STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		7/20/18

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

Electronically Signed | 07/17/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interviews for one (Resident # 7) out of six sampled residents, who were interviewed, the facility failed to assure a staff member talked with the resident in a respectful manner. The resident stated he felt discrimination for the first time in his life because of the manner he was addressed. The findings included: Record review revealed Resident 7 was admitted to the facility on 3/5/18 for rehabilitation following orthopedic surgery. Review of the resident's minimum data set assessment, dated 5/16/18, revealed the resident was cognitively intact. The resident was interviewed on 6/25/18 at 5:25 PM. During the interview the resident reported the following. When he was first admitted to the facility, he had a great deal of mobility limitations due to orthopedic problems and surgery. He had worked very hard during his facility therapy sessions. Following his therapy sessions, he would independently exercise as instructed to the best of his ability. This was because he wanted to get better and be more independent. Due to personal circumstances, which he could not control, he could not return to the home in which he resided prior to his orthopedic surgery. He had requested the social worker help him find housing he could afford, and the social worker was assisting him. Within the past few weeks, he had been working with a therapy staff member when	F 550	F-550 This 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 or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Root cause This alleged noncompliance was resulted from the accused individual attempts to communicate discharge process and expectation to resident #7. The Root cause analysis concluded that accused employee did not communicate in a manner that foster good customer service that is in alignment with the facility standards. The For affected resident: Upon learning of the allegation on 6/26/18, the accused individual was suspended pending investigation and a 24 hour initial allegation report was initiated by the Administrator and the DON. Detail investigation was conducted by the facility Administrator within five days of this alleged incident. The result of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 550	Continued From page 2 she starting to talk to him in a very rude manner. The staff member asked him what he was going to do and where he planned to go since he had improved. He conveyed to the staff member he needed some help finding a place to live. The staff member asked him, "Why should we find a place for you?" The resident felt the staff member asked it in a manner to convey it was not the facility's responsibility to help him. He reported she talked to him "bad," and he tried to explain to her that he did not like being in the position in which he was. The resident stated he could not help that he did not have a home where he could go, and he had worked very hard so he could make things better for himself. The resident stated he felt discriminated against by the therapy staff member. The resident also stated there had been someone else in the room when the incident occurred, and the incident had been reported to administrative staff. The Rehabilitation (Rehab) Director was interviewed on 6/26/18 at 11:15 AM. The Rehab Director reported the following. She had been called by another staff member who had witnessed the incident. The staff member, who had witnessed the incident, had informed her Physical Therapy Assistant (PTA) # 1 had been "over the top" in pushing the resident about helping himself. The Rehab Director had talked with the resident and felt PTA # 1 had acted unprofessional, but it had been the PTA's intent to motivate the resident. The Rehab Director stated she had taken corrective measure with the PTA. The witness to the incident was Occupational Therapist (OT) # 1. OT # 1 was interviewed on 6/26/18 at 4:30 PM. OT # 1 reported the following. She (the OT) had been completing	F 550	investigation unsubstantiated the allegation due to inconsistencies of resident #7 statements as well as witness's statement. Accused employee was re-educated on proper customer service by the Rehab director on 6/26/18. For other resident with the potential to be affected: All residents have the potential to be affected by this alleged non-compliance. Like residents and staff interviews were initiated on 6/26/18 conducted by the Director of Rehab and the Administrator to determine if any other residents had experienced the same treatment by the accused individual. No other residents were identified in the audit. In addition, therapy staff re-education was initiated on 6/26/18 by the Director of Rehab regarding customer service, abuse, and resident rights. Along with therapy staff re-education, 100% of facility staff will be re-educated by the Administrator, DON, ADON, or designee regarding customer service, abuse, and resident rights by 7/20/18. Any employee not educated by 7/20/2018 will not be allowed to work until educated. This education will also be added on the new hire orientation process for all new licensed nurses and nursing aides Effective 7/20/2018, and will also be provided annually. Facility plan to prevent re-occurrence: Effective 7/20/18, a resident rights audit tool will be completed by the Administrator, DON, ADON, or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 550	Continued From page 3 paper work while PTA # 1 was working with Resident # 7 on the day of the incident, and therefore could hear the conversation which had occurred. PTA # 1 had asked the resident about his discharge plans. The resident responded he was waiting for the social worker to help him find a place to live. PTA # 1 then responded, "Why do you feel it is the social worker's place to help you find a place to stay?" The PTA continued to tell the resident it was not the social worker's place to find him a place to stay or the government's responsibility to take care of him. The resident tried to tell the PTA that if he could find a place he would. The resident asked the PTA, "Do you think I want to be here? I don't want to be in this situation." The OT, who was witnessing the incident, could tell the resident was becoming uncomfortable with the conversation. The PTA kept pursuing the conversation even though the resident was uncomfortable. She continued to tell him that it was his responsibility to figure it out. The PTA and the resident continued to go back and forth about the issue. The OT reported she felt it was the role of therapists to motivate and provide help for residents in any manner they could. The OT reported during the exchange, which she had witnessed, the PTA offered no constructive advice to the resident in how he could help himself and therefore she did not perceive the exchange to be motivational if that was the PTA's intent. If it had been a motivational exchange, the OT felt the PTA should have offered advice on ways the resident could help himself and this was never done. The OT stated in addition to the comments made by the PTA, the PTA did not seem to recognize she needed to stop when he was uncomfortable. The OT perceived the exchange she had witnessed to be disrespectful to the resident, and she had	F 550	to interview 10 residents weekly for 60 days to ensure appropriate resident rights are being honored by all staff. The audit will consist of new admissions along with long term care residents. Effective 7/20/2018, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Responsible Party Effective 7/20/2018, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 7/20/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 550	Continued From page 4	F 550		

