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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	C 03/28/2012

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 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that clinical records were complete and with accurate documentation as evidenced by failure to document a medication ordered as PRN (as needed) for pain on the Medication Administration Records (MARs) and or nurse's notes for 3 (Residents #3, #9 & #6) of 3 sampled residents receiving pain medication. The findings include: 1. Resident #3 was admitted to the facility on 08/30/11 with multiple diagnoses including status post bilateral hip replacement and knee replacement. The quarterly Minimum Data Set (MDS) assessment dated 0/29/12 indicated that Resident #3 had memory and decision making problems. Review of the Physician's orders revealed that	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Resident number 3.6 and 9 medical records have been reviewed by Director of Nursing. Nurses that had documentation errors have been disciplined for incomplete documentation by Staff Development Coordinator. Residents receiving PRN narcotics have been identified by the Director of Nursing. Inservices were completed on 3/29/12 for licensed nurses and medication aids on proper PRN documentation guidelines by Staff Development Coordinator. New hire orientation will also reflect the guidelines for PRN documentation, and will be reviewed during orientation by Staff Development Coordinator. Audits on PRN documentation will be completed weekly X 4 weeks and then monthly X3 months by Director of Nurses, Staff Development Coordinator Unit Manager or designee to ensure compliance. Results of the audits will be reviewed at the monthly QA meetings by the QA committee.	4/9/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Baldwin
TITLE: Administrator
(X6) DATE: 4/10/12

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 514	Continued From page 1 Resident #3 was on Norco (pain medication) 5/325 mgs (milligram) 1 tablet by mouth every 6 hours PRN for pain. The Controlled Drug Receipt forms were reviewed. The form indicated that " each dose signed for here requires charting on the medication record " . The forms revealed that Norco was signed out on 11/09 (11:00 AM), 11/11 (12:00 N), 11/12 (5:00 PM), 11/24 (10:00 AM), 11/30 (7:30 AM), 12/4 (9:00 AM), 12/10 (9:00 AM), 12/11 (9:00 AM), 12/28 (3:00 PM), 12/31 (9:00 AM), 1/1 (9:00 AM), 1/13 (9:00 AM), 1/15 (9:30 AM), 1/22 (9:30 AM), 1/25 (12:00 N), and 2/14 (3:00 AM). There were no documentation on the MAR or the nurse's notes that Norco was administered to Resident #3 on the above mentioned dates. On 03/28/12 at 11:45 AM, Nurse #2 was interviewed. He stated that if he signed out a narcotic from the Controlled Drug Receipt and did not document on the MAR or the nurse's notes, it was because he was so busy and forgot to do it. On 03/28/12 at 1:00 PM, the administrative staff was interviewed. She stated that the nurses were expected to document on the MAR any medication that was administered to the resident. She further stated that she was not aware that nurses were not documenting the narcotics that were signed out from the Controlled Drug Receipt consistently on the MARs. She further stated that the nurses had received an in-service in January and February, 2012 regarding Medication Administration and Medication Documentation. She added that the Controlled Drug Receipt form was not part of the resident's clinical records.	F 514		

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F 514	Continued From page 2	F 514		

2. Resident #9 was admitted to the facility on 04/27/10 and was re-admitted on 07/23/11 with multiple diagnoses including Peripheral Vascular Disease. The quarterly MDS assessment dated 01/18/12 indicated that Resident #9 had no memory or decision making problems.

The doctor's progress notes dated 11/03/11 indicated " still has a lot of leg pain, increase Neurontin (use for management of postherpetic neuralgia) and add Norco " .

The doctor's orders were reviewed. On 11/03/11, there was an order for " Norco 5/325 mgs 1 tablet by mouth every 8 hours PRN for pain " . On 02/09/12, there was an order to " increase Norco 5/325 mgs 1 tablet by mouth to every 4 hours PRN for pain " .

