PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345529	B. WING			l	C 01/2019
NAME OF P	ROVIDER OR SUPPLIER	1	1		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	01/2019
				5	5201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH		F	RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	from 1/22/19 -1/25/19	The survey team returned					
	The following Immedi identified at:	ate Jeopardy citation was					
	CFR 483.21 at tag F6 (J).	660 at a scope and severity					
	Immediate Jeopardy removed on 2/1/19.	began on 12/13/18 and was					
	Tag F689 constituted Care.	Substandard Quality of					
	Past-noncompliance	was identified at:					
	CFR 483.25 at tag F6 (J)	689 at a scope and severity					
	The deficient practice and was corrected or	for F689 began on 1/15/19 1/19/19.					
	A Partial extended su	rvey was conducted.					
	The credible allegation 3/1/19.	n of removal was amended					
	provided to the facility results of the facility's (IDR). Tags F-600 an the information in tag reflect the results of the	ent of Deficiencies was y on 4/4/19 because of the Informal Dispute Resolution d F-624 were deleted and 0000 was changed to he IDR. Event #CJIL11. o the 2567 after CMS review					
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/21/2019

**Electronically Signed** 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING		C 02/01/2019		
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	H RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 000	Continued From page of the IDR materials	÷ 1	F 000				
F 624 SS=J	Preparation for Safe/CFR(s): 483.15(c)(7)	Orderly Transfer/Dschrg	F 624		2/20/19		
	preparation and orient safe and orderly transfacility. This orientation form and manner that understand.  This REQUIREMENT by:  Based on record review Adult Protective Service Doctor, Ombudsman, Staff, Home Health A Medical Technician, for staff members and for failed to provide 1 of (Resident #12) who with a safe discharge included discharge grapport for Resident sensure 1 of 4 sample discharge to have a seleaving the facility. The Resident #12's medic home assessment to a safe discharge homological medical proparation with facility failed to prosufficient preparation #12 to ensure safe arthe facility. The facility. The facility. The facility. The facility. The facility. The facility failed to prosufficient preparation #12 to ensure safe arthe facility. The facility.	e and document sufficient tation to residents to ensure sfer or discharge from the on must be provided in a at the resident can is not met as evidenced ews and interviews with sces Worker, Medical Transportation Company gency Worker, Emergency former and current facility from resident the facility as sampled residents were reviewed for discharge planning process that follows and caregiver \$12. The facility failed to residents (Resident #12) afe place to go to after the facility failed to assess all condition and complete a identify possible barriers for the segan on 12/13/2018 when		F 624 J  Corrective action accomplished for the residents found to have been affected the deficient practice.  Resident #12 was admitted on 5/23/20 for short term rehabilitation services. Resident #12 received skilled nursing rehabilitation services from 5/23/2018 to 7/11/2018. Resident #12 was discharged from Medicare covered ski services on 7/11/2018 after she met he therapy goals. Resident #12 remained the facility after 7/11/2018 for custodia care without a payer source.  On 10/10/2018, the facility Business Office Manager and Assistant Busines Office Manager discussed with resider #12 regarding her failure to make payment arrangement for her stay in the facility. Resident #12 voiced the understanding of her financial obligation.	by  218  and up  Iled er in I		

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			l	C / <b>01/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	70172013
				52	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH			ALEIGH, NC 27616		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 624	Continued From pag		F	624			
		ations, checking blood sugar					
		on of insulin or any other			On 11/15/2018; Business Office Mana	-	
		he facility failed to have a			provided resident #12 with the 30 □ da	-	
		esident the safety of the			discharge notice since resident #12 fai		
		relation to the resident's			after reasonable and appropriate notice		
		d ability to maneuver at			pay for her stay at the facility. Residen	İ	
		basic needs of food, water,			#12 discharge date was set for		
		nd medical care needs.			12/13/2018.		
	Immediate Jeopardy was removed on 02/01/19 at 3:45pm based on the allegation of compliance that was provided. The facility remains out of compliance at a lower scope and severity of D				On 12/12/2010 Decident #12		
					On 12/13/2018, Resident #12 was	to.	
					discharged from the facility to her privation home after the 30 days discharge notice		
	•						
	· ·	al harm with potential for arm that is not immediate			expired. Facility arranged transportatio transport resident #12 to her private ho		
		e education and ensure			via licensed non-emergency	IIIE	
		ut into place are effective			transportation company.		
		facility staff regarding the			transportation company.		
	discharge planning p				Although resident #12 failed to pay for	her	
	alconarge planning p	100000.			stay at the facility, after reasonable and		
	The Findings include	d:			appropriate notice was given, the state		
					survey agency alleged that; the facility		
	Resident #12 was ad	lmitted to the facility on			failed to provide and document sufficie	nt	
		oses that included heart			preparation and orientation to resident		
		onic obstructive pulmonary			#12 to ensure safe and orderly dischar		
		oression, neuropathy and			from the facility. The facility failed to tra	•	
	muscle weakness.	•			and orient the resident and or family		
					representative on administering		
	Review of the hospita	al discharge summary dated			medications, checking blood sugar and	l	
	5/23/18 revealed Res	sident #12 was found at			self-administration of insulin or any oth	er	
		by Emergency Medical			medical treatment. The facility failed to		
		patient reported she had			have a discussion with the resident and	d or	
		days for help and her			family representative to address the sa	-	
		EMS because they had not			of the home environment in relation to		
		nt for several days. EMS			resident□s physical condition and abili	ty	
	·	t's home was "knee-deep"			to maneuver at home, the resident □s		
		ill of rats and roaches. The			basic needs of food, water, electricity a		
	· .	have a blood sugar of 690			heat and medical care needs. The fac	-	
	milligrams per decilit	er (mg/dl).			failed to discuss with the resident and		
					family representative the level and type	e of	

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(		
		345529	B. WING			02/	01/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	:		
LINID/EDO		BAL 51011		5:	201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	HRALEIGH		R	ALEIGH, NC 27616			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 624	Continued From page	e 3	F	624				
	Record review of a so	ocial service progress note			support the resident needed from her			
	dated 5/29/18 for Res	sident #12 stated Adult			family, significant others, the communit	y,		
	Protective Services (A	APS) was working with the			home health agencies, and any other			
		d the resident's home would			government agencies and how the faci	lity		
		efore she could return			will assist the resident in getting the			
		lanned to return home after			support and assistance she needed.			
		y, stabilized her medical						
	condition and had her	r home cleaned.			The facility also failed to validate the	4		
	December may invest a se	one plan for Decident #10		post-discharge care is appropriate to resident #12 needs, and failed to valid				
					ite			
		oal identified that she would	orientation was provided in a form and manner that the resident #12 understo		od			
	return home with sup				manner that the resident #12 understoo	Ju.		
		d the facility would evaluate			Resident #12 was transferred to the			
	the resident's home for	<u> </u>			hospital for generalized weakness on			
		eting to discuss post change			12/13/2018 from her private home.			
	needs, assist the resi				Hospital records indicated resident #12	.		
		for discharge, notify the			was unable to take care of herself at he			
	residents physician to	discuss concerns and			home. Resident #12 is no longer in the			
	obtain orders for disc	harge supplies.			facility, no further actions warranted at	this		
					time.			
		ocial service progress note						
		dent #12 stated the Social			On 1/30/19; Chief Clinical Officer from	the		
	, ,	ormed the resident her last			Management and consulting company			
	l	rage was 7/11/18. The SW			contracted by the facility, conducted the	3		
		verage letter, advanced			root cause analysis for this alleged	لم		
		er and appeal process and			noncompliance. The analysis conclude			
	_	Resident #12 expressed to not ready to return home			the alleged noncompliance resulted fro the facility s failure to provide and	m		
		her lawyer involved if the			document sufficient preparation and			
		nrow her out. The SW			orientation to resident #12 to ensure sa	ıfe		
		lent that the facility was not			and orderly discharge from the facility.			
		providing this information per			The facility also failed to validate the			
		e guidelines. After continued			post-discharge care is appropriate to m	eet		
	·	esident she decided she			resident #12 needs, and failed to valida			
	would appeal the dec	ision and a follow-up			orientation was provided in a form and			
	meeting was planned	after notification of the			manner that the resident #12 understoo	od.		
	appeal decision.							

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED	
	A. BUILDI	NG		Ι,	_
345529	B. WING			l	01/2019
		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE DATE FIGURE		52	201 CLARKS FORK DRIVE NW		
HRALEIGH		R	ALEIGH, NC 27616		
Y MUST BE PRECEDED BY FULL					(X5) COMPLETION DATE
arterly Minimum Data Set 8 for Resident #12 revealed act and an active discharge the resident to return to the ired extensive two-person mobility, transfers, personal e one-person assistance se and bathing. She was and bladder. Review of MDS icated that Resident #12's ds and her height was 71  ansfer / discharge notice for 1/15/18 from the facility the date of discharge was for the transfer / discharge er having received opriate notice failed to pay Medicare / Medicaid) for her is information was given to c Ombudsman on  ocial service progress note esident #12 stated discharge if with the resident and she ge back to her home. The ome health services upon inquired about transfers as seded with toileting and the rould like continued activities of daily living e to ensure her balance and using the sliding board. The y working with therapy and e therapy team of resident's	F	624	Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.  Audits of 100% of residents□ discharged documentation in the last 90 days were completed by the Director of Nursing, assistant Director of nursing, Staff Development coordinator and/or unit manager on 1/30/19 to identify if any of resident was discharged without sufficience preparation and orientation to ensure so and orderly discharge from the facility. Other resident was identified to be affected by this alleged noncompliance.  Measures will be put into place or what systematic changes will be made to ensure that the deficient practice will no occur.  Effective 1/30/2019 the Director of Nursing, Director of Rehabilitation Central Staff Development coordinator and/or Director of Social services will be responsible to initiate and train/provide needed education to either resident and resident representative, or will train the designated licensed nurse who will the train the resident and/or resident representative. This education/training take place at least three days before resident is discharged from the facility. Staff members who will be responsible educate residents or resident □s	ther ent afe No	
	IDENTIFICATION NUMBER:	A BUILDI  345529  B. WING  TH RALEIGH  ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  BY ALEIGH  ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  BY ALEIGH  ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  BY ALEIGH  ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY MUST BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF DEFICIENCIES BY ALEIGH  ID PREFIT TAG  FOR ATEMENT OF PREFICE TAG  FOR ATEMENT OF PREFIT TAG  FOR ATEMENT OF TAG  FOR ATEMENT OF TAG  FOR ATEMENT OF TAG  FOR ATEMENT OF TAG	A. BUILDING	TH RALEIGH  ARTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SECIDENTIFYING INFORMATION)  Be 4  Level 4  Level 4  Level 4  Level 4  Level 50 of Level 1 to the interest of the transfer / discharge er having received priate notice failed to pay dedicare / Medicaidy for her is information was given to exponsible to mit manager on 1/30/2019 the Director of Nursing, Director of Social services will be responsible to initiate and train/provide needed education to either resident and train/provide needed education to either resident and the resident the resident and she potential service progress note ested to the rome. The ome health services upon inquired about transfers as reded with toileting and the rould like continued activities of daily living e to hensure her presentative. This education tile activation is representative. This education/training take place at least three days before residents is incharged from the facility. Staff members who will be responsible educate resident in the resident mit and for resident is discharge from the facility of the resident and she persentative of adily living the sliding board. The yworking with therapy and the representative include; Director of residents is discharge from the facility of the resident and or resident is discharge from the facility. The proposition is the proposition of the transfer is a resident seldent and she persentative. This education/training take place at least three days before residents is discharge from the facility. Staff members who will be responsible educate resident is discharge from the facility. Staff members who will be responsible educate residents include; Director of residentical continued and the resident seldent is discharged from the facility. Staff members who will be responsible educate residents include; Director of residentical continued and the resident seldent is discharged from the facility.	A BUILDING  345529  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE S201 CLARKS FORK DRIVE NW RALEIGH  ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC: IDENTIFYING INFORMATION)  BY ADDRESS, CITY, STATE, ZIP CODE S201 CLARKS FORK DRIVE NW RALEIGH, NC 27616  PREFIX TAG  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.  Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.  Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.  Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.  Address how corrective action will be accomplished for those residents—action will be accomplished for those residents—aving the potential to be affected by the same deficient practice.  Address how corrective actions will be accomplished for those residents—aving the potential to be affected by the same deficient practice.  Address how corrective actions will be accomplished for those residents—aving the potential to be affected by the same deficient practice.  Address how corrective actions will be accomplished for those residents—aving the potential to be affected by the same deficient practice.  Address how corrective actions will be accomplished for those residents—aving the potential to be affected by the same deficient practice.  Address how corrective actions will be accomplished for those residents—aving the potential to be affected by the same deficient practice.  Address how corrective action will be accomplished for those residents—aving the potential to be affected by the same deficient practice.  Address how corrective action will be accomplished for those residents—a

