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 05/10/2018

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation of 5/10/2018. Event ID #HCFQ11. Intake # NC00136926.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident and staff interviews, the facility failed to consider a resident's preference for positioning assistance for 1 of 1 residents reviewed for side rails, which resulted in a decrease of the maximum potential for bed mobility (Resident #22). Findings included: Record review revealed resident #22 was admitted to the facility on 3/5/2016 with diagnoses which included fractured left pubis and fracture of the left shoulder. Record review revealed a Side Rail Use and Alternative Assessment dated 12/9/2016 was completed for Resident #22. The Assessment indicated Resident #22 used the side rails for positioning and support. The assessment conclusion documented the side rails assisted the resident with positioning and were safe for the resident to use. There was no other Side Rail	F 558	The plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correction conclusion set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under federal law, and to demonstrate the good faith attempts by the provider to continue to improve the quality of life of each resident. F558 Reasonable Accommodations, Needs / Preferences Root Cause Analysis Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined that the facility did not consider a resident's preference for positioning assistance.	5/24/18

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

Electronically Signed | 05/23/2018

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F 558	Continued From page 1 Assessment noted in the medical record. Review of the Minimum Data Set (MDS) dated 3/1/2018 revealed Resident #22 was cognitively intact. The MDS indicated Resident #22 required limited to extensive assistance with all activities of daily living (ADLs) and required extensive assistance for bed mobility. The MDS indicated Resident #22 did not have bed rails. A review of Resident #22's Care Plan updated 3/1/2018 revealed a focus on ADLs. The interventions included the assistance of 1 person for bathing and perineal care. An observation and interview was conducted with Resident #22 on 5/9/2018 at 8:15 AM. Resident #22 was observed to be in bed with the head of the bed elevated. Resident #22 was alert and oriented and well kempt. There were no side rails or grab bars on the bed. The resident indicated around October 2017 someone came in her room and removed the side rails from her bed. The resident stated she asked why they were being removed as she used them when the staff changed her. The resident stated he was told the people from the State told the facility they could not use bed rails anymore. The resident reported no one from the facility talked to her about taking them off before or after they were removed. The resident stated she had limited use of her left arm and she used her right arm to hold the left rail to assist in positioning. The resident indicated she used the rails to assist when the staff changed her and now she had to grab under the mattress. The resident also reported she used the left rail to scoot to her side at times. The resident reported she felt she did not have the ability to move in the bed as well since the rails were removed.	F 558	Immediate Action Resident #22 was screened by therapy for an appropriate repositioning in bed and transfer device on 5/22/18. Resident was offered an alternative device to assist in repositioning in bed. Identification of Others On 5/22/18 interviews were conducted with all alert and oriented residents to determine who may want an assistive devise to assist with transfers and repositioning in bed by members of the administrative team. . If a need or request was present a therapy screen will be conducted. No other residents were identified. Our policy on side rails will be given to all new admissions and alternatives reviewed at that time. Systemic Changes Effective 5/24/18, 100% of staff were educated by the Director of Nursing and/ Executive Director on Resident's Rights and Resident's Choice. Any resident identified requiring an assistive device for repositioning and transfers will be addressed with an alternative. A therapy screen will be conducted on all residents requiring positioning devices for repositioning or transfers. Any staff not educated will not be allowed to work until educated. This education will be added to the new hire process. Monitoring The Director of Nursing/Unit Manager will monitor during clinical meeting 5 days per week (Monday-Friday) to ensure there have been no changes in any resident's mobility and need to be reassessed for repositioning and transfer devices. This	