The Controlled Drug Receipt form for February and March, 2012 was reviewed. The form indicated that " each dose signed for here requires charting on the medication record " . The form revealed that Norco 3/325 mgs. tablet was signed out on 2/26 (1:00 AM), 2/27 (8:30 PM), 2/29 (9:00 PM), 3/2 (1:00 AM), 3/2 (9:30 PM), 3/13 (9:00 PM, 3/14 (9:00 AM) and 3/15 (9:00 PM). The MARs and the nurse's notes for the above mentioned dates were reviewed and there were no documentation that Norco was administered to Resident #9.

On 03/28/12 at 9:15 AM, Nurse #1 was interviewed. Nurse #1 was the nurse who signed

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F 514	Continued From page 3	F 514		

out the Norco on 02/27, 02/29, 03/02, 03/13, and 03/15 from the Controlled Drug Receipt. She stated that she forgot to document that she had administered the Norco to Resident #9. She further indicated that she normally administers the medication to the resident and then document it on the MAR.

On 03/28/12 at 11:45 AM, Nurse #2 was interviewed. He stated that if he signed out a narcotic from the Controlled Drug Receipt and did not document on the MAR or the nurse's notes, it was because he was so busy and forgot to do it.

On 03/28/12 at 1:00 PM, the administrative staff was interviewed. She stated that the nurses were expected to document on the MAR any medication that was administered to the resident. She further stated that she was not aware that nurses were not documenting the narcotics that were signed out from the Controlled Drug Receipt consistently on the MARs. She further stated that the nurses had received an in-service in January and February, 2012 regarding Medication Administration and Medication Documentation. She added that the Controlled Drug Receipt form was not part of the resident's clinical records.
3. Resident #6 was admitted to the facility 06/22/06 and readmitted 09/06/11. Cumulative diagnoses included: Diabetes Mellitus, idiopathic peripheral neuropathy, AK (above the knee) amputation of the left leg and BPH (benign prostatic hypertrophy) with urinary retention. The quarterly Minimum Data Set (MDS) assessment dated 02/27/2012 indicated resident was cognitively intact.

A review of the physician's orders revealed that

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F 514	Continued From page 4 Resident #6 was on Oxycodone-APAP (Acetaminophen) (pain medication) 5-325 mg. (milligrams) one tablet by mouth every four hours as needed for mild-moderate pain and Oxycodone-APAP 5/325 mg two tablets by mouth every four hours as needed for severe pain. The Controlled Drug Receipt forms were reviewed. The form indicated that "each dose singed for here requires charting on the medication record". The forms revealed that Oxycodone-APAP 5-325 mg one tablet was signed out on 2/5/2012 at 12:00 PM., 2/6/2012 at 11:00 PM., 3/8/2012 at 3:20 AM. and 3/15/2012 at 5:00 AM. No documentation was noted on the MAR (medication administration record) or the nursing notes that Oxycodone/APAP (Acetaminophen) 5-325 mg. (milligrams) was administered to Resident #6 on the above mentioned dates. On 3/28/2012 at 11:40 AM, Nurse #2, when asked regarding the PRN medication given on 2/5/2012 and 2/8/2012, stated he did not know why he would not have documented the medication on the medication administration sheet (MAR). He stated he usually signed the medication out on the control sheet, then on the MAR and documented the administration of the medication on the back of the MAR. He further indicated he documented the effectiveness of the medication on the back of the MAR one to two hours after administration. The nurse who signed out the medication for Resident #6 on 3/8/2012 and 3/15/2012 no longer was employed at the facility and was unable to be contacted by phone.	F 514		

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F 514	Continued From page 5 On 03/28/12 at 1:00 PM, the administrative staff was interviewed. She stated that the nurses were expected to document on the MAR any medication that was administered to the resident. She further stated that she was not aware that nurses were not documenting the narcotics that were signed out from the Controlled Drug Receipt consistently on the MARs. She further stated that the nurses had received an in-service in January and February, 2012 regarding Medication Administration and Medication Documentation. She added that the Controlled Drug Receipt form was not part of the resident's clinical records.	F 514		