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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Healthcare/Ramseur	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 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. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (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 #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]. 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. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Corrective action for residents with the potential to be affected by the alleged deficient practice: 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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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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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)

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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.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35122 Based on record review and staff interviews, the facility failed to complete a Minimum Data Set (MDS) discharge assessment within the required time frame for 1 of 6 residents reviewed for discharge (Resident #58). Findings include: Resident #58 had been admitted on [DATE]. An admission MDS assessment had been completed on 11/8/23. Nursing documentation dated 11/18/23 at 1:05 PM noted Resident #58 had been discharged home. No discharge MDS assessment was observed in Resident #58's record. An interview with the MDS Coordinator was conducted on 4/30/24 at 3:38 PM. She explained when she became aware of a resident's pending discharge, she opened the MDS assessment at that time. She stated yesterday she noticed Resident #58's MDS discharge assessment had not been transmitted and explained she was unsure how it had been missed. On 5/01/24 at 2:59 PM an interview with the corporate Nurse Consultant was conducted. She stated she would expect MDS assessments to be transmitted within the required timeframe.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35122 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the area of medication for 1 of 26 residents whose MDS assessments were reviewed (Resident #24). Findings include: Resident #24 had been readmitted on [DATE] with diagnoses including Stroke and coronary artery disease. Review of Resident #24's Significant Change in Status MDS assessment dated [DATE] noted he had received anticoagulant (blood thinner) and antiplatelet (blood clot inhibitor) medication. Review of Resident #24's February 2024 Medication Administration Record (MAR) did not reveal he had received anticoagulant medication but had received antiplatelet medication. On 4/30/24 at 3:38 PM an interview with the MDS Coordinator was conducted. She explained when she completed MDS assessments she also checked the MAR. She stated anticoagulant should not been coded, only antiplatelet medication. On 5/01/24 at 2:59 PM an interview with the Corporate Nurse Consultant was conducted. She stated she would expect MDS assessments to be accurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on record review, observations and staff interviews, the facility failed to develop an individualized and comprehensive care plan for a resident with urinary incontinence, a resident at risk for aspiration and failed to care plan antibiotic use. This was for 4 of 25 residents whose care plans were reviewed (Resident #2, #85, #66, and #78). The findings included: 1. Resident #2 was admitted to the facility on [DATE] with diagnosis that included displaced subtrochanteric fracture of right femur, and diabetes mellitus with diabetic polyneuropathy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #2's cognition was intact. She had no behavior and no rejection of care. She was dependent on staff for toileting hygiene, shower/bath, and she required maximum assistance with personal hygiene. She was occasionally incontinent of bladder and always incontinent of bowel. Review of Resident #2's active care plan, dated [DATE], revealed no care plan related to incontinence care. An interview was conducted on [DATE] at 3:34 PM with the Director of Nursing (DON). She stated a focus or intervention area for incontinence care should have been part of Resident #2's care plan. An interview was conducted on [DATE] at 1:04 PM with the Minimum Data Set (MDS) Nurse. She verified there were no areas on Resident #2's care plan for assistance needed with incontinence care and there should have been an intervention added to the activities of daily living (ADL) focus. She stated it was an oversight that this intervention was not added on Resident #2's care plan. An interview was conducted on [DATE] at 3:21 PM with Resident #2. She stated she did have incontinent episodes of urine and she was always incontinent of bowel. She further stated she required staff to assist her with continence are. 2. Resident #85 was admitted to the facility on [DATE] with diagnosis that included dysphagia, oropharyngeal phase. Resident #85 expired on [DATE]. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #85's cognition was severely impaired. His swallowing and nutrition section was coded for swallowing disorder. Review of Resident #85's active care plan, dated [DATE], revealed no care plan related to dysphagia or aspiration precautions. An interview was conducted on [DATE] at 3:34 PM with the Director of Nursing (DON). She stated Resident #85's care plan should be person centered and should have included a focus or intervention for aspiration precautions due to his diagnosis for dysphagia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 1:04 PM with the Minimum Data Set (MDS) Nurse. She verified there were no areas on Resident #85's care plan to include aspiration precautions. She stated it was an oversight that this was not added on Resident #85's care plan. 3. Resident #66 was admitted to the facility on [DATE] with diagnosis that included infection and inflammatory reaction due to internal right knee prosthesis requiring intravenous (IV) antibiotics. Review of Resident #66's active care plan, dated [DATE], revealed no care plan related to intravenous (IV) antibiotics. An interview was conducted