reported it.

PTA # 1 was interviewed on 6/26/18 at 5:40 PM. PTA # 1 reported the following. She did talk to the resident about his discharge planning, and her intent was to motivate him. She had asked the resident what his discharge plan was, and he had told her the social worker was going to help him find a place to live. The resident had indicated it was the government's responsibility to help him, and she had told him, "No, not really." She said she perceived she had talked to the resident as she would have talked to one of her family members in trying to get them to take initiative.

The details of the OT's interview and the resident's description of the incident were shared with the Corporate Consultant and Director of Nursing (DON) on 6/26/18 at 6:15 PM. The Corporate Consultant and the DON were unaware the resident had felt discrimination. These staff members stated the incident had occurred on 5/19/18. At the time of the incident there was another administrator. This administrator no longer worked at the facility, and it was their understanding the incident had been managed. The Corporate Consultant and the DON were accompanied to talk to the resident once again at this time. The resident shared with these staff members the details of how he had been addressed. The resident stated it was the first time in his life he had felt discrimination when the PTA had talked to him in the manner in which she had. The resident stated he did not feel the PTA's intent was to be motivational.

Following the interview with the resident, the Corporate Consultant and the DON provided the 5/19/18 grievance form regarding the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 550	Continued From page 5 The grievance form had been filed because of the OT witness. The OT's description of the incident was not included on the form. The Rehab Director had documented the following on the form. The Rehab Director had talked to the resident about the incident on 5/21/18. The resident had voiced he had been talked to like he was the PTA's child, and was made to feel like he was not doing anything. The resident did not want the PTA to get in trouble. The Rehab Director noted on the form the PTA would not work with the resident again, and she (the Rehab Director) would discuss with the Executive Director about proper follow up with the PTA. According to the Corporate Consultant and the DON, follow up was done specific with the PTA, but they were not knowledgeable of other measures the former administrator had taken to assure all residents were treated with dignity. According to the Corporate Consultant and the DON, based on the resident's account of the incident on 6/26/18 at 6:15 PM, which they had personally heard, they recognized there needed to be further follow up by the facility to the incident.	F 550		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to serve food in a form that met the resident's individual needs for 1 of 6 sampled residents (Resident #10). The resident	F 805	F-805 Director of Nursing, Dietary Manager, Registered Dietitian, and the facility	7/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 805	Continued From page 6 was ordered chopped meat and was observed being served whole meat patties on two separate occasions during the survey. The finding included: Resident #10 was admitted to the facility on 02/20/14 with diagnoses that included left hemiparesis, traumatic brain injury, dysphagia-oropharyngeal phase and a history of diseases of the muscular skeletal and connective tissue systems. Review of the quarterly Minimum Data Set assessment dated 05/08/18 documented that Resident #10 had severely impaired cognition, required supervision with eating and was receiving a mechanically altered diet. Review of the care plan for Resident #10, revised on 05/09/18, documented one problem as "at increased nutritional risk related to chewing difficulties" with interventions that included assist with meals, attend dining room for meals, and provide diet as ordered. Goals included, in part, that the resident would be free from signs of aspiration or dysphagia with the current dietary order through the next review. Review of the June 2018 physician orders revealed that Resident #10 was to receive a regular diet with mechanical soft meat only and nectar thick liquid (start date of 02/08/17). Review of the resident's dietary slips on 06/26/18 and 06/27/18 read: "Diet order: nectar thick liquids, ground meat." During an observation of the evening meal on 06/26/18 at 6:45 PM it was noted that the tray	F 805	Executive Director discussed on 6/27/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from inadequate training/understanding of dietary staff, as the result the facility failed to serve food in a form that met residents (Resident #10). For affected resident: The incorrect trays on 6/26/18 and 6/27/18 for resident #10 were returned to the dietary department each time and the correct trays were brought back to resident #10. For other residents with the potential to be affected: All residents have the potential to be affected by this alleged non-compliance. On 7/15/2018 & 7/16/2018 Dietary Managers, Director of Nursing and/or Assistant Director of Nursing completed facility audit on residents' diets to ensure that diets ordered matches the tray cards system no other residents identified with diet orders not matching the tray card. On 7/15/2018 dietary manager observed the tray card process during the lunch meal to identify if any other resident mechanically altered diet orders received items in the tray not compatible with their specific physician ordered diet. No other resident was identified as receiving items on the tray not compatible with the ordered diet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 805	Continued From page 7	F 805		

