STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE RALEIGH, NC 27616

(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
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interview, the facility failed to provide psychological services for 1 of 1 sampled resident needing psychological services. (Resident # 4) Findings include: Resident #4 was admitted to the facility on 2/10/10. Diagnoses included Depression Disorder, recurrent severe with psychotic features and history of Subarachnoid Hemorrhage/ motor vehicle accident 2003. Review of a NN (Nurses Notes) dated 2/9/11 9:00am revealed the resident had an episode of increased anxiety. Vital signs were temperature 98.4, pulse 102, blood pressure 128/82 and respirations were 24. The physician was notified and a new order received to give an extra dose of Zyprexa (antipsychotic medication) and to get a psychiatric consult. A review of the physician order revealed an order dated 2/9/11 that read; "give extra 5mg of Zyprexa now. Psychiatrist consult." This order was signed by the physician.	F 250	Resident #4 was seen by Paradigm on 03/08/11 An audit of active charts was completed on 03/16/11 by Social Worker to ensure no New orders for psych services had been written and appropriately implemented. None were found. Orders will be reviewed by Director of Nursing, MDS coordinator, Dietary Manager, and Social Worker in morning meeting five days a week Resident Liason/Social Worker have been counseled by Administrator on 03/16/11 for failure to follow up on referral for Paradigm. Psych services audit will be conducted by Director of Nursing/ designee five times a week for 4 weeks and then three times a week for four weeks and then monthly times three months. Findings will be reported to the Quality Assurance Committee monthly times three months.	3/31/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Baldwin — TITLE: Administrator — (X6) DATE: 3/31/11

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 250	Continued From page 1 A review of the social work progress notes revealed no documentation that the order for a psychiatric consult had been completed. An interview with the social worker on 3/10/11 at 2:30pm revealed she was unaware of the physician order for a referral on 2/9/11. A review of the NN dated 2/18/11 at 3:00pm documented the physician was notified of a conversation between the resident and the social worker where the resident stated she had thoughts of harming her self. The NN indicated that the physician did not feel the resident was a threat to self or others at this time and a new order was received. The new order was to increase Zyprexa to 5mg twice a day and Xanax 0.25mg by mouth every 6 hours as needed. A family member was notified of the residents thoughts;the physician order for medication change and referral for a psychiatric consults. A review of the MAR (medication administration record) for February 2011 revealed the resident was receiving Zyprexa 5mg daily from 2/1/11 through 2/17/11. A review of the physician orders revealed an order dated 2/18/11 that read 1. increase Zyprexa to 5mg by mouth twice a day, 2. Xanax 0.25mg by mouth every 6 hours as needed, 3. contact phychiatric services for follow up. This order was signed by the physician. A review of the social work progress notes revealed an entry dated 2/18/11(no time) that read; "resident is alert and oriented x2 with STM (short term memory) deficits AEB (as evidenced by) not being able to recall SW (social worker) name, not able to recall month/year and need cues on BIMS (brief interview for mental status).	F 250		

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F 250	Continued From page 2 For the last 2 weeks resident expressed she feels down/depressed, tired, poor appetite, feel bad about herself and thought about better off being dead all related to wanting to go home. see her house, can't help family, granddaughter sick and wants to walk. Both SW's spoke with resident after comment and still no change in answer. Staff MD (medical doctor) notified. MD fells confident that resident will not harm herself, to contact psychiatric services and increase psychiatric medications. Resident continues resting in bed." No further entries in social worker progress notes. A review of the quarterly MDS (Minimum Data Set) dated 2/18/11 revealed Resident #4 was able to understand what others said to her and was able to make her self understood by others. The residents cognitive patterns were severely impaired. The MDS section titled Mood revealed the resident had thoughts of being better off dead, or of hurting herself nearly every day. On 3/9/11 at 3:32pm an interview with the resident liaison (social worker) revealed that she made a referral for a psychiatric referral after the physician ordered one on 2/18/11. She stated that "maybe last week the referral was returned because the wrong family member had signed the form." When asked if she followed up on the referral the SW responded "no" she (resident#4) is depressed and that will not change she will always be that way". 3/10/11 8:50am an interview with the resident revealed that some one came in the other day and spoke with her. She indicated that she enjoyed the conversation and that the lady was	F 250		