on [DATE] at 3:34 PM with the Director of Nursing (DON). She stated Resident #66's care plan should be person centered and should have included an area for intravenous (IV) antibiotics. An interview was conducted on [DATE] at 1:04 PM with the Minimum Data Set (MDS) Nurse. She verified there were no areas on Resident #66's care plan to include intravenous (IV) antibiotics. She stated it was an oversight that this was not added on Resident #66's care plan. 40197 4. Resident #78 was admitted to the facility on [DATE] with diagnoses that included neoplasm of the brain and dysphagia (difficulty swallowing). A review of Resident #78's medical record revealed an order dated [DATE] for Ciprofloxacin (an antibiotic) 750 milligrams (mg) 1 tablet twice a day for polymicrobial bacterial infection (acute and chronic diseases caused by various combinations of viruses, bacteria, and fungi). An Infectious Disease progress note dated [DATE] read that Resident #78 was on Ciprofloxacin for a polymicrobial bacterial infection for at least a year. Review of the active care plan, dated [DATE], revealed Resident #78 was not care planned for the use of an indefinite antibiotic. A significant change in status Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #78 had severe cognitive impairment and was coded for the use of an antibiotic. On [DATE] at 12:00 PM, an interview occurred with the MDS Coordinator who reviewed Resident #78's active care plan, verified a care plan was not present for the indefinity use of an antibiotic and felt it was an oversight. The Director of Nursing was interviewed on [DATE] at 2:22 PM and stated it was her expectation for the care plan to be person centered and should have included the use of the indefinite antibiotic.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on record review and staff interviews, the facility failed to review and revise the care plans in the areas of antibiotic use and JP drain (A Jackson Pratt (JP) drain is a surgical suction drain that gently draws fluid from a wound to help recover after surgery) for Resident #81. This was for 1 of 3 residents reviewed for care plans. The findings included: Resident #81 was admitted to the facility on [DATE] with diagnosis that included urinary tract infection (UTI), abscess to left kidney requiring a JP drain, and right foot diabetic ulcer. Record review revealed the JP drain and the peripherally inserted central catheter (PICC) line were removed on 03/25/24. Resident #81's active care plan, dated 04/04/24, revealed a focus that read resident had a peripherally inserted central catheter (PICC) line and a JP drain, requiring intravenous (IV) antibiotics and IV antibiotics for renal abscess. Date initiated: 04/04/24. An interview was conducted on 05/01/24 at 1:04 PM with the Minimum Data Set (MDS) Nurse. She verified the areas on Resident #81's care plan for peripherally inserted central catheter (PICC) line, JP drain, and IV antibiotics for renal abscess should have been removed. She stated it was an oversight that these areas on Resident #81's care plan had not been updated and removed. An interview was conducted on 4/30/24 at 3:34 PM with the Director of Nursing (DON). She stated the focus areas for peripherally inserted central catheter (PICC) line, JP drain, and IV antibiotics for renal abscess should have been removed on Resident #81's care plan.

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Healthcare/Ramseur	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review, observations, and staff interviews, the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions (Resident #31). This was for 1 of 4 residents reviewed for accidents. The findings included: Resident #31 was admitted to the facility on [DATE] with diagnoses that included dementia and lack of coordination. A review of Resident #31's medical record revealed on 1/27/23 she was found lying beside her bed and stated she fell off the bed while sleeping. It was noted that her room was rearranged and fall mat placed to the left side of the bed for safety. No further falls were indicated in Resident #31's medical record. An annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #31 had severe cognitive impairment and received supervision for bed mobility and moderate assistance with transfers. She was coded with no falls since the last assessment. Resident #31's active care plan, last reviewed 4/22/24, included a focus area for risk for falls due to impaired balance, history of falls, diagnosis of dementia with poor safety awareness and psychotropic medication use. An intervention, dated 1/27/23, included fall mat. On 4/30/24 at 11:35 AM, Resident #31 was observed lying in bed with her eyes closed. The bed was in the lowest position, however there was no fall mat beside the bed, in the room or bathroom. On 5/1/24 at 8:18 AM, Resident #31 was observed lying in bed with her eyes closed. The bed was in the lowest position but there was no fall mat beside the bed, in the room or bathroom. An interview occurred with Nurse #4 on 5/1/24 at 9:00 AM. She indicated she had worked at the facility for a few months and had not seen a fall mat being used for Resident #31. On 5/1/24 at 12:11 PM an interview occurred with Nurse Aide (NA) #6 and NA #7, who were familiar with Resident #31. They could not recall seeing fall mats in her room and were unaware one should be present. They stated they would have been informed during rounds and the nursing staff if a fall mat was to be utilized. An interview was completed with the Unit Supervisor #2 on 5/1/24 at 2:18 PM who recalled a fall mat present to the side of the bed for Resident #31 in the past but was unsure what happened to it. On 5/1/24 at 2:22 PM, the Director of Nursing (DON) was interviewed and recalled Resident #31 had a fall mat present in her room when an audit had been completed during March 2024. She was unaware the fall mat was not being used for Resident #31 nor why they were not present in her room. The DON stated it was her expectation for fall interventions to be implemented by the staff.