based on record review, observations, and staff and Medical Director interviews the facility failed to protect a resident's right to be free of sexual abuse for 1 of 3 residents investigated for abuse (Resident #7). A moderately cognitively impaired male resident (Resident #39) was found beside Resident #7's bed, a severely cognitively impaired female resident, with his hand moving under the covers around her groin area when a staff member entered Resident #7's room. Resident #7's brief was open and there was stool on the outside of her brief and on her sheets, and Resident #39 had stool on his hands. Resident #39 was interviewed and stated he was playing around with Resident #7 down there and waved his hand in a circular motion around his groin area. Resident #39 stated he had done something stupid, and he should not have done it. Resident #7 did not have the cognition to express or understand consent for physical sexual advances, and a reasonable person would have been traumatized by unwanted physical sexual advances. Immediate Jeopardy began on 5/2/2024, when the facility failed to protect Resident #7's right to be free of sexual abuse. Immediate Jeopardy was removed on 5/17/2024 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of D (no actual harm with potential for potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems that were put into place are effective. Findings included: Resident #7 was admitted to the facility on [DATE] with diagnoses of dementia and cognitive communication deficit. A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #7 was assessed as severely cognitively impaired; was dependent on staff for rolling from side to side in bed; was totally dependent for transferring to and from the bed to wheelchair; was always incontinent of bowel and bladder and was sometimes understood by others and sometimes understood others The Care Plan for Resident #7 which was reviewed on 3/21/2024 indicated she had difficulty with making her own decisions. Resident #39 was admitted to the facility on [DATE] with diagnoses of dementia and stroke. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #39 was moderately cognitively impaired and had no behaviors. Resident #39's Care Plan was reviewed and on 3/29/2024 the Care Plan indicated Resident #39 had episodes of verbally aggressive behaviors and should be approached in a calm manner. A Care Plan problem added on 4/4/2024 to the Care Plan indicated Resident #39 had a history of depression, he had scheduled psychiatric visits ordered, and he had difficulty recalling recent events due to dementia. A review of a written statement made by Nurse Aide #6 on 5/2/2024 indicated she walked into Resident #7's room and Resident #39 was sitting next to her bed, and she saw something move under the covers that appeared to be Resident #39's hand. The statement further stated she asked Resident #39 what he was doing, and he said nothing. The written statement further indicated when Resident #39 left the room he had stool on his fingers and Resident #7's brief was open and there was stool on the outside of her brief and on her sheet. On 5/14/2024 at 1:11 pm Nurse Aide #6 was interviewed, and stated she cared for Resident #7 on 5/2/2024 and walked into her room between 9:00 am and 9:30 am and Resident #39 was sitting beside her bed in his wheelchair and his hand was under the covers and she saw his hand moving around her groin area. Nurse Aide #6 stated Resident #7 was not upset but she was severely cognitively impaired. Nurse Aide #6 stated she asked Resident #39 what he was doing and when she asked him to leave the room, she noticed he had stool on his hand. She stated after Resident #39 rolled himself in his wheelchair to his room, Nurse Aide #6 stated she returned to Resident #7 to clean her up and when she pulled the sheet down her brief was open and there was stool on the outside of her brief and on her sheet. Nurse Aide #6 stated Resident #39 was sometimes confused and sometimes he was clear. Nurse Aide #6 stated Resident #38 could get up unassisted, moved himself in his wheelchair without assistance, and he wandered around the facility. Nurse Aide #6 stated Resident #38 sat in the doorway of Resident #7's room a lot but 5/2/2024 was the first time she found him in her room. A written statement dated 5/2/2024 by the Social Worker stated she interviewed Resident #39 and asked him what he was doing in Resident #7's room this morning and he stated, I was just playing around and when asked to elaborate on what he meant he said, I was just playing with her down there and he took his hand and waved it in a circular motion around his groin area and said, down there. The Social Worker's written statement indicated Resident #39 stated, I was doing something stupid that I should not have done. The Social Worker's written statement stated she explained to Resident #39 that Resident #7 was cognitively impaired and could not give consent to being touched sexually and he verbalized understanding that he knew what he did was inappropriate. On 5/14/2024 at 2:15 pm the Social Worker was interviewed and stated Resident #39 was coming down the hallway toward her office between 9:30 am and 9:45 am on 5/2/2024 and he stated, I was playing around with Resident #7 in her room, and he did a circular hand motion towards his groin area. The Social Worker stated he said, I did something stupid and the Social Worker stated because he said he did something stupid he understood what he had done was wrong. The Social Worker stated he told the Police Officer that investigated the sexual abuse allegation the exact same thing about an hour after she interviewed him. The Police Officer explained to Resident #39 that Resident #7's family would have to decide to press charges and the Police Officer returned to the facility later that day and notified Resident #7 of his court appearance date and that he was charged with sexual battery. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Police Report dated 5/2/2024 at 9:54 am indicated Resident #39 was charged with sexual battery of Resident #7. The Police Report further indicated Nurse Aide #6 entered Resident #7's room and found Resident #39 at her bedside with his hand under the blanket. Nurse Aide #6 indicated Resident #39 hand was moving under the blanket and Nurse Aide #6 confronted Resident #39 about what he was doing, and he stated, nothing. Nurse Aide #6 reported there was stool on Resident #39's fingers and she found Resident #7's brief open and there was stool outside the brief and on the bed. The Police Report stated Resident #7 was cognitively impaired and could not recall the alleged abuse or give consent. The Police Report stated the Responsible Party was interviewed and stated Resident #7 had dementia and frequently repeats what is said to her. The Responsible Party indicated he wished to pursue charges for the incident on behalf of Resident #7. An interview was conducted by phone on 5/15/2024 at 10:05 am with the Police Officer who responded to the allegation of sexual abuse on 5/2/2024. The Police Officer stated he