STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____ OCT 03 2012	C 09/20/2012

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UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family and staff interviews, the facility failed to provide grooming services for 3 of 4 sampled dependent residents as evidenced by not shaving 1 of 4 sampled residents (Resident #45) and not trimming fingernails for 2 of 4 sampled residents (Resident #80 and #137). Findings include: 1. Resident #45 was admitted to the facility on 10/20/06. Cumulative diagnoses included alzheimer ' s disease. It was noted in the grooming section of the undated Resident Status Sheet (care guide outlining care needs) for Resident #45 that staff were to shave him. The Annual Minimum Data Set (MDS) assessment of 08/20/12 indicated Resident #45 had long and short term memory problems as well as moderately impaired decision making skills. He needed extensive assistance with dressing, hygiene and bathing. According to the Care Area Assessment (CAA) summary, he	F 312	"Submission of this response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or were correctly cited and/or require correction". 1. Resident #45 has been shaved. Residents # 80 & #137 finger nails have been cleaned & trimmed. 2. All Residents residing in the Facility have had their nails & facial hair groomed appropriately. 10-11-12	

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

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.

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F 312	Continued From page 1 triggered in 8 areas including activities of daily living. Resident #45's care plan, last reviewed 09/05/12, identified a problem with impaired physical mobility related to extensive assistance with all activities of daily living. Staff were to anticipate his needs. Included in the interventions was to anticipate and meet his needs. During an observation of Resident #45, on 09/18/12 at 11:00 AM, he was noted to have facial hair on his upper lip, chin and neck area. During a family interview, on 09/18/12 at 11:40 AM, it was reported that the request had been made for 2 days this week that staff shave Resident #45. The family member reported it was upsetting that she had to ask 2 days in a row and he still was not shaved. It was reported that the desire was for him to be clean shaven daily. During an observation of Resident #45, on 09/19/12 at 8:20 AM, he was noted in his wheelchair with facial hair to his upper lip, chin and neck area. On 09/20/12 at 8:45 AM, Resident #45 was observed sitting in his wheelchair eating breakfast. The facial hair remained to his upper lip, chin and neck area.	F 312	3. Nurses have been in-serviced & given nursing round sheets which include grooming to be completed every shift. 4. DON and/ or designee will monitor weekly X 3 months negative findings will have correction action and will follow up for effectiveness. All findings will be addressed in the monthly QA meeting until deemed necessary.	10-11-12

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F 312	Continued From page 2 An interview was conducted with the hall nurse (Nurse #1), on 09/20/12 at 9:10 AM. She stated Resident #45 was not capable of asking to be shaved and his family had asked her last week for staff to shave him. During an observation of Resident #45, on 09/20/12 at 9:20 AM, the facial hair was still present to the upper lip, chin and neck area. The family member was visiting. The family member stated it was most upsetting that this was the 4th day and still Resident #45 had not been shaved. An interview was conducted with the nurse aide (NA#1) who was assigned to Resident #45 on 09/20/12 at 9:30 AM. He stated he was familiar with Resident #45. NA#1 stated Resident #45 received his bath on third shift. He commented that shaving was usually done with the bath. When questioned as to how often male residents were shaved, he responded that he shaved them about every 2 days unless they requested daily. NA#1 stated if the resident was unable to decide about shaving, he shaved them every other day. He commented that Resident #45 would say if he wanted to be shaved or not if he asked but he had not asked him if he wanted to be shaved today. NA#1 also commented that the family had requested for the resident to be shaved in the past. He added that he would shave him today. During an interview with the Unit Manager (UM #1), on 09/20/12 at 9:46 AM, she stated residents should be shaved at least every 2 to 3 days. She stated some of the residents could say when they	F 312		10-11-12