delivered to Resident #10 had a whole hamburger patty on it. When questioned, Dietary Staff Member #2 stated that the meat should have been ground and replaced the hamburger patty with ground meat.

During an observation of the breakfast meal on 06/27/18 at 8:50 AM it was noted that Resident #10 was served breakfast in bed. The food plate had been uncovered for the resident by staff and the resident had been repositioned in preparation to eat. The two sausage patties on the plate were whole. The meal tray was returned to the kitchen. Dietary Staff Member #2 stated that she plated the whole sausage patties, knowing that the resident was on ground meat, because the resident's family was usually present and cut up the resident's meat. No family members were present in the resident's room on 06/27/18 when the meal was served.

In an interview with the he Dietary Manager on 06/27/18 at 9:00 AM he commented that food served to a resident was to leave the kitchen in the form that was ordered by the physician. He said that it was not appropriate for staff to rely on family members or visitors to cut up a resident's meat. He said that he expected food to be served as ordered by the physician.

In an interview with Speech Therapist #1 on 06/27/18 at 9:10 AM she reported that she had met with the family the night before and had been informed that Resident #10 was having trouble chewing the ground meat. She said that the family had requested that the resident be downgraded to a pureed diet. She reported that the resident was agreeable to the diet change. She said that she had planned to start the pureed

Facility plan to prevent re-occurrence:

Effective 7/20/2018 the facility will provide diets to residents in the facility as ordered by the physician and will not include items not compatible with each resident's diet.

The dietary department will be re-educated by the dietary manager, dietician, or designee regarding the importance of not deviating from the diet order printed on the diet sheets and ensuring accuracy of diet matching what is placed on resident trays by 7/20/18.

Effective 07/20/18, a resident diet sheet audit tool will completed by the dietary manager, dietician, or designee to review accuracy of 10 random diet sheets 5 days a week for 60 days. The audit will consist of new admissions along with long term care residents.

The audits will be taken to the monthly QAPI meeting for committee to deem compliance.