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F 558	Continued From page 2 An interview was conducted with the facility Administrator (ADM) on 5/9/2018 at 9:04 AM. The ADM stated all the residents were assessed per the Facility Side Rail policy in September 2017 and October 2017. The ADM stated the assessments included transfer safety and repositioning. The ADM indicated the interdisciplinary team determined from the assessment tool if the rails were indicated, or if alternatives could be utilized. The ADM indicated side rails could be considered restraints so the decision was made to remove them facility wide. An interview was conducted with the Director of Nursing (DON) on 5/9/2018 at 10:33 AM. The DON reported they were unable to locate an updated and completed Side Rail Assessment for Resident #22. The DON indicated one was completed for every resident but there was no documentation of Resident #22 being assessed. The DON reported she did not remember if Resident #22 was assessed. A review of the facility Side Rail Policy indicated the Side Rail Use and Alternative Use Assessment would be completed on all residents. The policy indicated the interdisciplinary team would use the data collected from regular bed inspections and individual bed rail evaluations to bolster care planning and achieve positive resident outcomes. An interview was conducted with the Administrator (ADM) on 5/9/18 1:57 PM. The ADM stated the expectation was for the residents' needs and preferences be accommodated. The ADM indicated anytime changes were made which had the potential to affect the residents' positive outcome, the individuality of each	F 558	monitoring will be conducted daily for 4weeks, then weekly x 4 weeks and then monthly thereafter. Findings will be reported to monthly to the QAPI committee for recommendations or modification until a pattern of compliance is achieved.	

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F 558	Continued From page 3 residents' needs should be considered.	F 558		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to update the residents care plan to reflect a wedge mattress overlay with high sides for 2 of 2 residents reviewed for restraints (Resident #16 and	F 657	F 657 Care Plan Timing and Revision Root Cause Analysis Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined that	5/24/18

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F 657	Continued From page 4 Resident #90). Findings included: 1-Record review revealed Resident #16 was admitted to the facility on 5/7/2015 with diagnoses which included Lewy Body Dementia (a brain disorder associated with abnormal deposits of protein in the brain) and convulsions. Review of Resident #16's Care Plan updated on 12/13/2017 revealed a focus for falls with interventions which included a wedge overlay mattress placed on the resident's bed on 12/13/2017. The Care Plan indicated the wedge overlay was discontinued. There was no date documented for the discontinuation. Review of the Minimum Data Set (MDS) dated 2/19/2018 indicated Resident #16 was severely cognitively impaired and required total care for all activities of daily living. An observation was made of Resident #16 on 5/8/2018 at 3:48 PM. The resident was observed to be sitting in her room. There was a wedged mattress overlay observed on the resident's bed. An observation was made of Resident #16 on 5/9/2018 at 8:42 AM. The resident was observed resting in bed. There was a wedged mattress overlay observed on the resident's bed. An interview was conducted with the MDS Nurse on 5/9/2018 at 4:04 PM. The MDS nurse confirmed she completed the MDS assessments and updated the Care Plans for Resident #16. The MDS nurse stated she was told Resident #16's wedge mattress overlay was discontinued.	F 657	the facility failed to update the residents care plan to reflect a wedge mattress overlay with high sides. Immediate Action The care plan for resident #16 and #90 have been updated to include the changes in mattress surface by the MDS nurse on 5-22-18. Identification of Others The MDS Nurse will update all care plans for residents with any type of specialty mattresses by 5-23-18. Systemic Changes The administrator will inservice the MDS nurse on updating care plans with any ongoing changes in the residents care by 5-22-18. The administrator/Director of Nursing will also attend the care plan meeting for six weeks to ensure information is being updated on the care plan timely. The Administrator will audit a sample of the care plans weekly for six weeks to ensure the care plans have been updated to reflect care given to the resident. Comments will be reviewed with the MDS nurse weekly as a part of her ongoing education and expectation of a complete care plan. Monitoring The Administrator will audit a sample of the care plans weekly for six weeks to ensure the care plans have been updated to reflect care given to the resident. Comments will be reviewed with the MDS nurse weekly as a part of her ongoing education and expectation of a complete care plan. Results of the audits will be taken to the monthly Quality Assurance Performance Improvement Committee	

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F 657	Continued From page 5 The MDS nurse reported she was informed over a month ago during a morning clinical meeting but did not remember the date. The MDS nurse indicated she thought the overlay was used for a fall intervention. The MDS nurse further indicated she discontinued the overlay from the Care Plan in the computer but did not look at the resident's bed to confirm it was gone. The MDS nurse stated she did assess the resident when she was due for an MDS assessment but did not look at the resident's bed when she completed an assessment. The MDS nurse stated when she was told the overlay was discontinued she was also told she would be given a list of other residents whose overlay was discontinued. The MDS nurse reported she had never been given the list. An interview was conducted with the Administrator (ADM) on 5/9/2018 at 4:44 PM. The Administrator revealed every resident in the facility was assessed for current device and equipment use. The ADM indicated the MDS nurses were involved in the decision as to whether the equipment or devices were indicated and if they were safe for the residents. The ADM indicated if there was a wedged mattress on Resident #16's bed it should certainly be indicated on her Care Plan. The ADM reported all the residents were assessed for any safety issues and changes were made during the assessments. The ADM stated the assessments were completed on 2/3/2018. During the interview with the Administrator (ADM) she indicated all the changes identified from the assessments should have been verified as completed prior to the Care Plan revisions. The ADM indicated the Care Plans should not be	F 657	(QAPI) meeting monthly for two months, for recommendations or modification until a pattern of compliance is achieved.	