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F 312	Continued From page 3 wanted to be shaved but for those who couldn't, staff should be shaving them. UM #1 stated even if a resident was bathed on third shift, they should still be shaved. She added that if for some reason that resident was not shaved, it should be passed on to the day shift. Upon observation on 09/20/12 at 9:50 AM with the UM of Resident #45, she stated he was in need of shaving. The UM commented that his family had not approached her about Resident #45 not being shaved daily. 2. Resident #80 was admitted to the facility with diagnoses of diabetes, osteoporosis, and end stage dementia. Resident #80's current care plan updated 07/25/12 addressed dependency for activities of daily living with staff provision for hygiene. An annual Minimum Data Set (MDS) assessment completed 09/03/07 documented Resident #80 as having short term and long term memory and severe cognitive impairment. Resident #80 was documented as being dependant on staff for all activities of daily living and having no rejection of care. Review of an ADL (Activity of Daily Living) flow	F 312		

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F 312	Continued From page 4 sheet (tool used to direct care) documented Resident #80 as being dependant for grooming, bathing, and dressing. An observation made on 09/18/12 at 10:32 AM revealed Resident #80 sitting in a wheelchair. Resident #80's fingernails were observed to be approximately 0.5 centimeters past the tip of the fingers with black matter present under the fingernails. Observations made on 09/19/12 at 8:05 AM and 11:35 AM revealed Resident #80's nails to be approximately 0.5 cm past the tip of the fingers with black matter under the fingernails. In an interview with Nurse Aide (NA) #2 on 09/19/12 at 3:45 PM, she said Resident #80 required total assistance with all her activities of daily living and hygiene. NA #2 said Resident #80 did not refuse any care. An observation made with the Director of Nurses (DON) on 09/19/12 at 4:10 PM revealed Resident #80's nails to be long with black matter present under the nails. The DON said her expectation was for the resident's nails to be cut and cleaned. The DON said Resident #80 needed her nails cut and cleaned. In an interview on 09/20/12 at 10:05 AM, the DON said the facility did not have a written policy and procedure for nail care that the expectation was it was a part of routine care and should be done as needed. The DON said Resident #80 ' s fingernails had been cut and cleaned.	F 312		

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F 312	Continued From page 5 3. Resident #137 was admitted to the facility on 08/16/12 with diagnoses of Parkinson's disease and anemia. An admission Minimum Data Set (MDS) assessment completed on 08/13/12 identified Resident #137's cognition as intact, requiring extensive assistance from staff for all activities of daily living and hygiene, and having no rejection of care. Review of an ADL (Activity of Daily Living) flow sheet (tool used to direct care) documented Resident #137 needed staff assistance for activities of daily living and hygiene. On 09/18/12 at 10:25 AM, Resident #137's fingernails were observed to be approximately 0.5 cm past the tip of her fingers. Resident #137 responded they were too long for her and she would like to have them shorter. Resident #137 shook her head "no" when asked if staff had offered to cut them for her. On 09/19/12 observations made at 8:05 AM and 3:10 PM, Resident #137's fingernails remained the same. In an interview with Nurse Aide (NA) #2 on 09/19/12 at 3:55 PM, NA #2 said Resident #137 required total assistance with all her activities of daily living and had not rejected any care. An observation made with the Director of Nurses (DON) on 09/19/12 at 4:15 PM revealed Resident #137's fingernails to be the same. When the DON asked Resident #137 who cut her fingernails, Resident #137 responded a family	F 312		

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F 312	Continued From page 6 member had. When asked by the DON if she wanted staff to cut her fingernails, Resident #137 nodded her head, "yes." In an interview with the DON on 09/20/12 at 10:05 AM, the DON said Resident #137's family member had cut her fingernails at home but staff should have offered since it had not been documented that family would provide fingernail care. The DON said the facility did not have a written policy and procedure for nail care and the expectation was it was a part of routine care and should be done as needed. The DON said staff should have offered nail care to Resident #137 as she had been able to make her needs known. The DON said staff provided Resident #137 with fingernail care on 09/19/12.	F 312		10-11-12
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to monitor the use of an abdominal binder for 1 of 1 sampled residents (Resident #38) whose gastrostomy tube had come out. Findings include:	F 322	1. Resident #38's abdominal binder was applied per Physician order.	10-11-12