Compliance Date: 7/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 805	Continued From page 8 diet during the lunchtime meal to see how the resident tolerated the texture. She said that it was not appropriate for staff to rely on visitors to cut up a resident's meat. She commented that she expected food to be in the proper form when served to a resident.	F 805		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record review the facility failed to follow the prescribed diet and honor food preferences for 2 of 6 sampled residents reviewed for food preferences. Resident #3 was served a food item that was recorded as a food allergy on her meal ticket. The resident consumed a portion of the meal and had a mild allergic reaction. The facility also failed to assure resident food preferences were honored for a diabetic resident, Resident #9. Findings included: Example 1: Record review revealed Resident #3 was	F 806	F-806 This 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 or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. Director of Nursing, Dietary Manager,	7/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 806	Continued From page 9 admitted to the facility on 02/14/17 with diagnoses that included Type 2 diabetes mellitus and heart failure. Food allergies included dairy products, beef, and lactose as documented on the dietary ticket. The plan of care for Resident #3, revised on 04/25/18, included that the resident was at increased nutrition risk due to multiple food dislikes and allergies with a goal that the resident would receive foods that were complaint with her diet order. Interventions included, in part, dietary to provide diet as ordered; and food preferences, special requests and items would be honored and provided. It also included that the resident was non-compliant with her diet and requested foods that she was allergic to (beef sausage, milk products, etc...) with a goal that the resident would be complaint with her diet through the next review. Interventions included resident education and encouragement to be complaint with her diet. A Minimum Data Set assessment dated 04/25/18 documented that the resident had intact cognition and required limited assistance with eating. Review of the diet ticket dated 06/26/18 for Resident #3 documented: "Low concentrated sweets, no added salt, 2000 milliliter fluid restriction, no dairy!!!, no cheese, no milk, no ice cream, no butter, no sour cream." Review of the Nurse Practitioner documentation dated 05/28/18 at 2:38 PM revealed that the resident was allergic to milk. The Nurse Practitioner wrote that Nursing Assistant #3 reported to her that Resident #3 had consumed a couple bites of Turkey Alfredo for lunch and developed throat, tongue and lips swelling. She	F 806	Registered Dietitian, and the facility Executive Director discussed on 6/27/18 to identify the root cause of this alleged noncompliance. Root cause analysis conducted revealed, the alleged noncompliance resulted from inadequate training/understanding of dietary staff, as the result the facility failed to serve food in a form that met residents need. Resident #3 was served food recorded as a food allergy and resident #9 was served food that did not honor facility preferences. For affected residents: On 5/28/2018, Resident #3's plate was quickly removed by nursing aide #3 and nursing was informed immediately to provide any necessary treatment intervention for potential allergic reaction. Resident #9 is now being offered appropriate preferences. For other residents with the potential to be affected: Effective 7/20/2018, All residents have the potential to be affected by this alleged non-compliance. The dietary department will be re-educated by the dietary manager, dietician, or designee regarding the importance of offering appropriate food preferences/substitutes and careful review of food allergies on tray card not to be served by 7/20/18. Facility plan to prevent re-occurrence: Effective 7/20/18, A food allergy audit sheet will be completed by the DON, ADON, or designee on all current residents to identify any type of food	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 806	Continued From page 10 recorded that the resident was stable with no acute distress or airway obstruction. She ordered oxygen and Benadryl 50 milligrams stat. Review of the nursing note dated 05/28/18 at 3:04 PM documented: "Resident is allergic to dairy products. She was served Turkey Alfredo for lunch. This writer observed she had only a couple of bites of Alfredo. Benadryl 25 milligrams given for preventative and teaching done with resident to report any significant changes. At 2 PM the CNA reported to this nurse resident feels as though her throat and tongue were swelling. Upon examination there were no positive signs of swelling. Nurse Practitioner examined resident. Received orders to give Benadryl 50 milligrams by mouth stat. Oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath for food allergy. Oxygen saturation 95%. Denies any shortness of breath or chest pain. Denies any difficulty swallowing. Vital signs blood pressure 138/81, pulse 79, respirations 18. Staff will continue to monitor." In an interview conducted with Resident #3 on 06/26/18 at 9:25 AM she reported that she never asks for any food with milk, cream, or butter in it. She stated that she had not asked for the Turkey Alfredo when it was served to her. She said Nursing Assistant #3 jerked the plate away after she had only taken a few bites. She said she felt swelling in her throat and chest but that the reaction was caught when it started and that she had not developed hives. She reported that once she did eat the cheese pizza but had peeled the cheese off of it and had not had a reaction. She said that she loved pizza. In a follow up interview on 06/26/18 at 3:45 PM the resident again stated	F 806	allergy. Positive allergies will be noted on resident tray cards. Following the initial audit, a resident diet sheet audit tool will completed by the dietary manager, dietician, or designee to review accuracy of 10 random diet sheets 5 days a week for 60 days. The audit will consist of new admissions along with long term care residents. Effective 07/20/2018, the Executive Director, Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 07/20/2018, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 7/20/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 806	Continued From page 11	F 806		

that she had not asked for the Turkey Alfredo. When asked if she requested the Alfredo she replied: "Heaven's no! I certainly would not ask for Alfredo. It would make me sick."