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION	I ` '	(X3) DATE SURVEY COMPLETED	
						С	
		345529	B. WING _		d	2/01/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE		
				5201 CLARKS FORK DRIVE N	W		
UNIVERS	AL HEALTH CARE/NO	RTH RALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION YE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 624	resident stated apprend she would like prepare the resider assistance closer to the resider assista	age 5 ner right to appeal. The bealing was a waste of time to go home. The writer would not to return home and set up to her discharge date.  I social services progress note Resident #12 stated discharge ed again with the resident to epared for her transfer home esident will discharge to her be. She was provided with adent living and assisted living bus occasions, but the resident elent will transport home and services with the home health oice. Her motorized wheelchair ell as a bedside commode that the facility. The resident effacility. The resident effacility. The resident effacility and friends will assist ion and check in on her were no concerns brought to swriter by the resident.  The discharge summary for did 12/12/18 at 1:19 pm revealed address, physicians name and notes to the Ombudsman and eles phone number and adverse reactions. Attached to mary was a list of the ons and her care plan.	Fé	Staff Development coorsocial services #1 or # discharging nurse. The intended to train and or and or family represer resident smedical carbut not limited to admit medications, checking self-administration of imedical treatment. The discussion with the resident in relation physical condition and at home, the resident food, water, electricity medical care needs on that are relevant to the resident. The facility was resident and or family level and type of supponeeded from her famil the community, home and any other government of the support and needed. The facility was getting the support and needed. The facility was resident and or family other issues the facility resident to have a safe discharge as identified.	ordinator, Director of #2. And/or e education will be orient the resident ntative on the are needs including inistering globod sugar, insulin or any other ne facility will have a sident and or family rest the resident so the standard so the standard and the standard and the standard and the standard and the standard side the will discuss with the representative the ort the resident y, significant others, health agencies and sist the resident in discuss with the representative any y can help the e and orderly din the resident sin the resident sin the resident sin the representative any y can help the e and orderly din the resident sin the reside		
	12/13/18 for Resid was alert and orier No acute distress r assistance with AD	departmental note dated ent #12 revealed the resident ited, able to make needs know. noted. The resident required its, 2 person assist using		discharge planning on care plan.  Effective 1/30/19 the f weekly Case Manager chaired by the facility purse. Director of Reh	acility will conduct a ment meeting Administrator, MDS		

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
							c
		345529	B. WING_			02/	01/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	H RAI FIGH		5	201 CLARKS FORK DRIVE NW		
ONIVERSA	AL HEALIH CARE/NORT	MALLIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	even and unlabored. and insulin coverage  Record review of a stated 12/13/18 reveated resident's choice to reto an independent or health services were resident. The writer state worker that the reside home with home health resident. The writer state worker that the resident home with home health resident with home health resident with home health resident with home on transported home on transportation compated facility.  An EMS report dated EMS was dispatched a sick call. A 63-year-sitting in her motorizes she had been dischard home this afternoon at months. She reported 2:00 pm today and with the was not able to compate the facility.  Review of the hospital Resident #12 identified generalized weaknes herself. The patient her fibrillation, asthma, chemical resident with the state of the facility of the hospital resident weaknes herself. The patient her fibrillation, asthma, chemical reviews of the hospital resident weaknes herself. The patient her fibrillation, asthma, chemical reviews of the hospital resident weaknes herself. The patient her fibrillation, asthma, chemical reviews of the hospital reviews of the hosp	r problems, she was and bladder, breathing was Blood sugar was checked, provided.  ocial service progress note alled APS was informed of the eturn home verses transfer assisted living facility. Home set up per request of the poke with APS to alert case ent was being discharged alth services.  ed Resident #12 was 12/13/18 2:30pm by a ny that was paid for by the  12/13/18 7pm revealed to Resident #12's home for old female complained of ad wheelchair. She reported reged home from the nursing after staying there for 7 as she arrived home about as unable to transfer from toilet. The patient reported omplete her rehab while at all records dated 12/13/18 for ed her chief complaint was s and unable to take care of	F	524	Director of Nursing. Residents with pending discharges will be discussed in this meeting at least a week in advance allow the Director of Social Services #1 and/or #2 at least seven days to make necessary arrangements to ensure sufficient preparation and orientation for safe and orderly discharge from the facility in a form and manner that the resident will understand. During this meeting the person who is going to orienthe resident will be assigned.  Effective 1/30/19 and moving forward to facility will conduct home visits as deer appropriate and necessary by the facili licensed therapist and/or director of nursing to ensure resident will receive appropriate preparation, orientation and education individualized based on the findings from home visit before the discharge to ensure residenthas a safe and orderly discharge. The education and home visits will be conducted prior to resident sides dischargorate them will receive appropriate in the provided in the form and maintaine in resident sides the medical records. The fact will validate orientation was provided in form and manner that the resident will understand. In the instance where the resident is unable to understand, resident representative will be educated and/or Adult protective service will be notified effective 1/30/2019	e to  or  ent  he ned tty  d  t e. the ed ility i a	
	hypertension. She ha	d been at a skilled nursing months and was unable to			Effective 1/30/19 the facility will conduct discharge meeting and work with the	et a	

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(	С
		345529	B. WING _			02/	01/2019
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				52	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	IH RALEIGH		R	ALEIGH, NC 27616		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 624	Continued From pag	e 7	F	624			
		so she was discharged home			resident and/or resident representative	if	
		as unable to walk and used a			applicable, to develop interventions to	, "	
	_	r. She had to go to the			meet each resident⊡s discharge goals		
		ot able to get to the bedside			and to ensure a sufficient preparation a		
		lled EMS. EMS found the			orientation for safe and orderly dischar		
		rine and stool. The patient			from the facility in a form and manner t	-	
		or the past couple days and a			the resident will understand. Any identi		
	work up in the emerg	jency room revealed a			barriers will be addressed before the		
	urinary tract infection	and received 1 dose or			resident is discharged from the facility	and	
	Rocephin (an antibiotic). The patient was discharged from the hospital to a skilled nursing			hence reduce factors leading to			
					preventable readmissions to the hospit	al.	
	facility on 12/19/18.				This review will take place daily Monda	y	
					through Friday effective 1/30/19.		
		former Social Worker (SW)			Effective 1/30/2019 the director of social		
	on 1/25/2018 at 11:0				services will be ultimately responsible t		
	_	#12 on 12/13/2018. The SW			coordinate all discharge meetings in the		
		t wanted to go home and			facility. The facility will not discharge an	- 1	
		ighbors to help her. The SW			resident from the facility until the facility		
		family members present en she was discharged on			validates that all services are arranged and the resident is safe to be discharge		
		d the facility arranged for the			effective 1/30/2019	,u	
		any that took the resident					
		d she had contacted APS and			Effective 1/30/19 and moving forward t	he	
		Resident #12 was being			facility director of social services #1 or		
		ne SW added that Resident			and/or discharging licensed nurse will	"-	
		to another facility and she			provide and document sufficient		
		me. SW also indicated she			preparation and orientation to residents	3	
		visit to Resident #12's home.			and/or resident representative if		
		d no knowledge of another			applicable to ensure safe and orderly		
	cleaning up Residen	_			transfer or discharge. This orientation v	vill	
					be provided in a form and manner that		
	An interview with the	physical therapy staff			resident can understand. This education		
	member on 1/25/19 a	at 11:30 am revealed they			will be documented in resident□s medi	cal	
	had worked with Res	sident #12 prior to being			records.		
	_	f member stated the resident					
		er goals and would not have			Regional Clinical Consultant from the		
		herself at home alone. She			contracted Management and consulting	3	
		would have had a hard time			company conducted re-education for		
	trying to transfer here	self from her wheelchair to			current facility interdisciplinary team		

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			1	C	
NAME OF D	ROVIDER OR SUPPLIER	343323	5: 11::10	ет	TREET ADDRESS, CITY, STATE, ZIP CODE	02	/01/2019	
NAME OF P	ROVIDER OR SUPPLIER							
UNIVERSA	AL HEALTH CARE/N	ORTH RALEIGH			201 CLARKS FORK DRIVE NW			
				R/	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 624	Continued From p	age 8	F 6	524				
	the toilet without a	issistance.			involved on discharge planning to inclu	ıde		
					the Administrator, Director of Nursing,			
	An interview with	Nursing Aide #1 (NA) on			Director of Social services #1 and #2,			
		m who worked with Resident			Activity Director, Director of Rehabilitat	ion		
	#12 during her sta	y at the facility revealed the			services, MDS nurse and staff			
	resident needed a	ssistance with all her ADLs,			development coordinator on 1/30/19. T	his		
	however she could	d feed herself. NA#1 added			education emphasized on the importar	ıce		
	the resident wante	ed to go home.			of providing sufficient preparation and			
					orientation for safe and orderly dischar			
		the Director of Nursing (DON)			from the facility in a form and manner t	.hat		
		1:00 am revealed she had no			the resident will understand before			
	_	ident #12's discharge. DON			discharge to ensure each resident have	e a		
		former Social Worker handled			safe discharge from the facility. The education will involve the resident,			
	that discharged.				resident □s representative if applicable			
	An interview with	the Administrator on 1/25/2019			and will include information such as po			
		ed the SW completed the			discharge services from home health	0.		
		ident #12 and she was unaware			agencies, and/or Adult protective servi	ces		
		id for this resident to be			(if applicable). This education will be			
	transported home	. She stated she did not know if			completed by 1/30/19, any department			
	someone had mad	de a home visit prior to			head not educated by 1/30/19 will not I	oe		
	Resident #12's dis	scharge.			allowed to work until educated. Effective	/e		
					1/30/19 this education will be added or	1		
		ew on 1/25/19 at 1:30 pm with a			new hires education and provided			
		e skilled nursing facility that			annually for all new facility department			
		currently residing at revealed			heads.			
		admitted on 12/19/18 and			TI F. "" P: ( (N) : (DON)			
		e to total assistance with her could feed herself with staff			The Facility Director of Nursing (DON)			
	set-up.	could feed fierself with staff			Assistant Director of Nursing and/or sta development coordinator will complete			
	Sct-up.				100% education on the importance of			
	During an intervie	w with Resident #12 on			providing sufficient preparation and			
		pm revealed she was at the			orientation for safe and orderly dischar	ge		
		8 months. She stated she told			from the facility in a form and manner t	•		
	I -	nted to go home however she			the resident will understand before			
		ıld not take care of herself.			discharge to ensure each resident have	e a		
		ed the facility kicked her out			safe discharge from the facility. The			
	because she had	not paid them. She stated she			education will involve the resident,			
	had completed the	e Medicaid applications to get			resident □s representative if applicable			