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F 322	Continued From page 7 Resident #38 was re-admitted to the facility on 7/12/11 with cumulative diagnoses of diabetes, hemiplegia (weakness on one side of the body), and dysphagia requiring a gastrostomy tube. Resident #38's Quarterly Minimum Data Set dated 8/28/12 showed that Resident #38 had short and long term memory problems and was severely impaired in daily decision making. Resident #38 needed the extensive assistance of 1 person for eating (to provide liquid nutrition/fluids through the gastrostomy tube). A review of the Treatment Record of Flow Sheet for 8/1/12-8/31/12 showed an order to wash Resident #38's G-tube site daily with soap and water. A review of the Nurses Notes dated 8/7/12 at 5:00 PM showed Resident #38's G-tube had come out. A review of the Physician Telephone Orders dated 8/7/12 showed an order to send Resident #38 out (to the hospital) for dislodgement of the G-tube. A review of the Physician Telephone Orders dated 8/8/12 showed an order for an abdominal binder to protect the G-tube. A review of the Medication Administration Record dated 8/8/12 showed an order for a waist binder G-tube proctor on at all times with an FYI (for your information) note. A review of the Nurses Notes dated 8/8/12 at 3:10 PM showed Resident #38 had received a	F 322	2. No other resident in the facility have been affected by this deficient practice or have orders for abdominal binders. 3. All Nurse's & C.N.A's have been in-serviced on the importance of following Physician orders related to wearing an abdominal binder. On 9/21/12 an order to discontinue the abdominal binder for Resident # 38 was obtained and new order for a safe-lock was initiated. Resident has had no other instance of dislodgement since obtaining the new order.	10-11-12

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F 322	Continued From page 8 new order for an abdominal band to protect the G-tube from becoming dislodged. The Supply Clerk had been notified to order an X-large band. A review of the Nurses Notes from 8/9/12-8/14/12 showed no notes that Resident #38's abdominal binder was in place. A review of the Nurses Notes dated 8/14/12 at 1:00 PM showed Resident #38's abdominal binder was not in the resident's room or in the laundry. The note indicated that 2 binders were on order and should arrive in 1 week. A review of the Physician Orders for 9/1/12-9/30/12 showed a hand written note for a waist binder G-tube proctor to be on at all times. FYI was written next to the note. A review of the Medication Administration Record for 9/1/12-9/30/12 showed an order for a waist binder G-tube proctor on at all times with an FYI note. A review of the Treatment Record of Flow Sheet for 9/1/12-9/30/12 showed an order to wash Resident #38's G-tube site daily with soap and water. A review of Resident #38's Care Plan updated 9/5/12 showed a problem due to the use of gastrostomy tube for nutrition and hydration. Interventions included checking for safety devices at least every shift for proper placement and functioning. A review of Resident #38's Care Plan updated 9/5/12 showed a problem of a risk of aspiration	F 322	4. DON and/ or designee will review daily MD orders weekly times 3 months in order to ensure appropriate measures are followed for any future orders of abdominal binders. All finding will be addressed in the monthly QA meeting X 3 months or until deemed necessary.	10-11-12

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F 322	Continued From page 9 as evidenced by a gastrostomy tube. Interventions included verifying placement of the tube, verifying the rate of administration of feedings per physician order and crushing medications as ordered. Resident #38's Care Plans did not list the abdominal binder on the Care Plan. A review of the Nurses Notes dated 9/10/12 at 9:00 PM showed that NA #7 notified the nurse that Resident #38's G-tube had come out. On 9/20/12 a request was made to speak to the NA who had been working on 9/10/12 and had witnessed the dislodgement of the tube. The NA did not return the phone call to the facility and was unavailable for interview. A review of the Physician Telephone Orders dated 9/10/12 showed an order to send Resident #38 to the hospital for replacement of the G-tube. In an interview on 9/17/12 at 1:40 PM a family member of Resident #38 indicated that an abdominal binder which was to be in place at all times to prevent dislodgement of Resident #38's G-tube was not being used. In an observation of Resident #38 on 9/17/12 at 1:40 PM there was no abdominal binder in place to prevent the dislodgement of the G-tube. In an interview on 9/19/12 at 3:20 PM NA #7 indicated that Resident #38 was not wearing the abdominal binder that had been ordered to prevent dislodgement of the G-tube. She stated that the binder should be in Resident #38's closet or chest of drawers. She was unable to locate the	F 322		