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F 250	Continued From page 3 going to come and talk with her again. "It is nice to have some one to talk to. The SW comes in occasionally but not not very often. The resident was sitting in her wheel chair and was neatly groomed. On 3/10/11 at 11:00am an interview with the nurse practitioner from the phychiatric service revealed she had not seen the resident since she had the breakdown last year. When asked what the resident was like she responded that she had a traumatic brain injury from a MVA(motor vehicle accident) and that she was unpredictable. Further discussion revealed that she just received a referral to follow up with her again; she indicated she just manages the medication and the therapist is a different person. 3/10/11 an interview with the physician at 2:00pm revealed he checked in on the resident when ever he was in the building to see how she was. He remembers how she looked when she had a major break down last year and had to be hospitalized in the behavior unit. She was delusional and hallucinating she kept seeing her dead husband in her room. She was not like that this time I keep watching her eyes for that look she had last year and it was not there. I increased her medications and ordered a consult for her. When asked if he was aware that the first consult on 2/9/11 had not been done he said "no". When discussing the consult ordered on 2/18/11 he was unaware that she had not been seen until 3/8/11. The doctor stated his expectations would be that the nurse's would follow his orders. 3/10/11 at 2:30pm an interview with the DON revealed all physician orders are reviewed on the	F 250		

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F 250	Continued From page 4 following day during daily staff meeting. Also the nurse taking a referral order contacts the appropriate person to follow up on the referrals. The social worker entered the room and stated "I did not know about that referral on the 9th."	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide measurable objectives to meet a residents psychosocial needs for 1 of 1 sampled resident with psychosocial needs. (Resident #4) Findings include:Findings include:	F 279	F 279 Resident #4 's care plan was updated on 03/16/11 to Reflect current condition and interventions that are In place for her care. Measurable goals have been Added to current care plan. Resident Liason/Social Worker were inserviced on writing care plans with measurable goals on 03/16/11 for current charts.. Ten charts will be audited on care plans weekly at Standards Of Care meeting by MDS and/or Social Worker to identify any other care plans that are needing to be updated with measurable goals by April 20, 2011. Ten audits will be completed by Director of Nursing and/or designee weekly times four weeks then monthly times three months to ensure compliance. Findings will be reported to the Quality Assurance Committee monthly times three months.	3/21/11

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F 279	Continued From page 5 Resident #4 was admitted to the facility on 2/10/10. Diagnoses included Depression Disorder, recurrent severe with psychotic features and history of Subarachnoid Hemorrhage/ motor vehicle accident 2003. A review of the social work progress notes revealed an entry dated 2/18/11(no time) that read; "resident is alert and oriented x2 with STM (short term memory) deficits AEB (as evidenced by) not being able to recall SW (social worker) name, not able to recall month/year and need cues on BIMS (brief interview for mental status). For the last 2 weeks resident expressed she feels down/depressed, tired, poor appetite, feel bad about herself and thought about better off being dead all related to wanting to go home, see her house, can't help family, granddaughter sick and wants to walk. Both SW's spoke with resident after comment and still no change in answer. Staff MD (medical doctor) notified. MD fells confident that resident will not harm herself, to contact psychiatric services and increase psychiatric medications. Resident continues resting in bed." A review of the quarterly MDS (Minimum Data Set) dated 2/18/11 revealed Resident #4 was able to understand what others said to her and was able to make her self understood by others. The residents cognitive patterns were severely impaired. The MDS section titled Mood revealed the resident had thoughts of being better off dead, or of hurting herself nearly every day. A review of a care plan dated 2/18/11 revealed a problem STM (short term memory) deficit AEB (as evidence by) forgetfulness and unsafe	F 279		