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLI IDENTIFICATION NUMBER: A. BUILDING			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		Ι,	С	
		345529	B. WING				01/2019	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LIMINEDO	AL UEALTU CARE/NOE	OTH DAI FIGH		52	201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		R	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 624			F	624	and will include information such as podischarge services from home health agencies, and/or Adult protective service (if applicable). This education will be provided for all licensed nurses, to include the part time and as needed licen nursing staff. This education will be completed by 1/30/19. The education winvolve the resident, resident srepresentative if applicable and will include information such as post discharge services from home health agencies, Adult protective services (if applicable), Medication reconciliation, will be documented on the each resident sdischarge records acknowledged by the resident and/or representative of their understanding. A licensed nurse not educated by 1/30/19 will not be allowed to work until educate This education will also be added on the new hire orientation process for all new licensed nurses effective 1/30/19, and also be provided annually.	ces ude sed vill  Any ed ed		
	on 1/28/19 10:30am Resident #12 somet the resident knew he able to take her med The MD added we we therapy about her tre  Pre phone interview 1/28/19 at 11:00 am call from the facility know Resident #12 The APS worker exp	Pre phone interview with the medical doctor (MD) on 1/28/19 10:30am revealed that he last saw Resident #12 sometime in December. He stated he resident knew her medications and would be able to take her medication without assistance. The MD added we would need to talk to physical herapy about her transfer ability.  Pre phone interview with an APS worker on 1/28/19 at 11:00 am revealed he had received a call from the facility SW on 12/13/18 to let him know Resident #12 was being discharged home. The APS worker explained they were called in May 2018 about the condition of the resident's			The facility plans to monitor its performance to make sure that solution are sustained.  Effective 1/30/19 the Facility Administrator, Director of Nursing, Assistant Director and/or Nursing, RN supervisors will review all planned discharges to the community in the nex 72 hours to ensure that each resident receive sufficient preparation and orientation for safe and orderly discharger from the facility in a form and manner the	ct		

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345529	B. WING _		02/01/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE
				5201 CLARKS FORK DRIVE NW	
UNIVERSA	AL HEALTH CARE/NO	ORTH RALEIGH		RALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 624	placed in the nursi further involved wi	age 10 because the resident was ling facility they had not been th the resident's case. The APS the last communication he had	F€	the resident understood b from the facility. Any resid without sufficient educatio re-educated, staff membe	lent identified on will be
	with the facility SV going to remain at and didn't have an her. APS worker in history indicated the Resident #12's ho APS indicated that in Resident #12 hi Review of statem 1/28/19 at 11:10ar that staff talked to Medicaid application to her that would be liability which consminus \$30.00. She	W was that Resident #12 was the facility due to her health by family to help take care of indicated that Resident #12 nat someone need to clean up ime before her return home. It this information was indicated story with APS.  The story with APS indicated resident she did not have a on on file. Staff also explained the responsible for patient sist of social security check the completed her Medicaid		re-educated, staff member education will be identified re-educated to ensure add knowledge and skills on home resident/resident stands represeducation efficiently. Find monitoring process will be a daily Stand up report for stand up meeting binder a follow-ups are completed. Director of Nursing, Assis Nursing, Director of Service contact resident and/or rephone, within seven days check on resident to ensure is safe at home. This more will take place daily for 4 value and the stands are weeks, then monthing the stands and the stands are stands are stands are stands are stands and the stands are stands ar	d and equate ow to provide sentative dings from this e documented on rm and filed in after proper The Facility tant Director of ce 1 or 2 will presentative, by of discharge to re the resident nitoring process weeks, weekly x
	it went: but did have because she was bills so she could a paid 1,000.00 for 0. An interview with (BOM) on 1/28/20 indicated that she pick up her month indicated she was BOM stated that F 30 day notice and can go back home everybody and oth they are not gettin going to do: Nothing that "she was not get the same of th	pplication and told staff that she understood how went: but did have any money to pay anything ecause she was paying for her trailer and other ills so she could go back home (however she aid 1,000.00 for October).  An interview with Business Office Manager (BOM) on 1/28/2019 at 11:30am revealed she adicated that she went to see Resident #12 to ick up her monthly payment and Resident #12 adicated she was not paying anything here.  OM stated that Resident #12 told her to give her 0 day notice and Resident #12 indicated so she an go back home. Resident #12 stated "I owe verybody and other nursing facilities too and ney are not getting anything either, what are they oing to do: Nothing'. Resident #12 also stated that "she was not going to spend down her noney nor give any information on her life		or until the pattern of commaintained.  Effective 1/30/19, Facility and/or Director of Nursing findings of this monitoring facility Quality Assurance Performance Improvemer any additional monitoring of this plan monthly for thuntil the pattern of complia maintained. The QAPI commodify this plan to ensure remains in substantial cor	Administrator  will report  process to the  and  t Committee for  or modification  wree months, or  ance is  mmittee can  t the facility

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345529	B. WING				C 01/2019	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			01/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
F 624	insurance either."  An interview with fact 3:00 pm revealed sh conversation on 7/6/SW. She stated during SW explained to Rescoverage would be 7 stated during that me at the facility.  Pre phone interview conducted with the v transportation compa#12 home. He stated from the facility midd home. The van drive condition of her hom "dropped her off and Pre phone interview the facility Ombudsm aware of Resident # indicated he had not this resident's discharal An interview on 1/29 Aide (NA) #5 revealed Resident #12 when a stated the resident w known. The resident w known. The resident resident also choose added the resident resident resident as a she was able to feed An interview on 1/29.	ility SW #2 on 1/28/19 at e was a witness to the 2018 with the previous facility ng this meeting the previous sident #12 that her last day of 2/11/2018. Resident #12 eeting that she wanted to stay  on 1/29/19 at 10:45 am was an driver from the any that transported Resident depicked up the resident day and transported her ar stated he did know the e. He explained he just kept it moving".  on 1/29/19 at 11:17 am with man revealed she was not 12's discharge. Ombudsman received any information on arge.  /19 at 11:30 am with Nursing ed she had provided care for she was at the facility. She was able to make her needs would let the staff know if the bedside commode, but the et to wear a brief. NA #5 equired extensive one to ce with all her ADLs except	F	524				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C 02/01/2019	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			1210 1120 19	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 624	that the resident had in December. NA #2 with the resident on the and the resident told coming to help her what stated the resident conshe was unsure if the clean herself up after. She added the resident eds known. NA #2 knowledge if the facility before the resident who was at her own medications and that that when she was at her own medications. discharged Resident was unsure of the time reviewed and instruct take her medications. knew how to check her administer her insuling actually observed her revealed she was not paperwork for Resident was denied on 12/13/explained they had not the facility but from a Pre phone interview was a proposed to the resident was denied on 12/13/explained they had not the facility but from a	been discharged sometime explained she had worked he day she was discharged, her she would have an aide hen she got home. NA #2 build do some for herself, but resident would be able to having a bowel movement. In the was able to make her stated she had no ty hade made a home visit has discharged.  19 at 1:00 pm with Nurse #2 en the nurse for Resident to the facility. She stated the ny issues with taking her the resident had told her home she had administered Nurse #2 explained she e. She added she had hed the resident on how to She added the resident er blood sugar and but stated she had never doing this. Nurse #2 able to find the discharge ent #12.  In 1/30/19 at 3:45 pm with a far home health agency for services for Resident #12 its. The staff member of received a referral from	F	524			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED		
		345529	B. WING _			C 02/01/2019		
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		02/01/2013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 624	earlier in the year withe bathtub. He statt trailer that had a hornasty". EMS Worken how the resident evidence wheelchair because He explained when 12/13/18 Resident added the resident house, but he could boxes and papers a a horrible odor.  Pre phone interview EMS Worker #2 rev 911 and dispatched Resident #12's hom resident had a historobserved the resident out of the fire department resident out of the fire department resident on a stretch could smell the odo driveway. EMS Worwas very weak and	ge 13 e had been at her home hen the resident was stuck in ed the resident lived in a rrible odor and was very er #1 added he didn't know en got around in her there was so much clutter. he responded to the call on #12 met them at the door. He would not let them in the see that there was clutter, ill over the floor and there was  on 1/31/19 at 12:38 pm with ealed a call was received by to them as a sick call to he. Worker #2 indicated the rry with EMS and they had ent's home cluttered with trash of the home had a very bad this call the resident wouldn't e, but he could observe the ent. He explained they rolled he home to her driveway and assisted them with getting the her. Worker #2 indicated you r from the house down to reker #2 added the resident had urine and had stool on	Fé	324				
	1/31/19 at 3pm VD responsibility to ass everyone knew that he had to make a page 1/31/19 at 3pm VD	erview with the Van Driver on indicated that it is not his ess the Residents home but Resident #12's situation that ath in her house just to stack indicated that her home was ad horrible odor.						

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
		345529	B. WING			C 02/01/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		2/01/2019	
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 624	Continued From page 14		F 62	24			
	The Administrator w jeopardy on 1/30/20	as notified of immediate 19 at 11:30am.					
	compliance on 2/1/2	a credible allegation of 019 at 10:52am. The as amended on 3/1/19 to as					
	The creation of this Letter of Credible allegation constitutes a written allegation of compliance. Preparation and submission of this letter does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth by the survey agency. This letter is solely prepared because of 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.						
	original Allegation of accepted by the Sta We are making thes direction that CMS h and we are assured	s have been made to the Compliance that was te survey team on 1/30/19. The changes under the las requested the changes that those changes will not LJ was lifted for F 624.					
	residents found to he deficient practice. During the Survey th facility failed to provipreparation and orders ensure safe and orders.	complished for those ave been affected by the see State alleged that; the de and document sufficient intation to resident #12 to erly discharge from the sailed to train and orient the ly representative on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C ( <b>01/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	1		STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 02/	01/2019
				5201	CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NO	RTH RALEIGH		RAL	EIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 624	and self-administra medical treatment. discussion with the representative to a environment in relacondition and abilit resident's basic ne and heat and medifailed to discuss w representative the resident needed frothers, the communant any other gover facility will assist the support and assist Resident #12 was 11/15/2018 for non from 11/15/18 and planning discussion that resident indicatione On 12/13/1 transferred home awith Home care se was transferred to weakness on 12/13. At the time of the sidentified that the resident indication. On 1/30/19; Chief Management and by the facility, condition of this alleged nor concluded the alleger from the facility's famanagement teams	ications, checking blood sugar ation of insulin or any other. The facility failed to have a resident and or family ddress the safety of the home ation to the resident's physical y to maneuver at home, the eds of food, water, electricity cal care needs. The facility the the resident and or family level and type of support the orn her family, significant nity, home health agencies, ernment agencies and how the resident in getting the	F	624			