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F 322	Continued From page 10 binder when she looked for it. NA #7 indicated that the binder could be in the laundry. She stated that she knew Resident #38 needed the abdominal binder to keep her G-tube from coming out. In an observation of repositioning on 9/19/12 at 4:10 PM by NA #7 and NA #8, they carefully lifted Resident #38 up and to the left avoiding pulling on the G-tube. The NA' s placed a towel across Resident #38's abdomen to protect the G-tube and stated the abdominal binder could not be located. In an interview on 9/19/12 at 4:15 PM NA #8 indicated that Resident #38 usually had the abdominal binder on but it was missing that day. In an interview on 9/19/12 at 4:20 PM Nurse #5 stated Resident #38 should be wearing an abdominal binder at all times to hold the G-tube in place. She indicated that the G-tube had become dislodged twice recently. She stated that someone should have noticed the binder was not in place. In an interview on 9/20/12 at 7:45 AM NA #6 stated she knew Resident #38 should be wearing an abdominal binder to prevent the G-tube from being pulled out. In an observation on 9/20/12 at 7:45 AM Resident #38 was wearing an abdominal binder. In an interview on 9/20/12 at 9:45 AM Nurse #3 stated that Resident #38's G-tube site was cleansed every day. She indicated that she had cleansed the site during the 3 days of	F 322		10-11-12

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F 322	Continued From page 11 observations where Resident #38 was not wearing the abdominal binder. She stated that she did not notify nursing or replace the binder on Resident #38. She indicated that she was aware Resident #38 needed to wear the binder at all times and that if it was not worn the G-tube could become dislodged again. In an interview on 9/20/12 at 9:50 AM with the Supply Clerk she stated that on 8/9/12 she picked up an abdominal binder from a medical supply facility. She indicated that she ordered 2 more binders and they were delivered on or about 8/24/12. She stated that they were available in the supply room. In an interview on 9/20/12 at 10:00 AM the laundry room attendant stated every now and then an abdominal binder would be sent to laundry. She indicated that there were no abdominal binders in the laundry room at that time and that it had been "awhile" since one had been sent. In an interview on 9/20/12 at 10:58 AM Nurse #4 stated the staff had trouble keeping up with Resident #38's abdominal binder. She indicated that she had looked for the binder in the laundry room and the Physical Therapy room the previous afternoon, but was unable to locate Resident #38's abdominal binder. Nurse #4 stated she went to supply for a new binder and placed it on Resident #38. She indicated that it was a problem that Resident #38 was not wearing the binder as the G-tube could become dislodged more easily if not in place. She indicated she would expect any staff who worked	F 322		

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F 322	Continued From page 12 with Resident #38 to have gone to laundry to ask about the binder if it was not in place. In an interview on 9/20/12 at 3:30 PM the Director of Nurses (DON) stated she would expect someone to have noticed Resident #38's abdominal binder was not in place and to have put the binder on.	F 322		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to monitor the actual fluid intake for 1 of 1 sampled residents (Resident #128) who had orders for a fluid restriction. Findings include: The Resident Status Sheet (care guide which outlined care to be provided) for Resident #128, which was undated, indicated he was on a fluid restriction. Resident #128 was admitted to the facility on 03/10/11. Cumulative diagnoses included congestive heart failure, hypertension and alzheimer's disease. The quarterly Minimum Data Set (MDS) of 07/31/12 indicated Resident #128 had long and	F 327	1. Resident #128 now has an order to ensure total fluid intake in a 24 hr period noted on the MAR.	10-11-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

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F 327	Continued From page 13 short term memory problems as well as moderately impaired decision making skills. There were no behaviors noted. He needed set up only for eating. Resident #128's care plan, last reviewed on 08/08/12, identified a problem with him being at risk for dehydration related to a fluid restriction. In the approach section it was noted to monitor nutrition and hydration daily and encourage fluids with meals and between meals. According to the June, July and August 2012 medication administration records (MAR) in Resident #128's chart, there was on an order for a 1500cc (cubic centimeter) fluid restriction with an original date of 04/08/11. It indicated he was being provided 960 cc from dietary, 235 cc during the 7:00 AM to 3:00 PM shift, 235 cc during the 3:00 PM to 11:00 PM shift and 70 cc during the 11:00 PM to 7:00 AM shift. The date blocks had nurse initials but there were no fluid amounts noted on any of the MAR ' s to indicate how much fluid Resident #128 had consumed. According to the August 2012 meal consumption record for Resident #128, his meal intake ranged from 25% consumed to 100% consumed for 3 meals daily. There was no indication on this record as to how much fluid Resident #128 had actually consumed. The September 2012 MAR included the same 1500 cc fluid restriction order with initials from the	F 327	2. The Registered Dietician evaluated all Residents on fluid restrictions and orders have been obtained to ensure total of fluid consumption are calculated on a 24 hr basis. 3. Facility has implemented this new protocol for all residents on a fluid restriction diet. All nurses have been in-serviced on the new protocol.	10-11-12