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F 657	Continued From page 6	F 657		

changed without the MDS nurse assessment/verification of the changes. The ADM stated the expectation was for the assessments to be completed and the Care Plans to be accurate to meet the needs of the residents.

2-Record review revealed Resident #90 was admitted to the facility on 7/11/2015 with diagnoses which included Alzheimer's Disease and chronic pain.

Review of the annual Minimum Data Set dated 4/18/2018 revealed Resident #90 was severely cognitively impaired and required total care for all activities of daily living.

Review of Resident #90's Care Plan updated on 4/18/18 revealed no documentation of a wedge overlay mattress.

Review of the Care Card (guide for facility staff indicating residents' individual needs) located at the nursing station indicated Resident #90 was at a risk for falls and had a wedge overlay on her bed. There was no date on the Care Card.

An observation was conducted on 5/8/2018 at 9:08 AM of Resident #90. The resident was resting in bed. There was a wedge mattress overlay observed on the bed.

An interview was conducted with the MDS Nurse on 5/9/2018 at 4:04 PM. The MDS nurse confirmed she completed the MDS assessments and updated the Care Plans for Resident #90. The MDS nurse reviewed the resident's Care Plan and indicated there was no mention of the wedge overlay. The MDS nurse could not recall if

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F 657	Continued From page 7	F 657		

the Care Plan was revised to remove the overlay. The MDS nurse stated she was unaware of the wedge overlay on Resident #90's bed. The MDS nurse reported she was informed over a month ago during a morning clinical meeting that some of the wedge overlays were being discontinued but did not remember if Resident #90 was mentioned. The MDS nurse stated she did assess the resident when she was due for an MDS assessment but did not look at the resident's bed when she completed an assessment. The MDS nurse stated she was told by administrative staff she would be given a list of residents whose overlays were discontinued. The MDS nurse reported she had never been given the list.

An interview was conducted with the Administrator (ADM) on 5/9/2018 at 4:44 PM. The Administrator revealed every resident in the facility was assessed for current device and equipment use. The ADM indicated the MDS nurses were involved in the decision as to whether the equipment or devices were indicated and if they were safe for the residents. The ADM reported all the residents were assessed for any safety issues and changes were made during the assessments. The ADM stated the assessments were completed on 2/3/2018. The ADM reported if there was a wedge overlay on Resident #90's bed it should be indicated on her Care Plan.

During the interview with the Administrator (ADM) she indicated all the changes identified from the assessments should have been verified as completed prior to the Care Plan revisions. The ADM indicated the Care Plans should not be changed without the MDS nurse assessment/verification of the changes. The ADM

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F 657	Continued From page 8 stated the expectation was for the assessments to be completed and the Care Plans to be accurate to meet the needs of the residents.	F 657		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		5/24/18

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F 880	Continued From page 9 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to properly disinfect a multi-use blood glucose monitoring device after use, resulting in the potential for cross contamination for one of seven residents who received finger stick glucose testing	F 880	F880 Infection Prevention & Control Root Cause Analysis Based on the root cause analysis by the administrative team and the facility Executive Director, it was determined that the facility failed to properly disinfect a	