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C <b>02/01/2019</b>		
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	CODE	02/01/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O  (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	TION SHOULD BE THE APPROPRIA	DATE		
F 624	resident that can be Address how correct accomplished for the potential to be affect practice.  Audits of 100% of redocumentation in the completed by the Dir Director of nursing, Scoordinator and/or unidentify if any other rewithout sufficient preensure safe and ordefacility. This audit we any involuntary discridentified to be affect noncompliance.  Measures will be put systematic changes the deficient practice Effective 1/30/2019 to Director of Rehabilitat Development coording Social services will be train/provide the nee resident and/or resid train the designated train the designated train the resident and This education/training three days before residential to Center coordinator, Director of Nehabilitation Center coordinator, Director And/or discharging in	les and procedures, ounsafe discharging of a considered neglect. live action will be see residents having the led by the same deficient sidents' discharge least 90 days were lector of Nursing, assistant staff Development lit manager on 1/30/19 to lesident was discharged paration and orientation to learly discharge from the lead have included identifying large. No other resident was led by this alleged linto place or what leavily liberated by this alleged linto place or what leavily line made to ensure that leavily line made to either leavily line made to either leavily line made leavily line	Fé	524				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING				04/2040
NAME OF P	ROVIDER OR SUPPLIER	343323	1 2:	STE	REET ADDRESS, CITY, STATE, ZIP CODE	02/	01/2019
TO WILL OF TH	NOVIDER ON OUT FREIN				1 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	RTH RALEIGH			LEIGH, NC 27616		
	0.11.11.42.70.4.0	TITELENT OF DEFICIENCES			·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 624	Continued From pag	ge 17	F	624			
	family representative	e on the resident's medical					
	care needs including						
	-	ations, checking blood sugar,					
	self-administration o	f insulin or any other medical					
	treatment. The facili	ity will have a discussion with					
	the resident and or f	amily representative to					
		t's safety including but not					
		ronment in relation to the					
		ondition and ability to					
		the resident's basic needs of					
	food, water, electricity and heat and medical care needs or any other issues that are relevant to the safety of the resident. The facility will discuss						
	-	d or family representative the					
		pport the resident needed					
		ificant others, the community,					
		es, and any other government					
	_	ne facility will assist the					
		e support and assistance she					
		will discuss with the resident					
	and or family represe	entative any other issues the					
	facility can help the	resident to have a safe and					
	orderly discharge as	identified in the resident's					
	discharge planning of	on the comprehensive care					
	plan.						
		e facility will conduct a weekly					
		meeting" chaired by the					
		, MDS nurse, Director of					
		r Director of Nursing.					
	I -	ling discharges will be					
		eting at least a week in					
		e Director of Social Services t seven days to make					
		nents to ensure sufficient					
		ntation for safe and orderly					
	1	acility in a form and manner					
		understand. During this					
		who is going to orient the					
	resident will be assig						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	
		345529	B. WING			02/	01/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,                                      </u>	
				5	201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		R	RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	will conduct home vis and necessary by the and/or director of numbers of the receive appropriate peducation individualism from home visit beforesident has a safe and education and home to resident's discharge documented on "the and maintained in refacility will validate of form and manner that understand. In the in unable to understand will be educated and will be notified effective 1/30/19 the discharge meeting an and/or resident repredevelop interventions discharge goals and preparation and orien discharge from the factors leading to prehospital. This review through Friday effect Effective 1/30/2019 the will be ultimately resident gany rethe facility validates to	In moving forward the facility sits as deemed appropriate a facility licensed therapist resing to ensure resident's resident. Each resident will preparation, orientation and zed based on the findings re the discharge to ensure and orderly discharge. The visits will be conducted prior ge. The home visit will be home visit checklist form' sident's medical records. The rientation was provided in a at the resident will stance where the resident is d, resident's representative /or Adult protective services ve 1/30/2019 facility will conduct a and work with the resident esentative, if applicable, to so to meet each resident's to ensure a sufficient antation for safe and orderly acility in a form and manner understand. Any identified essed before the resident is facility and hence reduce eventable readmissions to the or will take place daily Monday	F	624			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	040020	1	STREET ADDRESS, CITY, STATE, ZIF		2/01/2019	
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/N	ORTH RALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 624	Continued From page 19		F	624			
	director of social sidischarging licensidocument sufficie residents and/or applicable to ensudischarge. This or form and manner understand. This resident's medica Regional Clinical Management and re-education for citeam involved on the Administrator, Social services #1 Director of Rehab and staff developing sufficier safe and orderly of form and manner before discharge safe discharge from the fore discharge safe discharge	Consultant from the contracted consulting company conducted urrent facility interdisciplinary discharge planning to include Director of Nursing, Director of I and #2, Activity Director, ilitation services, MDS nursement coordinator on 1/30/19. In phasized on the importance of the preparation and orientation for discharge from the facility in a that the resident will understand to ensure each resident have a somether facility. The education will not, resident's representative if I include information such as rvices from home health Adult protective services (if education will be completed by a threat the aduct to work until educated. This education will be added on on and provided annually for all					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD	NG _	<del></del>	, ا	C
		345529	B. WING			l	01/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIMINEDO	AL UEALTU CARE/NO	DTU DAL FICU		52	201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NC	RIH RALEIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 624	the facility in a form will understand bet resident have a sa The education will representative if an information such a home health agency services (if application provided for all lice time, part time and staff. This education 1/30/19. The education resident's represer include information services from home protective services reconciliation, and each resident's disby the resident and understanding. And by 1/30/19 will not educated. This educated. This educated nurses eff provided annually. The facility plans to make sure that sol Effective 1/30/19 the Director of Nursing Nursing, RN super discharges to the consure that each preparation and or discharge from the that the resident un from the facility. Ar	and orderly discharge from and manner that the resident fore discharge to ensure each fe discharge from the facility. involve the resident, resident's oplicable and will include as post discharge services from cies, and/or Adult protective oble). This education will be ansed nurses, to include full as needed licensed nursing on will be completed by ation will involve the resident, attative if applicable and will a such as post discharge to health agencies, Adult (if applicable), Medication will be documented on the charge records acknowledged differ representative of their y licensed nurse not educated be allowed to work until acation will also be added on ation process for all new fective 1/30/19, and will also be of monitor its performance to autions are sustained. The Facility Administrator, Assistant Director and/or visors will review all planned community in the next 72 hours in resident receive sufficient fentation for safe and orderly facility in a form and manner anderstood before discharge my resident identified without in will be re-educated, staff	F	624			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 02/01/2019		
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	- '	V20 1120 10		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 624	and skills on how to representative eduction from this monitoring on a daily "Stand up "stand up meeting be are completed. The Assistant Director of 1 or 2 will contact responding to the property of the time of the property of the time of the property of the implementation of the imple	ensure adequate knowledge provide resident/resident's ation efficiently. Findings process will be documented oreport" form and filed in inder" after proper follow-ups Facility Director of Nursing, f Nursing, Director of Service sident and/or representative, wen days of discharge to ensure the resident is safe toring process will take place eekly x 2 more weeks, then or until the pattern of ained.  acility Administrator and/or will report findings of this to the facility Quality ormance Improvement additional monitoring or blan monthly for three pattern of compliance is PI committee can modify this acility remains in substantial  on responsible for exceptable plan of correction e facility Administrator and the will be ultimately responsible on of this plan of correction to dains and maintains ince.	F	524				
	_	ion was verified on 02/01/19 y the following: verification of						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C <b>02/01/2019</b>
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	H RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	02/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 641 SS=D	release from and disc validating the staff ward discharges daily to verification, nursing a and services were and discharge, education consultant regarding for residents being ginotice including docupreparations, barriers to make home visits a contact the Ombudsh Accuracy of Assessm CFR(s): 483.20(g)  §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by:  Based on record revifacility failed to accurate Minimum Data Set (Nowas evident in 1 of 4 for falls. (Resident #6 was adm 8/24/18 with cumulating muscle weakness, un behavioral disturbance accident with right has	scharge of a resident to discharge begin at summary, medication charge instructions, as reviewing resident erify needed equipment, assessment, documentation ranged at the time of to the staff by the facility safe and orderly discharges wen a 30-day discharge mentation of discharge mentation of discharge and resident status, facility and education to the staff to man with all discharges. ents  of Assessments. t accurately reflect the  is not met as evidenced  ew and staff interviews the ately code falls on	F 624	F641 Immediate Action: The MDS Assessment for #6 was reviewed and corrected on 2/20/19 to ensure Section J as it pertains to falls be the MDS nurse  Identification of others affected: The MDS Nurse audited the last MDS assessment for all current residents on 2/20/19 to ensure the coding for Sectio	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY	
		345529	B. WING _	WING			C 01/2019	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT  SUMMARY ST		ID	STREET ADDRESS, CITY, STATE, ZIP CODE  5201 CLARKS FORK DRIVE NW  RALEIGH, NC 27616			02/01/2019 ETION (X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI: TAG	×	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 641	9/6/19 without injury.  Review of the quarter J1800 (Any falls since coded as zero (0) wh Under section J1900 with the number of fa resulted in no injuries documented falls since accurately noted on t  Interview on 1/25/19 Administrator and ME conducted. The MDS	rly MDS dated 10/7/18 under e admission/entry) was ich represented no falls. the MDS was not coded lls that occurred which s. So, the resident's 3 ce admission were not the 10/7/18 MDS.  at 10:30 AM with the DS coordinator was art. The administrator stated	F	641	related to falls were correctly coded. Three assessments were found to have been coded incorrectly was corrected in section J for each of the three residents identified in the audit and re-submitted 2/20/19  Systemic changes:  Education was provided to the MDS Nurse by the Executive Director, which included the review of the medical record to be able to code Section J as it relate to falls on 2/20/19.  Monitoring:  The Director of Nursing will audit 10 completed MDS assessments weekly frour weeks then a sample of 10 or more MDS assessments for two months to ensure the coding of Section J pertaining to falls in Section J is coded correctly. These audits will be kept in a binder in Executive Directors office. Findings were perfected to the QAPI Committee monthly for recommendations or modifications. If any negative findings a identified the Director of Nursing will continue to audit 10 completed MDS assessments weekly for four more week to establish a pattern of compliance is achieved. Any continuation of audits of completed MDS assessments done by the Director of Nursing will continue to reported to the QAPI committee for furt recommendations or modifications.	on on or e		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345529	B. WING		C <b>02/01/2019</b>		
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	RTH RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		1 02/01/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION		
F 660 SS=J	CFR(s): 483.21(c)(1) §483.21(c)(1) Disch The facility must dee effective discharge on the resident's discontent to be act transition them to pure reduction of factors readmissions. The factors readmissions are dentified to resident are identified development of a diresident are identified development of a diresident.  (ii) Include regular reidentify changes that discharge plan. The updated, as needed (iii) Involve the interby §483.21(b)(2)(ii), developing the dischip (iv) Consider careging and the resident's operson(s) capacity arequired care, as padischarge needs.  (v) Involve the resident representative in the discharge plan and res	arge Planning Process velop and implement an planning process that focuses charge goals, the preparation ctive partners and effectively pet-discharge care, and the leading to preventable acility's discharge planning resistent with the discharge 3.15(b) as applicable and- ischarge needs of each and result in the escharge plan for each e-evaluation of residents to at require modification of the discharge plan must be at the ongoing process of charge plan. Aver/support person availability are caregiver's/support and capability to perform and resident and and resident and resident and and res	F 66		2/20/19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			02/0	01/ <b>2019</b>
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		0112010
				5201	CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		RAL	EIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL 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 660	Continued From page	e 25	F 6	660			
	· -	tact agencies or other					
		nade for this purpose.					
	(B) Facilities must up						
		plan and discharge plan, as					
	•	nse to information received					
		I contact agencies or other					
	appropriate entities.	3					
		e community is determined					
		e facility must document who					
	made the determinat						
	(viii) For residents wh	no are transferred to another					
	SNF or who are discl	harged to a HHA, IRF, or					
	LTCH, assist residen	ts and their resident					
		lecting a post-acute care					
		ta that includes, but is not					
		IRF, or LTCH standardized					
	patient assessment of						
		on resource use to the extent					
		The facility must ensure that					
	the post-acute care s						
		ta on quality measures, and					
		e is relevant and applicable to					
	preferences.	of care and treatment					
		lete on a timely basis based					
		ds, and include in the clinical					
		n of the resident's discharge					
		plan. The results of the					
		iscussed with the resident or					
	-	tive. All relevant resident					
	information must be i						
		ilitate its implementation and					
		delays in the resident's					
	discharge or transfer						
		Γ is not met as evidenced					
	by:	dance and intended 20			F.000 I		
		riews and interviews with			F 660 J		
		vices Worker, Medical			Corrective action account to the different		
	Doctor, Ombudsman	, Transportation Company		(	Corrective action accomplished for thos	se	