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review, observations and staff interviews, the facility failed to clarify a consultation note and discontinue an order for PICC (peripherally inserted central catheter) line care (Resident #78). This was for 1 of 3 residents reviewed for antibiotic use. The findings included: Resident #78 was originally admitted to the facility on [DATE]. She was recently readmitted from the hospital on 2/16/24 with a diagnosis of polymicrobial bacterial infection (acute and chronic diseases caused by various combinations of viruses, bacteria, and fungi) with a PICC line present. A review of Resident #78's active physician orders included an order dated 2/17/24 for PICC line dressing change every seven days. Review of an Infectious Disease progress note dated 4/5/24, indicated the PICC line would be removed on 4/5/24. Resident #78's April 2024 Medication Administration Record (MAR) was reviewed and indicated the order to change the PICC line dressing every seven days was still active from 4/5/24 to 4/30/24. On 5/1/24 at 12:11 PM, an observation of personal care was made with Nurse Aides (NAs) #6 and #7 of Resident #78. There was no PICC line observed to either arm. Unit Supervisor #2 was interviewed on 5/1/24 at 2:18 PM. She indicated when a resident returned from an appointment the paperwork was reviewed by herself. She reviewed the Infectious Disease progress note dated 4/5/24 and stated she was unsure why the order to change the PICC line dressing every seven days had not been discontinued and removed from the MAR as the PICC line had been removed on 4/5/24 at the appointment. Unit Supervisor #2 felt it was an oversight. On 5/1/24 at 2:22 PM, the Director of Nursing stated she would have expected a clarification order to be obtained to discontinue the PICC line dressing change every seven days when it was removed on 4/5/24.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46095 Based on record reviews, observations, resident, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following an annual recertification and complaint survey on 06/11/21. This was for two deficiencies that were cited in the areas of Accuracy of Assessments and Free of Accident Hazards/Supervision/Devices. During a complaint survey on 05/16/23, one deficiency was cited in the area of Free of Accident Hazards/Supervision/Devices. In addition, four deficiencies were cited during the annual recertification and complaint survey on 02/23/23 in the areas of Encoding/Transmitting Resident Assessments, Accuracy of Assessments, Care Plan Timing and Revision, and Free of Accident Hazards/Supervision/Devices. The deficient practice in the areas of Encoding/Transmitting Resident Assessments, Accuracy of Assessments, Care Plan Timing and Revision, and Free of Accident Hazards/Supervision/Devices were recited on the current recertification and complaint survey of 05/06/24. The duplicate citations during three federal surveys of record and one complaint survey show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: F640- Based on record review and staff interviews, the facility failed to complete a Minimum Data Set (MDS) discharge assessment within the required time frame for 1 of 6 residents reviewed for discharge (Resident #58). During the facility's recertification survey of 02/23/23 the facility failed to complete and transmit a discharge Minimum Data Set (MDS) assessment and failed to transmit a discharge MDS assessment. This was for 2 of 2 residents selected to be reviewed for submission of Resident Assessments within the required timeframe. In an interview with the Administrator on 05/02/24 at 1:07 PM, he felt the repeat citations were due to Minimum Data Set (MDS) Nurse turnover. F641- Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the area of medication for 1 of 26 residents whose MDS assessments were reviewed (Resident #24). During the facility's recertification survey of 06/11/21 the facility failed to code the Minimum Data Set (MDS) accurately in the areas of prognosis, range of motion, and Preadmission Screening Resident Review (PASRR) level 2. This was for 3 of the 19 MDS's reviewed for accuracy. During the facility's recertification survey of 02/23/23 the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of medications for 2 of 21 residents whose MDS were reviewed. In an interview with the Administrator on 05/02/24 at 1:07 PM, he felt the repeat citations were due to Minimum Data Set (MDS) Nurse turnover. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F657- Based on record review and staff interviews, the facility failed to review and revise the care plans in the areas of antibiotic use and JP drain (A Jackson Pratt (JP) drain is a surgical suction drain that gently draws fluid from a wound to help recover after surgery) for Resident #81. This was for 1 of 3 residents reviewed for care plans. During the facility's recertification survey of 02/23/23 the facility failed to review and revise the care plan in the areas of falls, pressure ulcers, and medications. This was for 6 of 18 resident records reviewed. In an interview with the Administrator on 05/02/24 at 1:07 PM, he felt the repeat citations were due to Minimum Data Set (MDS) Nurse turnover. F689- Based on record review, observations, and staff interviews, the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions (Resident #31). This was for 1 of 4 residents reviewed for accidents. During the facility's recertification survey of 06/11/21 the facility failed to provide supervision to 2 residents with known behavioral symptoms to prevent the physical assault, unwanted physical contact, and/or unwanted advancements into the personal space of cognitively impaired residents. This was for 2 of 3 residents reviewed for resident to resident altercations. During the facility's recertification survey of 02/23/23 the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions. This was for 1 of 8 residents reviewed for accidents. During a complaint investigation survey on 05/16/23 the facility failed to provide a safe transfer for a resident who was at high risk for fractures, was non-ambulatory and required extensive assistance with a mechanical lift for transfers. This deficient practice was for 1 of 3 sampled residents reviewed for accidents. In an interview with the Administrator on 05/02/24 at 1:07 PM, he felt the repeat citations were due to the facility's leadership turnover.