interviewed Nurse Aide #6 and she stated she entered Resident #7's room and found Resident #39 in his wheelchair sitting beside the bed with his hand under the covers and when she approached him and asked what he was doing he said nothing, but she noticed stool on his fingers. The Police Officer stated Nursing Aide #6 stated after Resident #39 left the room she saw that Resident #7's brief was open and there was stool outside the brief and on the sheet. The Police Officer stated Resident #39 admitted to touching Resident #7 sexually and seemed to understand what he did was sexual battery. The Police Officer stated Resident #39 took advantage of a situation where no one was around, and Resident #7 confusion prevented her from stopping him. During an interview on 5/14/2024 at 10:00 am with Resident #7's Responsible Party by phone he stated the facility notified him on 5/2/2024 at 9:30 am that Resident #7 had been sexually abused. He stated Resident #7 is severely cognitively impaired and would not have understood what happened to her. The Responsible Party stated he felt Resident #7 was sexually abused because she was unable to call for help or report what was done to her. He stated Resident #7 was a very good woman and would not have instigated a sexual encounter and would have been very upset if she understood what happened. A Physician's Progress Note stated 5/6/2024 by the Medical Director indicated he saw Resident #7 and evaluated her mental status and ability to give/withhold informed consent. The Progress Note further stated Resident #7 was a poor historian due to her cognition and information was obtained through chart review and discussion with medical staff; and she was not able to give informed consent. A Physician's Progress Note dated 5/6/2024 indicated the Medical Director evaluated Resident #39 for the ability to give/withhold informed consent. The Progress Report stated Resident #39 had a history of dementia; had no recent cognitive decline noted; and Resident had cognitive impairment with poor ability to give or withhold consent and was unlikely to understand the nature of his actions. On 5/14/2024 at 5:32 pm the Medical Director was interviewed by phone and stated he did not believe Resident #39 understood what he was doing when he evaluated him on 5/6/2024 after the incident that occurred on 5/2/2024. The Medical Director stated Resident #39 responded, it was bad when he asked if he understood what he did was bad; and he responded, it was bad when he asked Resident #39 if he understood why what he did was bad. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #39 was interviewed on 5/14/2024 at 11:20 am and he stated he has lived at the facility for 2 years. When asked if he had any altercations with another resident he stated, I got in trouble for touching another resident. Resident #39 stated he did not know the name of the resident and stated he did not remember how long ago the incident happened. The Director of Nursing was interviewed on 5/14/2024 at 5:37 pm and stated Unit Manager #2 reported to her on 5/2/2024 around 9:30 am to 9:40 am that Resident #39 was found in Resident #7's room by Nurse Aide #6 sitting beside her bed in his wheelchair with his hand under the covers. She stated Nurse Aide #6 reported Resident #7's brief was open, and stool was on the outside of her brief and on her sheet, and Resident #39 had stool on his hand. The Director of Nursing stated they began an investigation and had substantiated the sexual abuse. On 5/15/2024 at 8:42 am the previous Administrator was interviewed by phone and stated the facility had initiated an investigation when Nurse Aide #6 reported Resident #39 was found in his wheelchair beside Resident #7's bed with his hand under the covers. The Administrator stated the Medical Director spoke with Resident #39 and the Medical Director felt Resident #39 did not understand what he had done wrong. The previous Administrator stated the Medical Director prescribed Zoloft (an antidepressant) to treat Resident #39's libido and aggression after the incident. The previous Administrator indicated Resident #39 was put on every 15-minute observations by nursing after the incident was reported and the Medical Director felt that every 15-minute observations by nursing was sufficient to protect Resident #7 and other resident's safety. He stated Resident #39 did wander in the facility between the every 15-minute observations. An interview was conducted with the Administrator on 5/17/2024 at 3:32 pm and he stated the facility had provided education to all staff regarding their Abuse Prevention, Intervention, Reporting, and Investigation Policy. He stated the facility was responsible for protecting the residents from all forms of abuse. The Administrator was notified of immediate jeopardy on 5/15/2024 at 4:24 pm. The facility provided the following Credible Allegation of Immediate Jeopardy Removal: Identify Those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance. On 5/2/2024 NA #6 observed Resident # 39's hand under the covers of Resident #7 in her bed in resident #7's room at around 9:00am. NA # 6 announced for Resident #39 to abstain from touching Resident # 7. NA #6 removed Resident #39 from Resident # 7's room. Nurse #6 completed a skin assessment on Resident #7 during 7p-7a shift on 5/2/2024 with no noted injuries. Law enforcement was notified on 5/2/2024 around 9:30 am. Resident # 7's responsible party was notified of occurrence on 5/2/2024. Resident # 7's emergency contact was also notified of the occurrence on 5/2/2024. Resident #7 was transferred to another room on 5/2/24 for her protection. Resident #39 had no prior history of sexual aggression prior to the incident on 5/2/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Abuse questionnaires were completed by the Business Office Manager, MDS Nurse, Admissions Director and Unit Manager on all residents with Brief Interview for Mental Status (BIMS) score of 9 and above with no adverse responses. Questionnaires were completed on 5/15/2024. The questions asked were as follows, 1. Do you feel safe? 2. Has anyone ever touched you inappropriately? 3. Are you afraid of anyone in the facility? The Unit Manager and/or Floor Nurse completed skin assessment for all residents with a BIMS score below 9 as of 5/15/2024 with no negative findings. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On 5/2/2024 at 9:40am Social Worker talked with Resident #39 about the incident that occurred and explained to resident #39 what he had done wrong. On 5/7/2024 the physician changed resident #39's medication to add Zoloft 25mg tablet daily by mouth for aggression. As of 5/15/2024, around 5:30pm resident #39 has been placed on 1 on 1 observation. MDS Nurse updated resident #39's care plan to reflect new behavior of sexual aggression and interventions for managing behavior as of 5/16/2024. MDS Nurse updated care guide for resident #39 on 5/16/2024 and staff notified of changes through care guide on 5/16/2024. MDS Nurse will continue to update interventions as needed. As of 5/15/2024 the Staff Development Coordinator educated 100% of facility staff on the facility abuse policy to include residents right to be free from abuse to include sexual, physical, mental, verbal and misappropriation of property as well as signs of abuse and reporting of abuse or potential abuse. Staff development Coordinator will provide education for abuse training to new hires during orientation. 