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25				С	
		345529	B. WING _			0:	2/01/2019	
NAME OF PI	ROVIDER OR SUPPLIER	L		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	270172010	
					201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NO	ORTH RALEIGH			ALEIGH, NC 27616			
040.15	CLIMMAD	Y STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		0(5)	
(X4) ID PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 660	Continued From p	age 26	F 6	660				
	Medical Technicia	h Agency Worker, Emergency n, former and current facility			residents found to have been affected the deficient practice.	by		
	failed to provide 1	d former resident the facility of 4 sampled residents			Resident #12 was admitted on 5/23/20	)18		
	, ,	th a safe discharge planning			for short term rehabilitation services.			
		ded discharge goals, needs and for Resident #12. The facility			Resident #12 received skilled nursing rehabilitation services from 5/23/2018			
		esident #12's medical condition			to 7/11/2018. Resident #12 was	up		
		ome assessment to identify			discharged from Medicare covered ski	lled		
		or a safe discharge home.			services on 7/11/2018 after she met he			
	possible barriers in	or a sale discharge nome.			therapy goals. Resident #12 remained			
	Immediate ieopard	dy began on 12/13/2018 when			the facility after 7/11/2018 for custodia			
		transported to her home			care without a payer source.			
		sment, preparation, home			, , , , , , , , , , , , , , , , , , ,			
	· ·	caregiver in place. There was no			On 10/10/2018, the facility Business			
		facility conducted a home			Office Manager and Assistant Busines	s		
	evaluation before	resident #12 was discharged on			Office Manager discuss with resident	<b>#12</b>		
	12/13/18. Immedia	ate Jeopardy was removed on			regarding her failure to make payment	,		
	1/30/19 based on	the allegation of compliance			arrangement for her stay in the facility.			
	that was provided.	. The facility remains out of			Resident #12 voiced the understanding	g of		
		ower scope and severity of D			her financial obligation.			
	·	ectual harm with potential for						
		Il harm that is not immediate			On 11/15/2018; Business Office Mana	•		
		lete education and ensure			provided resident #12 with the 30 □ da			
		n put into place are effective			discharge notice since resident #12 fa			
	_	of facility staff regarding the			after reasonable and appropriate notice			
	discharge planning	g process.			pay for her stay at the facility. Residen	.t		
					#12 discharge date was set for			
	The Findings inclu	ided:			12/13/2018.			
	D				On 12/13/2018, Resident #12 was			
		admitted to the facility on			discharged from the facility to her priva			
		agnoses that included heart			home after the 30 days discharge notic			
		chronic obstructive pulmonary			expired. Facility arranged transportation			
	1 ' '	depression, neuropathy and			transport resident #12 to her private he	פוווכ		
	muscle weakness	-			via licensed non-emergency			
	Deview of the hos	nital discharge summary dated			transportation company.			
		pital discharge summary dated Resident #12 was found at			Although resident #12 failed to pay for	hor		
		ub by Emergency Medical			stay at the facility, after reasonable an			

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C	
NAME OF D	20VIDED OD CLIDDLIED	343329	B. WING _	CTDEET ADDRESS SITV STATE 71D CO		2/01/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
UNIVERSA	AL HEALTH CARE/NO	ORTH RALEIGH		5201 CLARKS FORK DRIVE NW			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 660	Continued From p	age 27	F 6	660			
F 660	Services (EMS). To called out for seven neighbors had call heard from the path noted that the path with trash that was patient was found milligrams per decorated that the path with trash that was patient was found milligrams per decorated to a social 5/29/18 for Resided Services (APS) was identified the residulation of the completed the residulation and had review of a care part of 6/15/18 revealed thome with a goal in home with support included the facility home for possible meeting to discuss resident with obtain discharge, notify the discuss concerns a supplies.  Review of a social 7/6/18 for Resident (SW) had informed Medicare coverage explained the non-	he patient reported she had ral days for help and her ed EMS because they had not tient for several days. EMS ent's home was "knee-deep" is full of rats and roaches. The to have a blood sugar of 690	F6	appropriate notice was giver survey agency alleged that; failed to ensure the post-displanned destination and con was validated to meet reside Resident #12 was transferre hospital for generalized wea 12/13/2018 from her private Hospital records indicated rewas unable to take care of home. Resident #12 is no lofacility, no further actions watime.  On 1/30/19; Chief Clinical O Management and consulting contracted by the facility, co root cause analysis for this a noncompliance. The analysis the alleged noncompliance on the facility sillure to imple resident centered discharge should have started on adminvolved identifying resident discharge goals and needs, implementing interventions them; and continuously eval discharge goals and needs to resident #12 stay that would a safe and successful discharge care plan for residindicated the facility will eval #12 home for possible barried discharge. There is no evide facility conducted a home evaluation.	the facility charge stinuing care ent #12 needs. ed to the skness on home. esident #12 nerself at her arranted at this efficer from the grompany inducted the alleged is concluded resulted from ement a process that ission; #12 and to address uating the throughout I have assured arge. dent #12 luate resident ers before ence that the valuation		
	rights to the reside the SW that she w	ent. Resident #12 expressed to as not ready to return home get her lawyer involved if the		12/13/2018.	Gilaiyeu Oli		

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		345529	B. WING _			0	2/01/2019
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				52	01 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NO	RTH RALEIGH		R/	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 660	Continued From pa	nge 28	F	660			
	-	throw her out. The SW			Address how corrective action will be		
		sident that the facility was not			accomplished for those residents havir	ng	
		it providing this information per			the potential to be affected by the same	•	
	protocol and Medic	are guidelines. After continued			deficient practice.		
	discussion with the	resident she decided she					
		ecision and a follow-up			Audits of 100% of residents □		
		ed after notification of the			comprehensive care plan and/or basel	ne	
	appeal decision.				care plan were completed by the		
		L M: : D ( 0 ( //MD0)			Minimum Data Set (MDS) nurse on		
		rly Minimum Data Set (MDS) Resident #12 revealed her			1/30/19 to identify whether a resident	The	
		t and an active discharge plan			centered discharge plan was in place. audit concluded there were no other	me	
	_	e resident to return to the			residents identified without a resident		
	•	quired extensive two-person			centered care plan necessary to ensur	e	
		d mobility, transfers, personal			safe and orderly discharge from the		
		sive one-person assistance			facility.		
		use and bathing. She was			·		
	incontinent of bowe	el and bladder. Review of MDS			100% of comprehensive care plan and	/or	
		ndicated that Resident #12's			baseline care plan audits for all resider		
	weight was 389 por	unds and her height was 71			discharged to the community in the las	t 90	
	inches tall.				days were completed by the facility Director of Social Services #1 and/or #	2	
	Review of a transfe	er / discharge notice for			on 1/30/19 to identify any other resider	ıt	
		d 11/15/18 from the facility			discharged unsafely, and/or discharged		
		d the date of discharge was			without following a resident□s dischar	је	
		on for the transfer / discharge			plan of care. There were no other		
		after having received			residents identified as having an unsaf		
		propriate notice failed to pay			discharge in the last 90 days. The audi		
		r Medicare / Medicaid) for her			validated that each resident discharged		
		This information was given to he Ombudsman on			from the facility to their private home in the last 90 days had a resident centered		
	11/15/2018.	ne ombudaman on			discharge planning in place and their	ū	
					discharge from the facility was safe an	d	
	Review of a social	service progress note dated			orderly except for resident #12.	-	
		ent #12 stated discharge plans			,		
		h the resident and she would					
		ack to her home. The resident			Measures will be put into place or wha	t	
	requested home he	ealth services upon discharge.			systematic changes will be made to		
	The writer inquired	about transfers as well as			ensure that the deficient practice will no	ot	

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	0.0020	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	•	02/01/2019	
TVAIVIL OF T	TOVIDER OR OUT FEEL						
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE NW			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE	
F 660	Continued From pag	e 29	F 66	0			
		vith toileting and the resident		occur.			
		continued supervision with		Goodi.			
		living (ADLs) until discharge		Effective 1/30/19 each resident	t will have		
		e and stability for transfers		an individualized discharge car			
	using the sliding boa	•		created on admission and become	-		
	_	h therapy and the writer		each resident⊡s comprehensiv	-		
		team of resident's request		plan. Each resident⊟s dischar			
		ansfers. The discharge		plan will be reviewed and revis	-		
		wed with the resident		quarterly and with significant cl			
	including her right to	appeal. The resident stated		resident condition by the facility	y MDS		
	appealing was a was	te of time and she would like		nurse or designated licensed n	ursing		
	to go home. The writ	er would prepare the		staff. The care plan revision w	ill include,		
	resident to return hor	me and set up assistance		but not limited to, the inputs fro	m the		
	closer to her discharg	ge date.		resident, resident representativ			
				applicable and/or interested far	-		
		ervices progress note dated		member as permitted by the re	sident.		
		t #12 stated discharge plans					
	_	with the resident to ensure		Effective 1/30/19 and moving for			
		r her transfer home on		newly admitted resident have a	•		
		nt will discharge to her home		for discharge planning that incl			
		was provided with options for		following criteria ☐s; arranging a			
		nd assisted living facilities on		securing services (home health			
		, but the resident declined.		protective services from other	-		
		sport home and receive		agencies and the community.			
	home care services			items will be included in each r			
		ce. Her motorized wheelchair as a bedside commode that		individualized discharge care p	nan as		
	was in place as well was ordered by the fa			appropriate.			
	_	acility. The resident amily and friends will assist		Effective 1/30/19 and moving for	onward the		
		and check in on her		facility will conduct home visits			
		ere no concerns brought to		appropriate and necessary by			
	the attention of this w			licensed therapist and/or direct			
		arge summary for Resident		nursing to ensure resident □s h			
		at 1:19 pm revealed her		safe for the resident. During the			
		ss, physicians name and		visit the facility representative			
		otes to the Ombudsman and		conducting the visit will make s			
	home health services			resident have food, medicine a			
		verse reactions. Attached to		equipment □s necessary. The			
	the discharge summa			will be included in each resider			