In an interview with Dietary Staff Member #4 on 06/26/18 at 12:50 PM she stated that she was familiar with Resident #3 and knew which foods she was allergic to. She said that if the resident asked for something she was allergic to she was shown the meal ticket and told that she could not have it. She reported that a recent example included chocolate chip cookies. She said the resident had requested one but she knew that they had been made with milk. She stated that she informed the resident they contained milk and she no longer wanted one. She said that she had been working on the 100 hall the day that the resident ate the Turkey Alfredo. She stated that the cook had been new, was not aware of the resident's allergies, and had not read the meal ticket when he plated her food.

In an interview with Nursing Assistant #3 conducted on 06/27/18 at 9:30 AM she stated that she normally worked on the 100 hall and was familiar with Resident #3. She said that she was also familiar with the resident's food allergies including milk and beef. She said the resident normally ate chicken, pork and turkey. She used almond milk. She reported that she was taking care of the resident on 05/28/18 when she ate the Turkey Alfredo. She said that the cook who was plating the food that day (Dietary Staff #3) had never worked on the 100 hall and was not familiar with the resident's allergies. She said the resident was served the Turkey Alfredo by the kitchen. She stated that she did not recall that the resident had requested the Alfredo. She said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 806	Continued From page 12	F 806		

that after she served the Turkey Alfredo to the resident she realized that it contained milk and went back to the table and jerked the plate away from the resident who had already started eating. She said she immediately went and got the nurse and the Nurse Practitioner. She stated that if a resident requested a meal they were allergic to that she would inform the resident of the ingredients and tell the nurse before serving the food to the resident. She commented that once in the past that Resident #3 had insisted on having the cheese pizza being served but had peeled the cheese off and did not have any trouble after she ate it.

In an interview conducted with Nurse #1 on 06/27/18 at 9:40 AM she stated that she was familiar with Resident #3. She reported that the resident was alert and oriented and credible.

In an interview with the Nurse Practitioner on 06/27/18 at 10:25 AM she reported that she remembered the event involving Resident #3 eating the Turkey Alfredo. She said she was summoned immediately and assessed the resident. She said that the resident's tongue and lips were "pretty red" and that she was starting to have an allergic reaction. She reported that the reaction was mild so she only ordered Benadryl and did not have to give the resident any steroid shots. She commented that the resident told her that the Alfredo had been given to her and that she had not asked for it. She reported that Resident #3 was alert and oriented and would let someone know if something was wrong. She stated that she had reported the incident to the physician and followed up with the resident the next day to ensure that she was alright.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 806	Continued From page 13	F 806		

In an interview conducted with the Dietary Manager on 06/27/18 at 10:50 AM he stated that he expected food to be served as ordered according to the instructions on each meal ticket. He said the cooks were trained to read to each meal ticket prior to plating the food for each resident.

In an interview conducted with the Director of Nursing on 06/27/18 at 11:00 AM she stated that it was her understanding that Resident #3 had asked to be served the Turkey Alfredo that caused her to have an allergic reaction. She commented that Resident #3 was alert and oriented. She said that the resident knew what her allergies were. She said it was a resident's right to request food he or she may be allergic to but that staff was to notify the physician prior to honoring the request. She said the facility would then follow the direction of the physician.

Example 2:

Record review revealed Resident # 9 was admitted to the facility on 3/7/18. The resident had a diagnosis of diabetes.

Review of the resident's minimum data set assessment, dated 6/4/18, revealed the resident was cognitively intact.

Review of the resident's care plan, last revised on 6/5/18, revealed the facility had identified the resident was at risk for hypoglycemia and hyperglycemia. The goal of the resident was she not exhibit any signs or symptoms of hypoglycemia and hyperglycemia. The care plan noted the resident was non-compliant with her diet order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 806	Continued From page 14	F 806		

Review of the resident's current orders revealed she was to receive a low concentrated sweets diet.

Review of a nutritional screening and assessment form, dated 3/21/18, revealed it had been completed by a former dietary manager. The dietary manager noted the resident's likes and dislikes were reviewed. The dietary manager did not note what the food preferences were in her assessment.

Review of the resident's blood sugar readings for the month of June, 2018 revealed they ranged from 72 to 546.