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UNIVERSAL HEALTH CARE / GREENVILLE	2579 WEST 5TH STREET GREENVILLE, NC 27834

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F 327	Continued From page 14 nurses in the date blocks but no actual amounts consumed. This MAR also included an order with an original date of 08/20/12 to offer liquids and monitor the percentage consumed at 9:00 AM, 2:00 PM and 8:00 PM. In the date blocks, 100 had been documented to indicate percentage consumed in the date blocks from 09/01/12 until 09/20/12. There were no actual amounts noted to indicate how much fluid Resident #128 had consumed. The September 2012 physician's order sheet for Resident #128 included a 1500 cc fluid restriction order. Also included on the order sheet was to offer liquids and monitor the percent consumed at 9:00 AM, 2:00 PM and 8:00 PM. During a breakfast meal observation, on 09/19/12 at 8:25 AM, Resident #128 was noted to have a cup of coffee (240cc), a carton of milk (240cc) and a glass of juice (120cc) on his tray. There was no water pitcher noted at bedside. During a lunch meal observation, on 09/19/12 at 1:10 PM, Resident #128 was noted to have a cup of brown liquid (240cc) and a bowl of vegetable soup (approximately 120cc fluid) on his tray. During an interview with the hall nurse (Nurse #2), on 09/19/12 at 4:30 PM, she stated the nurse aides were responsible for recording the fluid amounts residents consumed in the ADL book at the nursing station. She stated the nurses reported the amounts of fluid consumed during	F 327	4. DON and/ or designee will review daily Physician orders weekly times 3 months and identify any residents on fluid restriction receive the appropriate protocol. All findings will be reviewed in the monthly QA meeting X 3 months on until deemed necessary.	10-11-12

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F 327	Continued From page 15 medication pass by the resident to the nurse aides and they included it in their totals in the ADL book. Nurse #2 stated the third shift nurse was responsible for totaling at the end of their shift. During an interview with Nurse Aide #3 (NA#3), on 09/19/12 at 4:40 PM, she stated she recorded the percentage of foods and liquids from the meal trays in the activities of daily living books (ADL) kept at the nursing station. She commented that fluids consumed were not documented separately but were included in the percentage totals. She stated if a resident was restricted in their fluids, it would be noted on his care guide plus the nurse would let them know as well. NA#3 stated a separate hydration sheet was used for any resident who was on a fluid restriction for them to document the actual amounts consumed. She commented that the nurses also recorded the amounts they provided to the resident on this sheet. NA#3 commented that she had no one in her assignment who was on a fluid restriction. She reported having Resident #128 in her assignment. She reported she had been instructed to document fluids given during snack times as well. During an interview with NA#4, on 09/20/12 at 8:30 AM, she stated when residents were on fluid restrictions, the kitchen provided the amounts they were allotted on their meal trays. She stated the total fluid consumption was not documented separately in the ADL book as it was included with the food intake as a percentage. NA#4 stated hydration sheets were not for all residents	F 327		

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F 327	Continued From page 16	F 327		

just those who needed to have their intake monitored. NA#4 stated residents with restrictions did not have water pitchers in their rooms. She stated Resident #128 was on a fluid restriction but did not self propel himself so could not obtain extra fluids. NA#4 also commented if there was no water pitcher in the room staff were aware not to offer fluids during snack times.

Resident #128 was observed eating breakfast on 09/20/12 at 8:30 AM. He had a carton of milk (240cc) and a small juice (120cc) on his tray. The tray slip indicated he was on a fluid restriction.