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · · · · · · · · · · · · · · · · ·			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C	
NAME OF DE	ROVIDER OR SUPPLIER	343323	5::	STREET ADDRESS, CITY, STAT		2/01/2019	
NAME OF PE	ROVIDER OR SUPPLIER						
UNIVERS#	AL HEALTH CARE/NO	RTH RALEIGH		5201 CLARKS FORK DRIVE I	NW		
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETION DATE	
F 660	Continued From page	ge 30	F6	60			
	residents' medication	ons and her care plan.		individualized discha	rge care plan as		
	rediaente medicatio	and their dare plant.		appropriate. The hon			
	Review of a departr	mental note dated 12/13/18 for		conducted prior to re			
	•	led the resident was alert and			e documented on the		
		ake needs know. No acute		home visit checklist f			
		resident required assistance		in resident □s medica			
		n assist using mechanical lift		in resident s medica	ai iecorus.		
	· ·	resident took her meds		Effective 1/30/2010 t	he facility will train the		
		ns, she was incontinent of		resident and/or family			
	• •	breathing was even and		regarding medication			
		ugar was checked, and insulin		and/or any other prod			
		Review of a social service		needs before resider			
		d 12/13/18 revealed APS was		the facility. This educ	_		
	• -	dent's choice to return home		documented in reside			
		n independent or assisted		records by the facility			
		health services were set up		services #1 or #2 and			
		esident. The writer spoke with		licensed nurse.	aror dioonarging		
		orker that the resident was		moonlood naroo.			
		ome with home health		Effective 1/30/19 the	facility will conduct a		
	services.	one war nome near		weekly Case Manage			
					Administrator, MDS		
	Record review reve	aled Resident #12 was		nurse, Director of Re			
		n 12/13/18 2:30 pm by a		Director of Nursing. F			
	•	pany that was paid for by the		pending discharges v			
	facility.	у што рана тог од што		1	a week in advance to		
	· - <b>,</b>			allow the Director of			
	An EMS report date	ed 12/13/18 7pm revealed		and/or #2 at least se			
		ed to Resident #12's home for		necessary arrangem			
		ar-old female complained of		resident discharge w			
		zed wheelchair. She reported		Member of facility ma			
	-	arged home from the nursing		the interdisciplinary to	-		
		after staying there for 7		stand up meeting for			
		ed she arrived home about		imminent discharge			
	•	was unable to transfer from					
	· · · · · · · · · · · · · · · · · · ·	e toilet. The patient reported		Effective 1/30/19 the	facility will conduct a		
		complete her rehab while at		discharge meeting ar			
	the facility.	•		resident and/or resid			
	•			applicable, to develo			
	Review of the hosp	oital records dated 12/13/18 for		meet each resident□			

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345529	B. WING _			02	/01/2019	
NAME OF PI	ROVIDER OR SUPPLIER		<u>'</u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				52	01 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NO	ORTH RALEIGH		R/	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 660	Continued From page	age 31	Fé	660				
	·	tified her chief complaint was			and to ensure a smooth and safe			
		ness and unable to take care of			transition from the facility to the			
	1 -	t had a history of atrial			post-discharge setting. The discharge			
		, chronic kidney disease,			meetings will be led by the facility □s			
		e, depression, diabetes and			Director of social services #1 and/or #2	2		
		had been at a skilled nursing			and take place at least three days prio			
		7 months and was unable to			resident is discharged from the facility,			
		I, so she was discharged home			unless the resident stay is less than 3			
		was unable to walk and used a			days, effective 1/30/19. Any identified			
		air. She had to go to the			barriers will be addressed before the			
		not able to get to the bedside			resident is discharged from the facility	and		
	i i	called EMS. EMS found the			hence reduce factors leading to	L_1		
		n urine and stool. The patient a for the past couple days and a			preventable readmissions to the hospi This review will take place daily Monda			
	· ·	ergency room revealed a			through Friday effective 1/30/19.	19		
		on and received 1 dose or			throught riday effective 1750/15.			
		piotic). The patient was			Effective 1/30/2019 the director of soci	al		
		e hospital to a skilled nursing			services will be ultimately responsible			
	facility on 12/19/18	· · · · · · · · · · · · · · · · · · ·			coordinate all discharge meetings in th			
					facility. The facility will not discharge a	ny		
	An interview with the	he former Social Worker (SW)			resident from the facility until the facilit	y		
		am revealed she discharged			validates that all services are arranged			
		2/13/2018. The SW indicated			and the resident is safe to be discharg	ed		
		d to go home and indicated			effective 1/30/2019			
		to help her. The SW stated			Eff. 1: 4/00/40   1   1   1			
		ily members present with the			Effective 1/30/19 and moving forward	ne		
		was discharged on 12/13/18.  ility arranged for the			facility will provide and document sufficient preparation and orientation to	_		
		pany that took the resident			residents and/or resident representati			
	· •	led she had contacted APS and			applicable to ensure safe and orderly	7C II		
		t Resident #12 was being			transfer or discharge. This orientation	will		
		The SW added that Resident			be provided in a form and manner that			
		go to another facility and she			resident can understand. This education			
	only wanted to go	<del>-</del>			will be documented in resident □s med	ical		
	_				records by the facility director of social			
		he physical therapy staff			services #1 or #2 and/or discharging			
		9 at 11:30 am revealed they			licensed nurse.			
		esident #12 prior to being						
	l discharged. The st	aff member stated the resident			Effective 1/30/19 and moving forward	.he		

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				_		(	c
		345529	B. WING _			02/	01/2019
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				52	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
	Continued From page had not completed had not completed had not care for added Resident #12 trying to transfer her the toilet without ass.  An interview with Nut 1/25/19 at 11:45 am #12 during her stay resident needed ass however she could feet the resident wanted.  An interview with the on 1/25/2019 at 11:0 knowledge of Resident #1:00 pm revealed discharge for Resident that the facility paid transported home. Someone had made Resident #12's discharge for the Resident #12 was contact the resident #12's discharge for the Resident #12 was contact the resident #12	ge 32  ter goals and would not have r herself at home alone. She would have had a hard time self from her wheelchair to sistance.  Trising Aide #1 (NA) on who worked with Resident at the facility revealed the sistance with all her ADLs, eed herself. NA # 1 added to go home.  The Director of Nursing (DON) to am revealed she had no ent #12's discharge.  The Administrator on 1/25/2019 the SW completed the ent #12 and she was unaware for this resident to be the stated she did not know if a home visit prior to	TAG	660	CROSS-REFERENCED TO THE APPROPRIA	ring ring s es on, he	DATE
	required extensive to	o total assistance with her ould feed herself with staff			changes will be discussed in the daily  stand up meeting daily Monday throu  Friday effective 1/30/19	gh	
	2:00 pm revealed sh for 8 months. She st wanted to go home could not take care	esident #12 on 1/26/2019 at the was at the former facility ated she told the facility she however she knew that she of herself. Resident #12 sked her out because she had			Regional Clinical Consultant from the contracted Management and consulting company conducted re-education for current facility interdisciplinary team involved on discharge planning to inclu the Administrator, Director of Nursing,		

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		,	C
		345529	B. WING				01/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HIMIVEDS	AL HEALTH CARE/NOR	TH PAI EIGH		52	201 CLARKS FORK DRIVE NW		
ONIVERS	AL HEALIH CARE/NOR	MALLIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	Medicaid application she never heard back did want to go home She added the facility family or support to have felt very bad oncome to help her go to there was no food at stated the facility toke be visiting her, so show needed once she go explained she had be and could not get he so she called 911. So day, and no one had give her medications discharged.  Pre phone interview home health compart they had received a the facility on 12/13/the records she was referral was denied a for the resident in Definition 1/28/19 10:30 am Resident #12 sometime to take her medications able to take her medications of the phone interview on 1/28/19 at 11:00 am Pre phone interview and the phone phone interview and the phone	stated she had completed the is to get help but never but ck. Resident #12 stated she but with services in place. It is knew she didn't have any nelp her at home. She stated be she got home and had no on the bathroom. She added it her home. Resident #12 did her that home health would be would have what she is thome. Resident #12 een home for several hours erself up to get on the toilet, she added she had felt bad all did checked on her except to so on the day she was  on 1/27/19 at 2pm with a my staff member #1 revealed referral for Resident #12 from 18. The staff member stated looking at indicated the and they provided no services becember 2018.  with the medical doctor (MD) revealed that he last saw time in December. He stated er medications and would be dication without assistance. Yould need to talk to physical ansfer ability.  with an APS worker on revealed she had received a	F	360	Director of Social services #1 and #2, Activity Director, Director of Rehabilitat services, MDS nurse and staff development coordinator on 1/30/19. Teducation emphasized on the important of developing, implementing, and evaluating each resident □s discharge planning at least 3 days before dischar to ensure each resident have a safe discharge from the facility. The educati will involve the resident, resident □s representative if applicable and will include information such as post discharge services from home health agencies, and/or Adult protective servic (if applicable). The education will also include making sure each resident has individualized discharge care plan creaton admission; reviewed and revised at least quarterly and with significant chartof resident condition; and at least 3 day prior to discharge to make sure the services are arranged and assured befthe resident is discharged. The educatialso emphasized on the importance of assuring resident have food, medicine and needed equipment □s necessary. These items will be included in each resident □s individualized discharge carplan as appropriate. This education will completed by 1/30/19, any department head not educated by 1/30/19 my department head not educated by 1/30/19 will not be allowed to work until educated. Effective 1/30/19 this education will be added on new hires education and provided annually for all new facility department heads.	his ce ge on ces an ted nge /s ore on	
		SW on 12/13/18 to let her was being discharged home.			The Facility Director of Nursing (DON),		

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(	
		345529	B. WING			02/	01/2019
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,                                      </u>	
				52	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH		R	ALEIGH, NC 27616		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 660	Continued From page		F	660			
		ained they were called in			Assistant Director of Nursing and/or sta	aff	
	-	condition of the resident's			development coordinator will complete		
		ause the resident was			100% education on the importance of		
	-	facility they had not been			developing discharge planning beginni	-	
		he resident's case. The APS			on admission and completed immediat	- 1	
	•	last communication he had			and/or within 48 hours of admission. The	_	
	-	as that Resident #12 was e facility due to her health			education emphasized the documentat requirements for all residents discharge		
		amily to help take care of			to the community to include but no limit		
	her.	army to help take date of			to physician orders, discharge education		
					and interdisciplinary team discussion.		
	Review of statement	from the Business office on			education will be provided for all licens		
	1/28/19 at 11:10am d	ated 10/10/2018 indicated	nurses, to include full time, part time and				
	that staff talked to res	sident she did not have a	as needed licensed nursing staff. This				
	Medicaid application	on file. Staff also explained	education will be completed by 1/30/19.				
	to her that would be re	esponsible for patient			The education will involve the resident,		
	•	of social security check			resident□s representative if applicable		
		ompleted her Medicaid			and will include information such as po	st	
		taff that she understood how			discharge services from home health		
		any money to pay anything			agencies, Adult protective services (if		
		ving for her trailer and other			applicable), Medication reconciliation, a	and	
	_	back home (however she			will be documented on the each		
	paid 1,000.00 for Octo	ober).			resident⊡s discharge records acknowledged by the resident and/or		
	An interview with Bus	iness Office Manager			representative of their understanding.		
		at 11:30am revealed she			representative of their understanding.		
	, ,	nt to see Resident #12 to			Any licensed nurse not educated by		
	pick up her monthly p	ayment and Resident #12			1/30/19 will not be allowed to work unti	1	
		t paying anything here.			educated. This education will also be		
	BOM stated that Resi	ident #12 told her to give her			added on the new hire orientation proc	ess	
	•	sident #12 indicated so she			for all new licensed nurses effective		
		esident #12 stated "I owe			1/30/19, and will also be provided		
	, ,	nursing facilities too and			annually.		
		nything either, what are they					
		Resident #12 also stated			The feelite of the State of the		
	that "she was not goir	•			The facility plans to monitor its		
	money nor give any ir	normation on her life			performance to make sure that solution	เร	
	insurance either."				are sustained.		