1:1 supervision will be documented and reported to the facility Administrator and Director of Nursing to ensure monitoring of resident. The Director of Nursing will ensure the 1:1 staff member is provided each shift with the staffing coordinator daily. As of 5/15/2024 all CNA's will be educated by the Director of Nursing/Staff Development Coordinator on supervision of resident during 1:1 duty. Education will include a goal of 1:1 in protecting other residents from any sexual aggression by resident #39 and ensuring resident #39 does not encounter resident #7 and documenting of any aggression during shift. On 5/15/2024 the facility completed Ad Hoc QAPI to review investigation and current action plan to ensure all components were done and followed. The facility administrator and Director of Nursing are responsible for continued compliance. Alleged date of IJ removal: 5/17/2024 Credible Allegation of IJ Removal: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Credible Allegation of IJ Removal was validated on 5/17/2024. The facility provided documentation of the in-service education that was provided to all facility staff which included review of the facility's Abuse Policy to include residents right to be free from abuse to include sexual, physical, mental, verbal and misappropriation of property; signs of abuse; and reporting of abuse or potential abuse. The Staff Development Coordinator provided the education to the staff which will also be covered in the facility's orientation of new employees. The Staff Development Coordinator was interviewed and stated they have ensured staff are educated on the abuse policy before they are allowed to care for residents. During interviews with staff from all departments, they were able to verbalize the types of abuse, resident's right to be free from abuse, signs of abuse, reporting of abuse and potential abuse and protection of residents from abuse. Observations were made of Resident #39 during the validation of the Credible Allegation, and he remained on 1 to 1 observation during the validation. The facility provided skin assessments that were completed on residents with a Brief Interview for Mental Status (BIMS) score of less than 9 and interviews forms that were completed on all residents with a BIMs score of 9 or above. The facility provided the minutes for their Quality Assurance Performance Improvement (QAPI) meeting which was completed on 5/15/2024. The alleged date of IJ removal of 5/17/24 was validated.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review, observations, and staff interviews, the facility failed to protect the residents right to be free from misappropriation of a narcotic medication (Oxycodone) prescribed to treat pain for Resident #16, Resident #75, and Resident #239. This was for 3 of 3 residents reviewed for misappropriation. The findings included: 1) Resident #16 was admitted to the facility on [DATE]. A review of Resident #16's quarterly Minimum Data Set assessment, dated 2/29/24, indicated her cognition was intact and she received opioid medication. Resident #16 had an order dated 2/13/24 for Oxycodone 10 milligrams (mg) every 6 hours as needed for 5 days and to record the resident's pain level. A review of Resident #16's February Medication Administration Record (MAR) revealed the resident received Oxycodone 10 mg administered by Nurse #2, #7, and #12 for pain on 2/14/24. The second Oxycodone order, dated 2/18/24, was for 10 mg every 6 hours as needed for pain. The Narcotic Count Sheet documented for Resident #16's Oxycodone 10 mg every 6 hours as needed for pain indicated the following: - On 2/22/24 the resident received her med at 6:22 am and one was wasted by Nurse #12. - On 2/25/24 the resident received her med at 1:00 am and one was wasted by Nurse #12. - On 2/26/24 the resident received her med at 3:10 am and one was wasted by Nurse #12. Resident #16 had a pain evaluation dated 2/28/24 which documented she had received pain medication within the past 5 days. She received pain medication and non-pharmacological interventions. The resident was satisfied with the current pain management plan and received her medication when requested. On 4/30/24 at 12:45 pm Resident #16 was interviewed and stated she received her pain medication and all medication as expected and had no concerns. On 5/1/24 at 11:40 am an interview was conducted with Resident #16. She remembered the surgical procedure and received pain medication as requested. The resident had not remembered any concerns regarding the treatment of her pain. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A drug testing collection and results dated 2/16/24 for Nurse #2 was reviewed. She was tested for Amphetamines, Barbiturates, Benzodiazepine, Burprenorphine, Cocaine, Marijuana, Methylenedioxymethamphetamine, Methamphetamine, Methadone, Opiates/Morphine, Oxycodone, and Phencyclidine. All tested negative. A drug testing collection and results dated 2/16/24 for Nurse #7 was reviewed. She was tested for Amphetamines, Barbiturates, Benzodiazepine, Burprenorphine, Cocaine, Marijuana, Methylenedioxymethamphetamine, Methamphetamine, Methadone, Opiates/Morphine, Oxycodone, and Phencyclidine. All tested negative. On 5/6/24/at 10:02 am an interview was attempted by telephone with Nurse #7. She was not available, and a message was left. A review of the hand-written statement dated 2/28/24 by Nurse #12 documented the following: I previously have had an addiction to oxycodone and sought help through treatment. I was clean and stayed so for years. I got a couple of oxycodone from my sister that I took yesterday 2/27 before my shift. A drug testing collection and results dated 2/28/24 for Nurse #12 was reviewed. She was tested for Amphetamines, Barbiturates, Benzodiazepine, Burprenorphine, Cocaine, Marijuana, Methylenedioxymethamphetamine, Methamphetamine, Methadone, Opiates/Morphine, Oxycodone, and Phencyclidine. The Oxycodone tested positive, and all other drugs tested negative. On 5/6/24 at 10:05 am an interview was attempted by telephone with Nurse #12. She answered the phone and then hung up. 2) Resident #75 was admitted to the facility on [DATE]. Resident #75's 5-day Minimum Data Set assessment dated [DATE] documented her cognition as intact, received as needed pain medication, and received opioid medication. Resident #75 had an order dated 2/20/24 for Oxycodone 5 mg every 4 hours as needed for pain. A review of Resident #75's Narcotic Count Sheet for February 2024 documented on 2/24/24 at 7:00 pm, one tablet of oxycodone 5 mg was documented as wasted by Nurse #12 and witnessed by Nurse #6. A review of a typed statement, signed by Nurse #6 and dated 3/5/24 documented, I was called into the facility to write a statement to verify that I did waste Oxycodone with Nurse #12 for Resident #75. Those initials are not my initials. I had not wasted the Oxycodone with Nurse #12. On 5/3/24 at 2:52 pm an interview was attempted with Nurse #6 and a voicemail was left which requested a call back. A drug testing collection and results dated 2/16/24 for Nurse #6. She was tested for Amphetamines, Barbiturates, Benzodiazepine, Burprenorphine, Cocaine, Marijuana, Methylenedioxymethamphetamine, Methamphetamine, Methadone, Opiates/Morphine, Oxycodone, and Phencyclidine. All tested negative. 