Nurse #1 was interviewed about fluid restrictions on 09/20/12 at 10:10 AM. She stated she did not document the actual amounts of fluids residents consumed while on fluid restriction. She stated the amounts they were allowed to provide were listed on the MARs.

The hall nurse (Nurse #3) was interviewed about fluid restrictions on 09/20/12 at 10:30 AM. She stated when residents had physician's orders for fluid restrictions, the nurses take the amount nursing was allowed to provide and divide it between the three shifts. She stated the nurse aides document the resident's intake in the ADL book at the nursing station. Nurse #3 stated she did not document the amount Resident #128 consumed during medication pass as she passed medications to him twice on her shift. She added that she probably gave him half a cup of liquid with each medication pass. Nurse #3 reported

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F 327	Continued From page 17 Resident #128 was dependent upon staff for fluids. She also stated dietary did not track amounts consumed as they only provide a certain amount on his meal trays. When questioned how much fluid Resident #128 had consumed on her shift, she stated she could not say as no one was recording amounts consumed. After discussion, Nurse #3 stated she agreed that the system needed adjusting and she would change the MAR to reflect amounts of fluids consumed per shift so the nurses would begin documenting amounts. During an interview with the Dietary Manager (DM), on 09/20/12 at 10:45 AM, she stated when residents had physician's orders for a 1500 cc fluid restriction she provided a total of 960 cc on the three meals trays. She stated she provided 240cc per meal tray to add up to the total of 960 cc. The DM commented the balance of the 1500 cc was provided by the nursing department. She stated she did not track or monitor those residents for amounts consumed, she only provided what they were allowed to have. The DM stated usually residents who were restricted did not receive jello, watermelon or soup on their trays. When it was reported that Resident #128 received soup on his lunch tray on 09/19/12, the DM stated there should not have been any liquid in the soup or a very minimal amount but in either case, the soup was not included in the totals she provided for him as it was a chunky soup. The Assistant Director of Nurses (ADON) was interviewed on 09/20/12 at 11:15 AM. He stated when residents were on a fluid restriction the total amount that they were allowed to have was	F 327		

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F 327	Continued From page 18 broken down per shift. He stated the nursing staff was expected to adhere to those amounts. The ADON stated the nurse aides should be reporting the fluid amounts consumed from meals to the nurses for them to document on the resident's MAR. He also stated totals should be included on the MAR. Upon observation of Resident #128's September 2012 MAR, he stated he could not say how much fluid Resident #128 had consumed during any time period. The ADON stated the facility did not have a system in place to monitor or track the amount of fluids Resident #128 was consuming on a daily basis and he would not know whether or not he received the full 1500 cc. The Director of Nurses (DON) reported during an interview on 09/20/12 at 11:30 AM that nurses were initialing the MAR to attest to the fact that they did not provide more than the amount that was allotted for them to provide. She stated there was no need for staff to document on a hydration sheet as the nurses were signing off that the resident received the allotted amounts on that shift. When questioned if she could report the total amount of fluids that Resident #128 had consumed over a 24 hour time period, she responded she could not show actual fluid intake but he was not receiving more than he was allowed per the MAR.	F 327		10-11-12

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	345181	A. BUILDING 01 - MAIN BUILDING 01 B. WING NOV 27 2012	10/31/2012

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, and no automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: found unsealed openings in walls located at laundry room and by fire alarm control panel on 100 hall.	K 012	- Unsealed openings have been closed in walls located @ laundry room and by fire alarm control panel on 100 hall. - Building has been assessed for any unsealed openings. - Will add to the monthly P.M. schedule. - A walk thru will be done on a monthly basis, any negative finding will be brought to the monthly QA meeting.	11-6-12
K 038 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1, 19.2.1	K 038		

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

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.