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C <b>02/01/2019</b>
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/01/2010
				5201 CLARKS FORK DRIVE NW	
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH	<b>I</b>	RALEIGH, NC 27616	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 660	Continued From pag	e 35	F 660		
	An interview with fac	ility SW #2 on 1/28/19 at		Effective 1/30/19 the Facility	
	3:00 pm revealed she	e was a witness to the		Administrator, Director of Nursing,	
	conversation on 7/6/2	2018 with the previous facility		Assistant Director and/or Nursing, F	RN
	SW. She stated durir	ng this meeting the previous		supervisors will review all planned	
		sident #12 that her last day of		discharges to the community in the	
	_	//11/2018. Resident #12		24 hours to ensure that each reside	
	_	eeting that she wanted to stay		discharge goals and plan of care wa	
	at the facility.			implemented appropriately. (This re	view is
	I	on 1/29/19 at 10:45 am was		intended to evaluate the systemic	
	conducted with the v			changes implemented that discuss	
		any that transported Resident		resident □s discharges at least three	
		I he picked up the resident ay and transported her		prior to discharge). Any issues identify	
	_	r stated he did know the		during this monitoring process will be addressed promptly. Findings from	
		e. He explained he just		monitoring process will be documen	
	"dropped her off and			a daily Stand up report form and file	
		Nopt it moving .		stand up meeting binder after prope	
	Pre phone interview	on 1/29/19 at 11:17 am with		follow-ups are completed. This mon	I
		nan revealed she was not		process will take place daily for 4 w	<u> </u>
	aware of Resident #1			weekly x 2 more weeks, then month	
				months or until the pattern of compl	iance
	An interview on 1/29/	/19 at 11:30 am with Nursing		is maintained.	
		ed she had provided care for			
		she was at the facility. She		Effective 1/30/19, Executive Directo	
		ras able to make her needs		and/or Director of Nursing will repor	
		would let the staff know if		findings of this monitoring process t	o the
		ne bedside commode, but the		facility Quality Assurance and	
		to wear a brief. NA #5		Performance Improvement Committ	
		equired extensive one to		any additional monitoring or modific	I
	1	ce with all her ADLs except		of this plan monthly for three month	is, or
	she was able to feed	HEISEII.		until the pattern of compliance is maintained. The QAPI committee ca	an l
	An interview on 1/20	/19 at 11:50 am with NA #2		modify this plan to ensure the facility	
		miliar with Resident #12 and		remains in substantial compliance.	у
		been discharged sometime		Terriaine in substantial compilance.	
		explained she had worked			
		the day she was discharged,			
		her she would have an aide			
		then she got home. NA #2			

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		345529	B. WING		,	C )2/01/2019
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP COD 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	•	210112013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 660	she was unsure if the clean herself up after the she added the residenceds known. NA #2 knowledge if the fact before the resident of the fact before the fact	could do some for herself, but he resident would be able to her having a bowel movement. Hent was able to make her 2 stated she had no dility hade made a home visit was discharged.  2 stated she had no dility hade made a home visit was discharged.  2 sen the nurse for Resident at the facility. She stated the any issues with taking her at home she had administered at home she had on the resident on how to so she added the resident her blood sugar and an but stated she had never her doing this. Nurse #2 but able to find the discharge hent #12.  2 on 1/30/19 at 3:45 pm with a man a home health agency for services for Resident #12 and the received a referral from	F 6	60		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345529	B. WING _			02/	01/2019
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STAT	E, ZIP CODE	1 02.	0112010
LINIVEDS/	AL HEALTH CARE/NORT	TH BALEICH		5201 CLARKS FORK DRIVE N	IW		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 660	Continued From page	e 37	F 6	660			
F 660	how the resident ever wheelchair because to the explained when he 12/13/18 Resident #1 added the resident whouse, but he could shoxes and papers all a horrible odor.  Pre phone interview of EMS Worker #2 reversed the many of the tesident #12's home resident had a history observed the resident up to the ceiling and sodor. He stated on the let them in the house clutter was still preser the resident out of the the fire department as resident on a stretched could smell the odor driveway. EMS Work was very weak and he herself.  During a second interest of the them in the house clutter was still preserved the resident on the them in the house clutter was still preserved the resident out of the them in the house clutter was still preserved the resident on a stretched could smell the odor driveway. EMS Work was very weak and he herself.  During a second interest of the them in the house was a second interest. The head to make a pather boxes. VD also in clutter, nasty and had the could be a second interest of the them.	in got around in her there was so much clutter. The responded to the call on 2 met them at the door. He ould not let them in the see that there was clutter, over the floor and there was on 1/31/19 at 12:38 pm with aled a call was received by the them as a sick call to a worker #2 indicated the with EMS and they had the home had a very bad his call the resident wouldn't, but he could observe the note. He explained they rolled the home to her driveway and sesisted them with getting the ter. Worker #2 indicated you from the house down to the er #2 added the resident ad urine and had stool on the resident #12's situation that the home house just to stack adicated that her home was a horrible odor.					
	The facility provided a	a credible allegation of					

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C 2/01/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		2/01/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 660	allegation was amental The creation of this is constitutes a written Preparation and sub constitute an admissiprovider of the truth correctness of the consurvey agency. This because of requirem law, and to demonst by the provider to impact resident.  As of 3/1/19 change original Allegation of accepted by the Stat We are making these direction that CMS is and we are assured impact the date the industry and the deficient practice. During the Survey the facility failed to ensure planned destination validated to meet residents found. Hosp #12 was unable to the home. Resident #12 further actions warrants Resident #12 was gifted to the sident #12 was gifted to the sident #12 was gifted the s	2019 at 6pm. The credible ided on 3/1/19 to as follow:  Letter of Credible allegation allegation of compliance. mission of this letter does not sion or agreement by the of the facts alleged or the onclusions set forth by the letter is solely prepared in the interest and federal rate the good faith attempts in prove the quality of life of as have been made to the Compliance that was the survey team on 1/30/19. The changes under the last requested the changes that those changes will not be a survey to the compliance that the last requested for F 660.  Complished for those are been affected by the last alleged that the rethe post-discharge and continuing care was sident #12 needs. Resident to the hospital for so on 12/13/2018 from her ital records indicated resident ake care of herself at her is no longer in the facility, no	F 6	60			

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		345529	B. WING _			C <b>02/01/2019</b>
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	•	02/01/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 660	from 11/15/18 and 12 planning discussions that resident indicate home On 12/13/18 transferred home at I with Home care serv was transferred to th weakness on 12/13/2 At the time of the sur identified that the residentified that the residentified nursing facility was needed as a resilucation. On 1/30/19; Chief CI Management and coby the facility, conductor this alleged nonconcluded the allege from the facility's fail management team the supervisors understated Prohibition and policity specifically related to resident that can be address how correct accomplished for the potential to be affecting the Minimum Data Scidentify whether a resident was in place. The were no other reside	evith Resident #12 including of she had family support at Resident #12 was her request by the facility ices in place. Resident #12 hospital for generalized 2018 from her private home. Evey allegations it was sident was residing in another v., no other corrective action bult of Resident #12's inical Officer from the insulting company contracted cited the root cause analysis ompliance. The analysis of an oncompliance resulted cure to ensure that the facility inat consist of the department and the center's Abuse in an approximate the sea and procedures, in unsafe discharging of a considered neglect. In its action will be see residents having the end by the same deficient sidents' comprehensive care care plan were completed by the tend of the centered discharge the audit concluded there into identified without a	F6	660		
	safe and orderly disc	re plan necessary to ensure charge from the facility.  Sive care plan and/or utils for all residents				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION	(X3) DATE	SURVEY PLETED
		345529	B. WING				C (04/2040
	ROVIDER OR SUPPLIER			5201 C	TADDRESS, CITY, STATE, ZIP CODE CLARKS FORK DRIVE NW IGH, NC 27616	<u> 1 02/</u>	01/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 660	discharged to the corwere completed by the Services #1 and/or #1 other resident discharged without for discharge plan of carresidents identified a discharge in the last that each resident distheir private home in resident centered distheir discharge from orderly except for resident changes will be put systematic changes will be put systema	mmunity in the last 90 days he facility Director of Social 2 on 1/30/19 to identify any rged unsafely, and/or hollowing a resident's he. There were no other having an unsafe hold days. The audit validated he facility to he last 90 days had a he facility was safe and he facility was had he facility was safe and he facility have an hold face or what hold he have an hold face or each resident's have an resident will have an he part of each resident's hold be reviewed and revised hold with significant change of he facility MDS nurse or hoursing staff. The care plan hout not limited to, the inputs hiddent representative, if he rested family member as he dent. hoving forward all newly he a care plan for discharge he following criteria's; he services (home health, he form other government	F	560			
	included in each residuscharge care plan a Effective 1/30/19 and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	343323	B. W	CTDE	EET ADDRESS, CITY, STATE, ZIP CODE	02	/01/2019
NAME OF PI	ROVIDER OR SUPPLIER						
UNIVERSA	AL HEALTH CARE/NO	ORTH RALEIGH			CLARKS FORK DRIVE NW		
				RAL	EIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 660	and/or director of thome is safe for the visit the facility repairs the visit will make medicine and need. These items will be individualized disc. The home visits were sident's dischard documented on "the and maintained in Effective 1/30/201 resident and/or far regarding medicate other procedures for resident is dischard education will be comedical records by services #1 or #2 and the medical records by services #1 or #2 and the medical records by services #1 or #2 and Residents with pediscussed in this madvance to allow the medical recessary arranger	age 41  the facility licensed therapist nursing to ensure resident's ne resident. During the home presentative who is conducting sure the resident have food, ded equipment's necessary. The included in each resident's charge care plan as appropriate. The home visit will be ne home visit checklist form' resident's medical records. The home visit will be ne home visit checklist form' resident's medical records. The facility will train the mily or significant other, ion administration and/or any the resident needs before reged from the facility. This documented in resident's the facility director of social and/or discharging licensed. The facility will conduct a weekly not meeting' chaired by the or, MDS nurse, Director of for Director of Nursing. The precious at least a week in the Director of Social Services ast seven days to make the and orderly. Member of	F	660			
	team during the da resident with immi 1/30/2019. Effective 1/30/19 t discharge meeting and/or resident re	ent will alert the interdisciplinary aily "stand up meeting" for any nent discharge effective  the facility will conduct a g and work with the resident presentative, if applicable, to					