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F 880	Continued From page 10 (Resident #12). Findings included: A review of the facility policy and procedure titled Cleaning and Disinfecting Glucometers and dated January 2018 stated: IV. Policy It is the policy of the facility to clean and disinfect multi-patient use blood glucose meters. Blood glucose monitors that are shared among residents must be cleaned and disinfected between each use. V. Procedure 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. 2. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected then the meter should not be used for multiple patients. 3. The glucometers should be cleaned and disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus. 5. All nursing staff is trained in the proper procedure, protective equipment required, and safety precautions. The procedure for cleaning the glucometer was written: 6. Retrieve 2 disinfectant wipes from container. Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Discard disinfectant wipe in waste receptacle. Perform hand hygiene. A review of medical records revealed Resident #12 was admitted 11/8/2017 with diagnoses of	F 880	multi-use blood glucose monitoring device after use. Immediate Action The nurse for the 200 hall was immediately inserviced on proper cleaning of the glucometers by the Director of Nursing Identification of Others Any resident receiving blood sugar monitoring has the potential to be affected therefore a blood glucometer was obtained for every resident to have their own meter. Systemic Changes The Director of Nursing (DON) will inservice all licensed nursing staff on the proper procedures of cleaning the glucometers to be completed by 5-24-18. Any staff not educated will not be allowed to work until educated. This education will be added to the new hire process. Monitoring The DON and Unit Managers will audit 5 times a week for eight weeks a sample of finger sticks on alternating shifts to ensure the licensed nurses are properly cleaning glucometers and storing them in a manner that will prevent any infection controls issues. Results of the audits will be taken to the monthly Quality Assurance Performance Improvement Committee (QAPI) meeting monthly for two months, for recommendations or modification until a pattern of compliance is achieved.	

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F 880	Continued From page 11	F 880		

hypertension, diabetes mellitus and Alzheimer's disease.
During an observation of medication pass on 5/19/2018 at 4:30 PM, Nurse #1 checked Resident #12 finger stick blood sugar and found it to be elevated. Nurse #1 took the supplies for the blood sugar check from Resident #12's room and disposed of the supplies. Nurse #1 took an alcohol wipe from the box of alcohol wipes in the top drawer of the med cart, wiped the glucometer completely, set the glucometer on a dry tissue, folded the tissue around the glucometer and set the glucometer in a cup on top of the med cart. When asked if an alcohol wipe was used, Nurse #1 responded "yes." Nurse #1 stated the glucometer was used for multiple residents. When asked if a germicidal wipe was appropriate for cleaning, Nurse #1 stated those were very harsh and thought an alcohol wipe was good. Nurse #1 stated "the alcohol should be fine, there wasn't any blood on the glucometer." A second glucometer was observed wrapped in a dry tissue on top of the medication cart.
On 5/9/2018 at 4:40 PM, in an interview, the Director of Nursing (DON) stated the facility policy was followed by staff to clean glucometers. A copy of the policy and procedure was obtained and reviewed and revealed glucometers were to be cleaned with germicidal wipes according to the manufacturer's instructions.
Nurse #1 who cleaned the glucometer with an alcohol wipe, stated at 4:55 PM on 5/9/2018 he worked at the facility for over a year and was a full time employee. When asked if he was oriented to cleaning glucometers, the Nurse stated he guessed so.
On 5/9/2018 at 5:00 PM, the 100 hall Nurse stated she cleaned the glucometers with germicidal wipes and produced a container of the

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 05/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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germicidal wipes kept on the cart.
At 5:05 PM on 5/9/2018, the 400 hall Nurse stated she used the germicidal wipes to clean the glucometers and retrieved the container of germicidal wipes from the drawer on the med cart.
On 5/9/2018 at 5:15 PM, in an interview, the DON stated all nurses were oriented to cleaning the glucometers and Nurse #1 had been oriented. A list of residents on the 200 hall that had finger stick blood glucose checks noted seven residents. The DON stated each med cart had 2 glucometers, for a total of ten glucometers.
A review of the manufacturer's manual revealed the glucometer was intended for home use or for medical professionals use in a clinical setting. The cleaning recommendation was wipe with a damp cloth. The manual stated blood or control solution should not get into the meter if used correctly.
On 5/9/2018 at 5:20 PM, in a telephone interview, a customer service representative with the manufacturer stated there should be single dose glucometers for the residents. The representative read from the manual that the glucometer should be cleaned with a damp cloth. When asked about a disinfectant the representative stated ideally, each resident would have their own glucometer.
On 5/9/2018 at 5:35 PM, in an interview, the DON stated there was no documentation to show the instructions were being followed. The DON stated her expectation was the glucometers would be cleaned and disinfected after each use.