3) Resident #239 was admitted to the facility on [DATE] and was discharged on [DATE]. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #239 had an order for Oxycodone 10 mg every four hours as needed for pain dated 2/23/24. A review of Resident #239's Narcotic Count Sheet indicated Oxycodone 10 mg was signed out by Nurse #12 on 2/28/24 at 12:42 am, 3:42 am, and 7:42 am (night shift). Resident #239's pain assessment was completed on 2/27/24 at 12:07 pm, 2/27/24 at 4:47 pm, 2/28/24 at 9:21 am and 2/28/24 at 4:59 pm. She had no pain and required no Oxycodone pain medication as needed. Review of a 5-day Minimum Data Set assessment dated [DATE], documented Resident #239's cognition as intact and received opioid medications. Review of a facility interview with Resident #239 on 3/1/24 indicated she reported she had only requested Oxycodone at 8:00 PM on 2/27/24. The facility provided the follwing corrective action plan: 1. Corrective action for resident(s) affected by the alleged deficient practice: Day shift nurse reported to the Unit Manager and Director of Nursing on 2/28/24 a licensed nurse had potentially taken as needed narcotics from a resident narcotic card. The Regional Nurse Consultant and Staff Development Coordinator audited all active resident's narcotics and determined medication narcotic discrepancies with 4 residents, Oxycodone 10 mg as needed tablets. No negative outcomes for the 4 residents as they were as needed medication, and the facility had this medication in backup. The medications were replaced prior to residents requesting them. The Director of Nursing suspended the Licensed Nurse who was suspected of misappropriation during the investigation immediately on 2/28/24 upon learning of the incident. Director of nursing completed the 24-hour report to the Division of Health and Human Services on 2/28/24. The Director of Nursing then began an investigation of missing narcotics and interviewed the licensed nurses and medication aides who had worked on the carts of missing narcotics. The Director of Nursing submitted the five-day report upon completion of the investigation on 3/6/24 to DHHS. The Director of Nursing notified the local Police Department on 2/28/24, the Board of Nursing and Drug Enforcement Agency (DEA) on 2/29/24, by the Director of Nursing. Facility notified the Medical Director on 2/28/24 of the missing as needed narcotics and the residents involved. Residents were assessed on 2/28/24 with no adverse effects as the medications were as needed medications. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 100% audit was conducted on 2/28/24 by the Regional Nurse Consultant and Staff Development Coordinator of the control sheets and each medication on all medication carts to verify that all narcotic medication and control sheets were accounted for. It was discovered that the seven Oxycodone tablets among four residents were missing/not properly accounted for. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education was initiated with all licensed nursing and medication aides by the Director of Nursing or Staff Development Coordinator on the pharmacy policy related to maintaining narcotics on the medication carts, signing of shift-to-shift count sheets, counting, and verifying the narcotic count was correct, wasting and signing with 2 nurses, following the physician order, as well as diversion of narcotics. Education was completed by 3/1/24. Staff will not be permitted to work after 3/1/24 until education is completed, including agency staff. Education will be a part of orientation for all new hire and agency licensed staff prior to working their first shift. The Director of Nursing will continue to maintain file folders for narcotics in the facility for receiving and returning meds and verify narcotic medication count of delivery manifest sheets received from pharmacy. The facility will follow the facility's policy in maintaining control medications. The licensed nurses will receive and document receiving the controlled medication from pharmacy. The nurses will document the number of sheets in the narcotic count book for the number of medication packages located in the locked medication cart. If a medication is discontinued two nurses will remove the card and the medication record and document the number of cards and the sheets that remain on the cart. The nurse will give the removed sheet to the Director of Nursing to maintain. Two nurses will return the discontinued meds to pharmacy, and two nurses will sign and verify. The medications will be placed in a locked tote and placed in the locked medication room to return to pharmacy. The nurses will give a copy of the record and a copy of the return to pharmacy sheet to the Director of Nursing to maintain in a file cabinet in her office. Two nurses will complete a shift-to-shift count to verify that the number listed on the narcotic record matches the amount of medication in the cart and verify that the numbers of sheets are correct. 4. Monitoring Procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing and/or Designee began an audit of medication carts related to narcotic count being correct, the medication cards match the control sheets, the shift-to-shift count sheet are being signed at the start and the end of the shift and any narcotic that needs to be wasted is being signed appropriate by 2 nurses on 2/28/24. Auditing will be completed 5 times per week for 4 weeks, weekly for 4 weeks, then monthly. An ad hoc Quality Assurance and Performance Improvement (QAPI) team meeting was completed on 2/28/24 to review and discuss the action plan. The Director of Nursing will report all findings of audits to the QAPI team monthly for any needed improvement. The date of completion was 3/1/24. Validation of the corrective action plan was completed on 5/3/24: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Universal Healthcare/Ramseur		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 Jordon Road Ramseur, NC 27316	

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The action plan was validated by reviewing the education provided to the staff, reviewing the interviews with staff and residents, and reviewing the daily Quality Monitoring documentation. Residents were interviewed during the survey, and none reported untreated pain. Nursing staff were interviewed and indicated they had all received education on narcotic diversion. The facility completion date of 3/1/24 could not be validated because the facility was educating staff on 3/1/24. The competion date was 3/2/24.