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F 279	Continued From page 6 decision making, repetitive anxious complaints regarding family issues. Stated feelings of feeling better off dead, but would not harm self. There were 3 identified goals. The first goal was "Respond to question/statement with appropriate verbalization x 90 days." The second goal was "Display logical progression of thought by making safe decisions thru next review." The third goal was "Will be receptive to areas of compromise to address feelings of unhappiness and conflict thru next review." On 3/9/11 at 3:32pm an interview with the resident liaison (social worker) responsible for writing the care plan confirmed the goals written were not measurable.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview, the facility failed to implement interventions related to a problem for feeling of being better off dead for 1 of 1 sampled resident with these feelings. (Resident #4). Findings include:Findings include: Resident #4 was admitted to the facility on 2/10/10. Diagnoses included Depression Disorder, recurrent severe with psychotic features and history of Subarachnoid Hemorrhage/ motor	F 282		

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F 282	Continued From page 7 vehicle accident 2003. A review of a care plan dated 2/18/11 revealed a problem STM (short term memory) deficit AEB (as evidence by) forgetfulness and unsafe decision making, repetitive anxious complaints regarding family issues. Stated feelings of feeling better off dead, but would not harm self. Interventions listed included; brief visits for interaction, consult with ------ (name of phycological services on changes. and socialization and provide social support and reassurance. These interventions were to be provided by social services department. A review of the social work progress notes revealed an entry dated 2/18/11(no time) that read; "resident is alert and oriented x2 with STM (short term memory) deficits AEB (as evidenced by) not being able to recall SW (social worker) name, not able to recall month/year and need cues on BIMS (brief interview for mental status). For the last 2 weeks resident expressed she feels down/depressed, tired, poor appetite, feel bad about herself and thought about better off being dead all related to wanting to go home. see her house, can't help family, granddaughter sick and wants to walk. Both SW's spoke with resident after comment and still no change in answer. Staff MD (medical doctor) notified. MD fells confident that resident will not harm herself, to contact psychiatric services and increase psychiatric medications. Resident continues resting in bed." No further entries in social worker progress notes. A review of the quarterly MDS (Minimum Data Set) dated 2/18/11 revealed Resident #4 was able to understand what others said to her and	F 282	F-282 Resident #4 was seen by Paradigm on 03/08/11 An audit of active charts was completed on 03/16/11 by Social Worker to ensure no New orders for psych services had been written and appropriately implemented. None were found. Orders will be reviewed by Director of Nursing, MDS coordinator, Dietary Manager, and Social Worker in morning meeting five days a week Resident Liason/Social Worker have been counseled by Administrator on 03/16/11 for failure to follow up on referral for Paradigm. Psych services audit will be conducted by Director of Nursing/ designee five times a week for 4 weeks and then three times a week for four weeks and then monthly times three months. Findings will be reported to the Quality Assurance Committee monthly times three months.	3/21/11

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F 282	Continued From page 8 was able to make her self understood by others. The residents cognitive patterns were severely impaired. The MDS section titled Mood revealed the resident had thoughts of being better off dead, or of hurting herself nearly every day. On 3/9/11 at 3:32pm an interview with the resident liaison (social worker) revealed that she made a referral for a psychiatric referral after the physician ordered one on 2/18/11. She stated that "maybe last week the referral was returned because the wrong family member had signed the form." When asked if she followed up on the referral the SW responded "no" she (resident#4) is depressed and that will not change she will always be that way". 3/10/11 8:50am an interview with the resident revealed that some one came in the other day and spoke with her. She indicated that she enjoyed the conversation and that the lady was going to come and talk with her again. "It is nice to have some one to talk to. The SW comes in occasionally but not not very often. The resident was sitting in her wheel chair and was neatly groomed. On 3/10/11 at 11:00am an interview with the nurse practitioner from the phychiatric service revealed she had not seen the resident since she had the breakdown last year. When asked what the resident was like she responded that she had a traumatic brain injury from a MVA(motor vehicle accident) and that she was unpredictable. Further discussion revealed that she just received a referral to follow up with her again; she indicated she just manages the medication and the therapist is a different person.	F 282		