GW

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345181	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/31/2012

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K 038	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include, office doors through out the facility require two motion of hand to open door to exit corridor(admin, nursing office, bathroom front lobby etc). 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 038	- Two motion locks ordered on 11-6-12 for non compliant office doors, nursing office, front bathroom lobby. - Building has been assessed for any non compliant doors. - Only two motion commercial door handles will be ordered when needed. - A walk thru will be done on a monthly basis, any negative finding will be brought to the monthly QA meeting.	11-30-12
K 051 SS=E	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		

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	345181	A. BUILDING 01 MAIN BUILDING 01 B. WING	10/31/2012

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K 051	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: when fire alarm system was activated, the audile/visual signal form horn/strobe devices were not synchronize through out facility. 42 CFR 483.70(a)	K 051	Requested waiver, see letter attached. Until system upgrade, nurses will check for flashing lights down the hallways every two hours this will be done on a daily basis. Any negative findings will be brought to the monthly QA meeting.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: all sprinkler heads located in kitchen area show signs of corrosion. 42 CFR 483.70(a)	K 062	- 30 corroded sprinkler have been identified. - Sprinkler heads have been ordered and to be replaced. - New sprinkler system to be installed by August 2013. - A walk thru will be done on a monthly basis to ensure there are No signs of corrosion to existing heads. - Any negative findings will be addressed and and brought to the monthly QA meeting.	12-2-12
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / GREENVILLE	2576 WEST 5TH STREET GREENVILLE, NC 27834

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K 144	Continued From page 3 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	- New generator has been installed generator cranks and transfers when tested. - Generator will be inspected and exercised under load for 30 minutes per month in accordance with NFPA99. - Any negative findings will be addressed and brought to the monthly QA meeting.	12-8-12
K 147 SS=E	This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: generator failed to crank and transfer when tested 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2	K 147	- Extension cords have been removed from room 408 and 409. Electrician into add more receptacles to rooms. - All rooms have been assessed for extension cords. - Extension cords discovered have been removed from those rooms.	
	This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: extension cords were being used in residents bedrooms 408 and 409 for TV to be plugged into. 42 CFR 483.70(a)			

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			- Electrician scheduled to add more receptacles to the rooms. - Monthly rounds will be completed to ensure the deficient practice does not re-occur. - Any negative finding will be brought to the monthly QA meeting.	12-2-12

Universal Healthcare

GREENVILLE • 2578 West 5th Street • Greenville, NC 27834

Ph: 252-758-7100 • Fax: 252-758-1485

NOV 27 2012

11/17/12

Dear Mr. Washburn,

I am requesting a waiver for tag K051 in regards to the signal form horn/strobe devices were not synchronized. I am requesting this waiver until August 2013. Before August 2013 we will be adding on a new wing and sprinkling the entire facility. I am requesting to do a system upgrade during this time. All repairs and renovations will be capital expenses. Thank you for your consideration in this matter.

Heather G. McLamb, Administrator

FACILITY REQUEST FOR WAIVER OR VARIANCE

TO BE COMPLETED BY STATE AGENCY

☑ Life Safety Code (405.1134a)

☐ 7-Day R.N. Requirement

☐ Medical Director (405.1911b)

☐ Physical Environment

☐ Patient Room Size (405.1134c)

☐ Beds Per Room (405.1134e)

1. Name of Facility Universal Health Care/ Greenville

Address 2578 West 5th Street Greenville, NC 27834

2. Type Facility: NH

3. Vendor No. _____

Program: XVIII/XIX ☐ XIX ☐

Provider No. 345181

4. Date of Survey: Life Safety Code 10/31/2012

General _____

5. Expiration Date of Current Agreement:

6. State Agency recommendation: ☑ Approved ☐ Waiver/Variance Previously Approved

☐ Not Approved

7. Reason for Recommendation: replacing horn/ strob fire panel when building will be sprinkled 8/8/13.

8. Period for which Waiver/Variance is Recommended: 8/8/..

9. 12/3/2012
Date

10. _____
Authorizing Signature of State Agency

TO BE COMPLETED BY REGIONAL OFFICE

1. Waivers/Variance Approved

(a) _____
(b) _____
(c) _____
(d) _____

12. Waivers/Variance Not Approved

(a) _____
(b) _____
(c) _____
(d) _____

3. _____
Program Reviewer Signature

_____
Date

4. _____
Discipline Reviewer Signature

_____
Date

5. _____
Authorizing Signature
Acting Director, Survey & Certification

_____
Date

LSC Waiver