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review, observations, and staff and Medical Director interviews the facility failed to implement the following components of the abuse policy: (a) immediately report an allegation of sexual abuse of a severely cognitively impaired female resident (Resident #7) by a moderately cognitively impaired male resident (Resident #39) to the Administrator; (b) the facility failed to provide a physical examination of a severely cognitively impaired female resident (Resident #7) by a trained/licensed professional for signs of sexual abuse; (c) the facility failed to protect a severely cognitively impaired female resident (Resident #7) and all other residents from the possibility of sexual abuse when they failed to put Resident #39 on one-to-one observations when there was an allegation of sexual abuse against Resident #7; (d) the facility failed to assess all other residents in the facility when an allegation of sexual abuse was reported; and (e) the facility failed to report the allegation of abuse to the Adult Protective Services. This deficient practice affected 1 of 3 residents (Resident #7) investigated for allegations of abuse and had the high likelihood of affecting other vulnerable residents residing in the facility. Immediate jeopardy began on 5/2/2024, when the facility failed to immediately report an allegation of sexual abuse to the Administrator, provide assessment of the alleged victim of sexual abuse, provide protection for the alleged victim of sexual abuse and protect other residents in the facility from the possibility of abuse by assessing other residents in the facility for signs of sexual abuse. Immediate jeopardy was removed on 5/17/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems that were put into place are effective. Findings included: 1.a. A review of the facility's Abuse Prevention, Intervention, Reporting, and Investigation Policy, revised 2/2021, indicated upon receiving an allegation of physical and sexual abuse the Executive Director and Director of Health Services should be notified immediately to arrange for the examination of the resident. Resident #7 was admitted to the facility on [DATE] with diagnoses of dementia, stroke, and cognitive communication deficit. Resident #39 was admitted to the facility on [DATE] with diagnoses of dementia and stroke. A written statement made by Nurse Aide #6 on 5/2/2024 stated she walked into Resident #7's room and Resident #39 was sitting next to her bed, and she saw something moving under the covers that appeared to be Resident #39's hand. The statement further stated Nurse Aide #6 asked Resident #39 what he was doing, and he said, Nothing. The written statement indicated when Resident #39 left the room he had stool on his fingers and Resident #7's brief was open and there was stool outside the brief and on her sheets. The written statement did not indicate who Nurse Aide #6 notified of the allegation of abuse. (continued on next page)

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F 0607

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

During an interview with Nurse Aide #6 on 5/14/2024 at 1:11 pm she stated she cared for Resident #7 on 5/2/2024 on the 7:00 am to 7:00 pm shift and she walked into the room between 9:00 am and 9:30 am and Resident #39 was sitting next to Resident #7's bed in his wheelchair and his hand was under the bed covers and she saw his hand moving around her groin area. Nurse Aide #6 stated Resident #7 was not upset but she is severely cognitively impaired. Nurse Aide #6 stated she asked Resident #39 what he was doing, and he said, Nothing. Nurse Aide #6 stated when asked Resident #39 to leave the room there was stool on his hand. Nurse Aide #6 stated when she returned to Resident #6, she pulled down the covers and her brief was open and there was stool on the outside of her brief and on the sheets. Nurse Aide #6 stated she told Medication Aide #4 about what she witnessed, and Medication Aide #4 told her she would notify Unit Supervisor #2.

On 5/14/2024 at 1:29 pm Medication Aide #4 was interviewed and stated Nurse Aide #6 told her she found Resident #39 in Resident #7's room and he had his hand under Resident #7's covers and when he pulled his hand out from under the bed covers, he had stool on his hand and Resident #7's brief was open and there was stool on the outside of her brief and on the bed covers. Medication Aide #4 stated she told Unit Supervisor #2 about the allegation of sexual abuse about 30 minutes after Nurse Aide #6 told her because Unit Supervisor #2 was in a meeting, and she did not want to disturb the meeting. Medication Aide #4 stated when Unit Supervisor #2 came to the unit after the meeting she notified her of the allegation of sexual abuse.

Unit Supervisor #2 was interviewed on 5/14/2024 at 1:35 pm and she stated she did not remember what time it was when she was notified of the allegation of sexual abuse, but it was before 10:00 am. She stated she was coming from the morning meeting, and she does a round of the facility after the meeting. When she went to 200-hall to check on Medication Aide #4 she was told about the allegation of sexual abuse. Unit Supervisor #2 stated she went to Resident #7's room and Nurse Aide #6 was providing incontinence care. She stated there was stool on the sheet, but the brief had been removed. Unit Supervisor #2 stated she reported the allegation of sexual abuse to the Director of Nursing after she checked on Resident #7.

The Director of Nursing was interviewed on 5/14/2024 at 5:37 pm and stated she was in her office and between 9:30 am and 9:40 am on 5/2/24 when Unit Supervisor #2 came to her office and reported the allegation of sexual abuse of Resident #7. She stated she was told by Unit Supervisor #2 that Nurse Aide #6 went into Resident #7's room and Resident #38 was sitting beside her bed in his wheelchair with his hand under the sheet and when she came into the room, he pulled his hand out. The Director of Nursing stated she was told Resident #38 had stool on his hand. The Director of Nursing stated they began an investigation immediately and the police were called. She stated she was not aware Medication Aide #4 had not reported the allegation of sexual abuse to Unit Supervisor #2 until 30 minutes after it was reported to her. The Director of Nursing stated that all allegations of abuse should be reported immediately.