Review of progress notes revealed the Nurse Practitioner (NP) had seen the resident on 6/20/18 because of low blood sugars. The NP noted she saw the resident again on 6/22/18 because her blood sugar was 441 before lunch. On the date of 6/22/18, the NP noted she had provided the resident with diet education and recommended she take in less sugar and carbohydrates. The NP documented the resident stated she understood the information she was given about the recommendation, and communicated that she (the resident) was in agreement with the diet plan.

Review of the 6/25/18 lunch menu revealed the following items were to be served. Turkey Alfredo with Penna Pasta, spinach, a dinner roll, and strawberries with topping. An alternate meal was listed as hamburger with lettuce and tomato and French fries.

On 6/25/18 at 1 PM Resident # 9 was observed in a small dining room. Food was being served from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 806	Continued From page 15	F 806		

a small kitchenette area which serviced the resident's hall. The resident was served Turkey Alfredo with Penna Pasta, spinach, and a roll. When the resident was served her plate, she commented that she did not want the spinach. She was instructed by staff that she could set it aside. The resident stated she did not like the spinach. Dietary Staff Member # 1 stated the resident could have mashed potatoes or French fries. Resident # 9 stated she already had pasta and therefore mash potatoes were another starch and she did not want the French fries. Dietary Staff Member # 1 stated there might be another choice in the main kitchen, and she would have to check.

On 6/25/18 at 1:15 PM the resident was observed to have finished her meal. No one had brought her an alternative choice to the spinach. No one had served her any strawberries for dessert. The resident had eaten her Turkey Alfredo with Penna Pasta and had not eaten her roll.

On 6/25/18 at 1:20 PM, it was observed that one resident in the small dining room was eating strawberries. Nurse Aide (NA) # 1 was observed handing out ice cream to other residents in the small dining room. NA # 1 could not find any strawberries to serve to Resident #9.

NA # 2 was interviewed on 6/25/18 at 1:25 PM. NA # 2 stated there should have been strawberries on the kitchen cart, but there was none to give to Resident # 9.

Resident # 9 was interviewed in her room on 6/25/18 at 1:30 PM. The resident reported the following. She would have "loved" to have had a salad instead of the spinach that day, but salads

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 806	Continued From page 16	F 806		

were rarely offered. There were many food choices she would prefer to have that were more in line with a diabetic diet, and which she did not receive. The resident stated the Nurse Practitioner had been talking to her about eating less carbohydrates and starches to help her control her blood sugar. She really wanted to eat better, but it was difficult to do so with the food choices she was served. The resident pointed out that the main items she had been offered for her lunch meal that day were high carbohydrate and starches. The resident stated she had never talked to the registered dietician since she had resided at the facility, but felt it would be helpful to do so. The resident reported she was still hungry following her lunch meal, and she would probably eat a snack later. She expressed that she worried about her blood sugar dropping, and therefore she ate the carbohydrates and sugars she was served to keep her blood sugar up.

The dietary manager, who was newly hired to the facility, was interviewed on 6/26/18 at 1:45 PM. The dietary manager reported the following. There were other alternative choices which had been available in the main kitchen for the resident to have been offered for lunch on 6/25/18 than the potatoes and French fries. The dietary manager said the potatoes and French fries were not a good choice to offer a diabetic resident, who was trying to control their blood sugar with diet options. The strawberries, which had been on the menu, should have been available to be served to Resident # 9 at lunch on 6/25/18. The dietary staff had not thawed enough strawberries on 6/25/18 to serve all the residents, and therefore sugar free ice cream and regular ice cream had been sent to residents when the facility ran out of strawberries.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 806	Continued From page 17 Interview with the Registered Dietician (RD) on 6/26/18 at 3:45 PM revealed it had not been brought to her attention the resident had concerns about food choices and controlling her blood sugars. The RD stated there were always good choices available in the kitchen, and salads could be easily offered to diabetic residents. The NP was interviewed on 6/26/18 at 2:55 PM. The NP reported the following. She did think the resident wanted to eat food items that would better control her blood sugar. The facility did not offer a standard diabetic diet to residents, and she had recently educated the resident regarding wise food choices she could make on her own. The food items and alternatives, which had been offered to Resident # 9 at lunch on 6/25/18, were shared with the NP. According to the NP, the choices given to the resident on 6/25/18 were not in line with what she had been educating the resident to eat. The NP also was aware the resident would get hungry and then snack some, and stated the facility had a lot of high carbohydrate snacks and it would be good if the resident could be offered snack options which she liked and which were not high carbohydrate.	F 806		