The previous Administrator was interviewed on 5/15/2024 at 8:42 am and he stated he had moved to another facility but was the administrator of the building at the time of the allegation of sexual abuse. He stated he was told by the Director of Nursing about the allegation of sexual abuse, and an investigation was initiated immediately. He stated he was not aware Medication Aide #4 had not report the allegation until 30 minutes after she was told by Nurse Aide #6. He stated all allegations of abuse should be reported to the administration immediately.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. The facility's Abuse Prevention, Intervention, Reporting and Investigation Policy, revised 2/2021, indicated a physical examination of the resident should be conducted by an appropriately trained/licensed professional (attending physician, emergency room physician). Unit Supervisor #2 was interviewed on 5/14/2024 at 1:35 pm and she stated she was coming from her morning meeting on 5/2/2024 before 10:00 am, when she did a morning round, and went to the 200-hall to check on Medication Aide #4. She stated Medication Aide #4 told her Nurse Aide #6 walked into Resident #7's room and Resident #39 was sitting in his wheelchair beside the bed with his hand under the sheet. She stated she was told Resident #39 had stool on his hand and Resident #39's brief was open and there was stool on the sheet and on the outside of the brief. Unit Supervisor #2 stated she went to Resident #7's room and Nurse Aide #6 was providing incontinence care for Resident #7. Unit Supervisor #2 stated she did not assess Resident #7 and she did not know if anyone else assessed Resident #7. The Director of Nursing was interviewed on 5/14/2024 at 5:37 pm and she stated it was reported to her on 5/2/2024 between 9:30 and 9:40 am that Resident #38 was found by Nurse Aide #6 in Resident #7's room sitting beside her bed in his wheelchair with his hand under the covers. She stated when Resident #38 pulled his hand from the covers he had stool on his fingers and when Nurse Aide #6 pulled back Resident #7's covers her brief was open and there was stool on the outside of her brief and on the sheets. The Director of Nursing stated someone did assess Resident #7, but she was not sure who had provided the assessment. A follow-up interview was conducted with the Director of Nursing on 5/15/2024 and she stated there was not a physical assessment of Resident #7 immediately after the allegation of sexual abuse was reported. She stated there was a skin assessment completed on 5/2/2024 on the 7:00 pm to 7:00 am shift. A phone interview was conducted with Nurse #6 on 5/15/2024 at 12:03 pm and she stated she did a skin assessment on 5/2/2024 between 9:00 pm and 10:00 pm and Resident #7 did not have any bruising or injuries to her perineum. The previous Administrator was interviewed on 5/15/2024 at 8:42 am and he stated the Medical Director was made aware of the allegation of sexual abuse immediately, but he did not know when Resident #7 was physically assessed after the incident. c. The facility's Abuse Prevention, Intervention Reporting, and Investigation Policy stated a resident who is allegedly mistreated by another resident is removed from contact with that resident during the investigation. The policy further stated residents are to be protected during incident investigations; and residents will be protected from the alleged offender. A written statement made by Nurse Aide #6 on 5/2/2024 stated she walked into Resident #7's room and Resident #39 was sitting next to her bed, and she saw something moving under the covers that appeared to be Resident #39's hand. The statement further stated Nurse Aide #6 asked Resident #39 what he was doing, and he said, Nothing. The written statement indicated when Resident #39 left the room he had stool on his fingers and Resident #7's brief was open and there was stool outside the brief and on her sheets. (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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with Nurse Aide #6 on 5/14/2024 at 1:11 pm she stated she cared for Resident #7 on 5/2/2024 on the 7:00 am to 7:00 pm shift and she walked into the room between 9:00 am and 9:30 am and Resident #39 was sitting next to Resident #7's bed in his wheelchair and his hand was under the bed covers and she saw his hand moving around her groin area. Nurse Aide #6 stated Resident #7 was not upset but she is severely cognitively impaired. Nurse Aide #6 stated she asked Resident #39 what he was doing, and he said, Nothing. Nurse Aide #6 stated when she sent Resident #39 out of the room there was stool on his hand. Nurse Aide #6 stated when she returned to Resident #6, she pulled down the covers and her brief was open and there was stool on the outside of her brief and on the sheets. Nurse Aide #6 stated she told Medication Aide #4 about what she witnessed, and Medication Aide #4 told her she would notify Unit Supervisor #2. Nurse Aide #6 stated Resident #39 was in his room when she went to tell Medication Aide #4 about the allegation of sexual abuse but there was not anyone with him and they did not put him on one-to-one observation until the Patient Care Associate (PCA) came to sit with him. She stated she did not know what time the PCA was assigned to Resident #39. On 5/14/2024 at 1:29 pm Medication Aide #4 was interviewed and stated Nurse Aide #6 told her she found Resident #39 in Resident #7's room and he had his hand under Resident #7's covers and when he pulled his hand out from under the bed covers, he had stool on his hand and Resident #7's brief was open and there was stool on the outside of her brief and on the bed covers. Medication Aide #4 stated she told Unit Supervisor #2 about the allegation of sexual abuse about 30 minutes after Nurse Aide #6 told her because Unit Supervisor #2 was in a meeting, and she did not want to disturb the meeting. Medication Aide #4 stated Resident #38 was not put on one-to-one observation until later that morning when the Patient Care Associate (PCA) was assigned to watch him and after she left at 3:00 pm that day he was put on every 15-minute checks. Medication Aide #4 stated staff were supposed to check to see where Resident #39 was every 15 minutes and document that we saw him. She stated she did not know why Resident #39 was not kept on one-to-one observation. Unit Supervisor #2 was interviewed on 5/14/2024 at 1:35 pm and she stated she did not remember what time it was when she was notified of the allegation of sexual abuse, but she stated it was before 10:00 am. She stated she was coming from the morning meeting, and she does a round of the facility after the meeting and when she went to 200-hall to check on Medication Aide #4 she was told about the allegation of sexual abuse. Unit Supervisor #2 stated she went to Resident #7's room and Nurse Aide #6 was providing incontinence care. She stated there was stool on the sheet, but the brief had been removed. Unit Supervisor #2 stated she reported the allegation of sexual abuse to the Director of Nursing after she checked on Resident #7. Unit Supervisor #2 stated Resident #39 was in the hallway away from his room when she went to check on Resident #7, she stated they did not put Resident #39 on one-to-one observation until after she reported the allegation of sexual abuse to the Director of Nursing and then he went to every 15-minute checks the next day. Unit Supervisor #2 stated Resident #39 is very mobile in his wheelchair and he wanders around the facility. The Police Officer was interviewed on 5/15/2024 at 10:05 am and he stated he came to the facility on [DATE] at 9:58 am to investigate. He stated when he arrived at the facility Resident #7 was in his wheelchair in the hallway and no one was supervising him when he approached him to interview him. During an interview with the Patient Care Associate (PCA) on 5/14/2024 at 2:01 pm, who spoke only Spanish, and the Director of Nursing provided interpretation, the PCA stated she was assigned to Resident #39 at 12:15 pm on 5/2/2024 and she observed him until 3:00 pm. She stated she kept notes in her notebook of where he went during the one-to-one observation. The PCA stated Resident #39 tried to get close to Resident #7 once on 5/2/2024 when she was observing him, but she redirected him. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/14/2024 at 11:12 am Resident #7 was observed in her wheelchair on the 200-hall and she went up and down the hallway but did not go into any resident rooms. Staff were observed at the nurses' desk but did not redirect Resident #7 back to the 100-hall where she resided. Resident #7 rolled past Resident #39's room door twice in her wheelchair during the observation. Resident #7 was observed until 11:20 am. The Director of Nursing was interviewed on 5/14/2024 at 5:37 pm and she stated they put Resident #39 on one-to-one observation after the incident was reported. On 5/15/2024 at 3:08 pm the Director of Nursing was interviewed again and stated she was not aware Resident #39 was not put on one-to-one observation until 12:15 pm. She stated they decided to monitor him on every 15-minute checks after 3:00 pm on 5/2/2024 because they felt they could watch him closely enough with every 15-minute checks to ensure Resident #7 and all other residents were safe. d. The facility's Abuse Prevention, Intervention, Reporting, and Investigation Policy, revised on 2/2021, indicated the facility will assess and interview all residents who came in contact with the accused when investigating an abuse allegation. Unit Supervisor #4 was interviewed on 5/14/2024 at 5:25 pm and stated she had not physically assessed Resident #7 on 5/2/2024 after the allegation of sexual abuse was reported. Unit Supervisor #4 stated she was not asked to do assessments or interviews with any other residents after the allegation of sexual abuse was reported on 5/2/2024. During an interview with the Director of Nursing on 5/15/2024 at 3:08 pm she stated the facility did not complete physical assessments with residents that were cognitively impaired or interview any residents that were not cognitively impaired to see if there were any further allegations of sexual abuse in the facility when the sexual abuse allegation was reported on 5/2/2024. The previous Administrator was interviewed by phone on 5/15/2024 at 8:42 am and he stated when the allegation of sexual abuse of Resident #7 by Resident #39 was reported on 5/2/2024 the facility moved Resident #7 to another room on a different hallway; placed Resident #39 on every 15-minute checks; and the Medical Director and police were notified of the allegation of abuse. The previous Administrator stated he spoke with the Medical Director after the incident on 5/2/2024 to see if the facility needed to do anything else to protect Resident #7 and other residents and the Medical Director stated they had done everything they could do. The current Administrator was interviewed on 5/17/2024 at 4:42 pm and stated the facility's staff have received in-service education regarding the facility's Abuse Prevention, Intervention, Reporting, and Investigation Policy. The current Administrator stated the staff should have assessed all residents who came in contact with the accused when the allegation was reported on 5/2/2024. e. The facility's Abuse Prevention, Intervention, Reporting, and Investigation policy, revised 2/2021, indicated the facility would notify Adult Protective Services when an allegation of abuse is reported. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Nursing was interviewed on 5/15/2024 at 4:03 pm and she stated the facility did not notify the North Carolina Division of Social Services, Adult Protective Services regarding the allegation of sexual abuse of Resident #7 that was reported on 5/2/2024. She stated she was not aware she should notify Adult Protective Services. The previous Administrator was interviewed by phone on 5/15/2024 at 8:42 am and he stated when the allegation of sexual abuse of Resident #7 by Resident #39 was reported on 5/2/2024 the facility moved Resident #7 to another room on a different hallway; placed Resident #39 on every 15-minute checks; and the Medical Director and police were notified of the allegation of abuse. The previous Administrator stated he spoke with the Medical Director after the incident on 5/2/2024 to see if the facility needed to do anything else to protect Resident #7 and other residents and the Medical Director stated they had done everything they could do. The Administrator was notified of immediate jeopardy on 5/15/2024 at 4:43 pm. The facility provided the Credible Allegation of Immediate Jeopardy Removal: F607 Abuse Reporting: The facility failed to implement the abuse policy related to reporting and protection. Identify Those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance. On 5/2/2024 CNA #1 observed Resident # 39's hand under the covers of Resident #7 in her bed in resident #7's room at around 9:00am. CNA # 6 announced for Resident # 39 to abstain from touching Resident # 2. CNA #7 removed Resident # 39 from Resident # 7's room. After an allegation of sexual abuse, a nurse was not notified immediately; staff was cleaning up the resident before a nurse came to the room, a nurse did not complete an initial assessment until that night on 7p-7a shift. The facility failed to provide a physical examination of a cognitively impaired female resident (Resident #7) by an appropriately trained/licensed professional for signs of sexual abuse or other forms of abuse immediately after a moderately cognitively impaired resident (Resident #39) was found in his wheelchair at her bedside with his hand under her covers on 5/2/2024. Resident #7 was not assessed by the Medical Director until 5/6/2024. Medical Director ordered Zoloft 25 milligrams by mouth daily for aggression on 5/6/2024. Resident # 39 was not put on 1 on 1 monitoring until 12:15 pm. The resident stayed on 1 on 1 until 3 pm and then was on every 15-minute checks. Resident #39 was placed on one-to-one supervision on 5/15/2024 at around 5:30 pm. The facility failed to assess if other residents had been abused until 5/15/2024. The facility failed to report the abuse allegation to APS until 5/16/2024. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Abuse questionnaires were completed by the Business Office Manager, MDS Nurse, Admissions Director and Unit Manager on all residents with Brief Interview for Mental Status (BIMS) score of 9 and above with no adverse responses. Questionnaires were completed on 5/15/2024. The questions asked were as follows, 1. Do you feel safe? 2. Has anyone ever touched you inappropriately? 3. Are you afraid of anyone in the facility? The Unit Manager and/or Floor Nurse completed skin assessment for all residents with a BIMS score below 9 as of 5/15/2024 with no negative outcomes. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. As of 5/15/2024 the Regional Director of Operations and Regional Clinical Nurse educated the Director of Nursing, Administrator, Medical and Staff Development Coordinator on abuse policy to include residents right to be free from abuse to include sexual, physical, mental, verbal and misappropriation of property as well as signs of abuse and reporting of abuse or potential abuse. Education also included the process and action to protect residents if any type of abuse including sexual abuse occurs according to facility policy and procedure on abuse. Actions to include assessment of all residents involved, immediate protection for all residents, immediate reporting to Management, state agencies, Ombudsman, APS, families, physician, immediate protection for all residents, and law enforcement. On 5/16/2024 Staff Development Coordinator and/or Director of Nursing educated all nursing staff on proper procedures for reporting any suspected abuse and immediate reporting to the Administrator and Director of Nursing for direction. Education will include direction for resident assessment immediately following incident, physician notification by Nurse for direction of care for resident and need to send out to hospital for further examination. On 5/2/2024 at 9:40am Social Worker talked with Resident #39 about the incident that occurred and explained to resident #39 what he had done wrong. On 5/7/2024 the physician changed resident #39's medication to add Zoloft 25mg tablet daily by mouth for aggression. As of 5/15/2024, around 5:30pm resident #39 has been placed on 1 on 1 observation. On 5/15/2024 the facility completed AdHoc QAPI to review investigation and current action plan to ensure all components were done and followed. The facility administrator and Director of Nursing are responsible for continued compliance. Alleged date of IJ removal: 5/17/2024 (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Credible Allegation of IJ Removal was validated on 5/17/2024. The facility provided documentation of the in-service education that was provided to all staff which included the review of the facility's Abuse Policy and included immediate reporting of any allegations of abuse to the Administrator immediately; provide a physical examination by a trained/licensed professional for any signs of sexual abuse; provide protection for the resident that is the victim of abuse; provide protection for all other residents when an allegation of abuse is reported; and report any allegations of abuse to the proper authorities. The Staff Development Coordinator was interviewed and stated they have ensure all staff are educated regarding the reporting of abuse allegations to the administrator immediately; provide a physical examination by the physician or if the physician is not available send the resident to the emergency department for evaluation if there is an allegation of sexual abuse; provide protection for the abused individual and all other residents; and reporting of allegations of abuse to the proper authorities. She stated all staff that have been allowed to work have had the abuse education. During the validation of the Credible Allegation of IJ Removal observations of Resident #39 were made and the facility was providing one-to-one observation of the resident. The facility staff (sampled from all disciplines) were able to verbalize the types of abuse; what steps they should take to assess and protect the resident of an alleged abuse; and what authorities should be notified of allegations of abuse. The facility provided skin assessments that were completed on residents with a Brief Interview for Mental Status (BIMS) of less than 9 and interview forms that were completed on all residents with a BIMS of 9 or above that were conducted on 5/15/2024. The facility also notified Adult Protective Services of the allegation of sexual abuse for Resident #7 on 5/16/2024. The facility provided minutes of their Quality Assurance Performance Improvement (QAPI) meeting which was conducted on 5/15/2024. The alledged IJ removal date of 5/17 24 was validated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Universal Healthcare/Ramseur		STREET ADDRESS, CITY, STATE, ZIP CODE 7166 Jordon Road Ramseur, NC 27316	

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review and staff interviews, the facility failed to provide the resident and/or Resident Representative (RR) written notification of the reason for a hospital transfer for 2 of 2 residents reviewed for hospitalization (Residents #78 and #86) and the facility failed to send a copy of a 30-day discharge notice to the Ombudsman for 1 of 1 resident (Resident #64) reviewed for facility-initiated discharge. The findings included: 1. Resident #78 was originally admitted to the facility on [DATE]. Resident #78's medical record revealed she was transferred to the hospital on 1/5/24 and readmitted back to the facility on [DATE]. Additionally, Resident #78 was transferred to the hospital on 1/29/24 and readmitted back to the facility on [DATE]. There was no documentation of a written notice of transfer provided to the resident and/or RR. On 4/30/24 at 11:15 AM, an interview occurred with the wound nurse, who had transferred Resident #78 to the hospital on 1/29/24. She stated that when a resident was transferred to the hospital, a medication list, resident summary, and bed hold policy was sent with them. The RR was notified via phone. During an interview with the Social Worker on 4/30/24 at 3:32 PM, she stated she didn't provide any written information to the resident and/or RR when a resident was transferred to the hospital. The Director of Nursing was interviewed on 4/30/24 at 3:34 PM and explained when a resident was transferred to the hospital the nursing staff called the RR but didn't mail anything to them in writing. On 5/1/24 at 8:40 AM, an interview was conducted with the Administrator who was familiar with the regulation. He stated he was unaware written notification to the resident and/or RR for the reason for a hospital transfer was not being sent and would expect the regulation to be followed. 46095 2. Resident #86 was admitted to the facility on [DATE]. Resident #86's admission Minimum Data Set (MDS) dated [DATE] indicated his cognition was intact. Review of Resident #86's electronic medical record read he was transferred to the hospital on 01/02/24. There was no documentation in the resident's medical record that written notice of transfer or discharge was provided to the resident and/or Resident Representative (RR). Resident #86 returned to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345523	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview was conducted on 4/30/24 at 3:32 PM with the facility Social Worker (SW). She stated she had been at the facility since [DATE] and was not mailing a notice of discharge or transfer to the RR when the resident was admitted to the hospital. She was unaware she needed to send notification to the resident or RR in writing. An interview was conducted on 4/30/24 at 3:34 PM with the Director of Nursing (DON). She stated when a resident was transferred to the hospital the nursing staff called the RR but did not provide written notice of transfer or discharge. An interview was conducted on 5/1/24 at 8:40 AM with the Administrator who was familiar with the regulation. He stated he was unaware of written notification to the resident and/or RR for the reason for a hospital transfer was not being sent and would expect the regulation to be followed. 38904 3. Resident #64 was admitted to the facility on [DATE] and continued to reside in the facility. A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #64 was cognitively intact. Review of Resident #64's record revealed a 30-day notice of discharge was provided to the resident on 5/7/2024. Further review revealed no evidence a copy of the notice was provided to the Ombudsman. During an observation and interview with Resident #64 on 5/15/2024 at 10:32 am he stated he was told he would be discharged soon but was not able to state why he was being discharged . He stated the facility gave him a notice of discharge and told him he had to leave. Resident #64 stated he was ready to get out of the facility. During an interview by phone with the Ombudsman on 5/15/2024 at 11:59 am she stated the facility should report a 30-day discharge notice to her within 48 hours of issuing the notice to the resident. The Ombudsman stated she had not received the notification Resident #64 received a 30-day discharge notice. On 5/14/2024 a phone interview was conducted with the Social Worker, and she stated she issued the 30-day discharge notice on 5/7/2024 to Resident #64 but she did not notify the Ombudsman because she had waited for the Business Office Manager to give her the documentation of the facility's attempts to collect the debts Resident #64 owed to the facility. The Business Office Manager was interviewed on 5/15/2024 at 12:55 pm and she stated she supplied the documentation of the attempts to collect the debts of a resident who was issued a 30-day discharge notice for non-payment. She stated Resident #64 wanted to return home and he was able to care for himself. She stated the Social Worker did not need the documentation of the attempts to collect the debts to notify the Ombudsman of the 30-day discharge notice the Social Worker gave Resident #64 on 5/7/2024. On 5/17/2024 at 4:42 pm the Administrator was interviewed and stated the Social Worker should have notified the Ombudsman when Resident #64 was issued the 30-day discharge notice for non-payment.