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	· /	MPLETED
		345529	B. WING			C 02/01/2019
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	1	)2/0 I/20 I <del>9</del>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 660	transition from the fa setting. The discharge facility's Director of sand take place at lear resident is discharge resident stay is less 1/30/19. Any identifies before the resident is and hence reduce far readmissions to the latake place daily Mon 1/30/19.  Effective 1/30/2019 twill be ultimately residischarge meetings in not discharge any rethe facility validates fand the resident is sand the resident in the resident or erepresentative if apported y transfer or discharging transfer or discharging licensed Effective 1/30/19 and administrative team, Administrator, Director #2, added the review new admits to an exidence in the setting of the setting in the setting is the setting in the setting is the setting in the setting in the setting is the setting in the setting in the setting is the setting in the setting in the setting is the setting i	to ensure a smooth and safe cility to the post-discharge ge meetings will be led by the ocial services #1 and/or #2 st three days prior to d from the facility, unless the than 3 days, effective ed barriers will be addressed a discharged from the facility ctors leading to preventable hospital. This review will day through Friday effective the director of social services consible to coordinate all in the facility. The facility until sident from the facility until that all services are arranged afe to be discharged effective dimoving forward the facility iment sufficient preparation sidents and/or resident licable to ensure safe and escharge. This orientation will be and. This education will be ent's medical records by the cial services #1 or #2 and/or nurse. If moving forward the facility's which includes	F 6	60		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345529	B. WING			1	C (04/2040
NAME OF P	ROVIDER OR SUPPLIER	0.0020			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	01/2019
TO UNE OF TH	NOVIDEN ON OUT FEET				5201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NO	RTH RALEIGH			RALEIGH, NC 27616		
	I						T
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 660	Continued From pa	ge 43	F	660			
	review of residents'	discharge planning during					
		eads meetings, it will assure					
		ge planning process that					
		dent's discharge goals,					
		or effectively transition, and					
	ensure post-discha	rge care is appropriately					
	arranged.						
	Effective 1/30/19 ar	nd moving forward the					
	weekend Registered Nurse supervisor and/or						
	designated licensed	d nurse will review new					
		last 24 hours to ensure that					
	I -	rge care plan in place					
		ssion. This process with take					
		ay and Sunday effective					
		of this systemic process will					
		the "Deily Stand up meeting					
		the "Daily Stand up meeting					
		m this systemic changes will daily stand up meeting" daily					
		iday effective 1/30/19					
		onsultant from the contracted					
	_	consulting company conducted					
		rrent facility interdisciplinary					
		ischarge planning to include					
		Director of Nursing, Director of					
		and #2, Activity Director,					
		tation services, MDS nurse					
	and staff developme	ent coordinator on 1/30/19.					
	This education emp	phasized on the importance of					
		enting, and evaluating each					
		e planning at least 3 days					
		ensure each resident have a					
		n the facility. The education will					
		t, resident's representative if					
		include information such as					
	1 -	vices from home health					
	-	dult protective services (if					
		ucation will also include					
	l making sura aach r	esident has an individualized					1

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		345529	B. WING _			C 02/01/2019
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		02/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 660	reviewed and revise significant change of least 3 days prior to services are arrange resident is discharge emphasized on the i resident have food, i	created on admission; d at least quarterly and with f resident condition; and at discharge to make sure the d and assured before the ed. The education also mportance of assuring medicine and needed	F 6	60		
	included in each res discharge care plan education will be cordepartment head no be allowed to work u 1/30/19 this education	mpleted by 1/30/19, any t educated by 1/30/19 will not intil educated. Effective on will be added on new hires ded annually for all new				
	Director of Nursing a coordinator will compimportance of developed beginning on admission immediately and/or with the discussion of the community to include orders, discharge exteam discussion. The for all licensed nurse time and as needed education will be coneducation will involve representative if applicable), Medicibe documented on the discussion of the coneducation such as the coneducation of the coneducation will involve the coneducation of the coneducation will involve the coneducation of the coneducation will involve the coneducation of the coneducation of the coneducation of the coneducation will involve the coneducation of the c	of Nursing (DON), Assistant and/or staff development plete 100% education on the oping discharge planning sion and completed within 48 hours of admission. In assized the documentation residents discharged to the ele but no limited to physician flucation, and interdisciplinary is education will be provided es, to include full time, part flicensed nursing staff. This impleted by 1/30/19. The ele the resident, resident's flicable and will include post discharge services from es, Adult protective services cation reconciliation, and will the each resident's discharge ed by the resident and/or				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		X3) DATE SURVEY COMPLETED
		345529	B. WING			C
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT			STREET ADDRESS, CITY, STATE, ZIP CO 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	ODE	02/01/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIAT	(X5) COMPLETION DATE
F 660	not be allowed to wor education will also be orientation process for effective 1/30/19, and annually. The facility plans to make sure that solution Effective 1/30/19 the Director of Nursing, A Nursing, RN supervised discharges to the contone to ensure that each roand plan of care was (This review is intended changes implemented discharges at least the Any issues identified process will be address from this monitoring on a daily "Stand up meeting bir are completed. This replace daily for 4 weels then monthly x 3 mor compliance is maintate Effective 1/30/19, Exc Director of Nursing with monitoring process to Assurance and Perfor Committee for any accommodification of this ple months, or until the pin maintained. The QAF	r understanding. of educated by 1/30/19 will of until educated. This e added on the new hire of all new licensed nurses of will also be provided nonitor its performance to ons are sustained. Facility Administrator, assistant Director and/or ors will review all planned numuity in the last 24 hours esident's discharge goals implemented appropriately. ed to evaluate the systemic of that discuss resident's aree days prior to discharge). during this monitoring ssed promptly. Findings process will be documented report" form and filed in order" after proper follow-ups monitoring process will take as, weekly x 2 more weeks, of this or until the pattern of ined. ecutive Director and/or ill report findings of this of the facility Quality mance Improvement additional monitoring or an monthly for three attern of compliance is of committee can modify this colity remains in substantial	F 6	60		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
		345529	B. WING _			C 02/01/2019
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	'H RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		02/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 660	Continued From page	e 46	F 6	660		
	Effective 1/30/19 the Director of Nursing w	ce.				
F 689 SS=J	and as evidenced by re-education for licen documentation for disincluding assessment admission, discharge release from and discipation and services were and discharges daily to verification, nursing a and services were and discharge, education consultant regarding for residents being ginotice including documentations, barriers to make home visits a contact the Ombudsh Free of Accident Haz-CFR(s): 483.25(d) Accidents The facility must ensure §483.25(d)(1) The reas free of accident has \$483.25(d)(2)Each residents as free of accidents as	scharge of a resident t, discharge begin at summary, medication charge instructions, as reviewing resident erify needed equipment, assessment, documentation ranged at the time of to the staff by the facility safe and orderly discharges wen a 30-day discharge mentation of discharge and resident status, facility and education to the staff to man with all discharges. ards/Supervision/Devices (2)	F€	889		2/18/19

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345529	B. WING			1	C <b>01/2019</b>
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT			52	REET ADDRESS, CITY, STATE, ZIP CODE 01 CLARKS FORK DRIVE NW ALEIGH, NC 27616	<u>  02/</u>	01/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	by: Based on record rev physician (MD) interv provide supervision to resident from falling of residents reviewed for fell out of bed which when the staff memb unattended in bed. An moved the resident fr herself before the resinjuries. As a result of sustained large bruist down across right but middle buttock. Resides ame day of the fall.  Findings included:  Resident #13 was rea 8/10/17 with a diagnor vascular accident, acc hypertension, Alzheir aphasia and acute king a gastrostomy (stome nutrition, fluids and model  The Minimum Data Sindicated the resident impaired and stated to communicate her nee herself be understood resident needed exte mobility, transfer and assistance.	iew, staff interviews, and iew, the facility failed to prevent a totally dependent out of bed for 1 of 4 sampled or accidents. Resident #13 was in the high position er left the resident dditionally, the staff member om the floor back to bed by ident was assessed for any if the fall, the resident es from right rib mid back ttocks and skin tear on right lent #13 expired later the admitted in the facility on esis of multifocal cerebral ute encephalopathy, mer's disease, dysphagia, dney injury. The resident had ach) tube placed for her	F	689	Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345529	B. WING			C 02/01/2019		
NAME OF PROVIDER OR SUPP				5201	ET ADDRESS, CITY, STATE, ZIP CODE  CLARKS FORK DRIVE NW  EIGH, NC 27616	1 021	01/2019	
PREFIX (EACH D	EFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
required a tot. Living (ADL). for further AD The approach for aspects of The Hospice to 1/14/19 sho months. Then issues for the no oxygen (O Sat - (blood o ranges from 9 range is 94% noted in their  An investigati 1/16/19 at 11: the Nursing A on 1/15/19 ar turned the rest from the bed, status change NA #1 turned when she turn floor, she ran She was unal around back i uncomfortable was tangled in Administrator resident fell o NA panicked, back to bed. A NA ran out an Several phone	11/2/18 wall assistant The goal Ladecline es included ADL.  Nurse visit owed no control of the were not resident at 2) treatment (2) treatment (2) treatment (3) treatment (4) to 99%). The same on report (5) to 99%). The same on report (5) assessment (6) to the doctor of the first the feed as report first (6) the first of the doctor of of the d	ras reviewed. The resident face with Activities of Daily was to have no evidence through the next review. The determined the extensive to total care thing notes from 12/24/18 thanges from the previous signs of any respiratory and the resident needed ent. The O2 saturation (O2 et)) from the assessment with room air (Normal There was no skin bruising ents.  For the incident written on the Administrator stated NA) #1 was providing care the resident's bed. NA#1 there side and stepped away for to alert the nurse of a go the resident was on the for again to get the nurse. The fire the nurse and turned in and felt the resident was poor because the resident was poor because the resident the firem a high position. The the bed, pulled the resident to bed, the	F 6	89				

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
<b>345529</b> B.	. WING _		C <b>02/01/2019</b>		
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/NORTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE  5201 CLARKS FORK DRIVE NW  RALEIGH, NC 27616	02.01/20.10		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			
Continued From page 49 unsuccessful to conduct an interview with her.  A nurses' notes on 1/15/19 written by Nurse #1 revealed that NA #1 called the nurse to the room of Resident #13 at 11:30 AM. The NA showed the nurse some bruises on the resident's right side. The note stated that there was a skin tear and scratch on resident's right buttocks area with some discoloration on right side of the rib cage.  An interview with Nurse #1 was conducted on 2/1/19 at 10:40 AM. The nurse stated that on 1/15/19 she immediately notified unit supervisor and the Assistant Director of Nursing (ADON) of the bruising and skin tear. Nurse #1 also notified the family member, the hospice nurse and the Medical Doctor (MD) of the bruising and skin tear. The MD ordered chest x-ray and monitoring the resident for any distress. She further stated that the family member came to the facility and stayed with the resident. The chest x-ray was never performed due to the resident's passing away later that day.  Another interview with Nurse #1 on 2/1/19 at 2:14 PM she stated she assessed the resident when she was called in the room at 11:30 AM on 1/15/19 including monitoring her vital signs which were within normal limits and the resident's respiration increased with signs of anxiety. She stated that an Ativan 0.5mg was given as requested by the family member and to help the resident calm down. Nurse #1 also stated that NA #1 originally denied any knowledge of what caused the bruises from the resident. Nurse #1 also stated the bruising on the right rib and right buttock were like a hand/finger marks. The nurse stated that NA #1 came back about 30 minutes later and admitted that she knew what had	F6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 02/01/2019	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP COD 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	E	02/01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	she walked away from orning care to get resident's eye and waresident was sliding that she intercepted the resident was moseveral times on 01/2 resident was in stab the resident was in stab the resident was in the nurse said they didnathere was no report fell out of bed and the head injury. The fand they checked the resident was resident was no report fell out of bed and the head injury. The fand they checked the resident was a large hem indicated a large hem indicated a large hem indicated and was assessment.  An interview with the conducted on 2/1/15 Nurse stated that she 1/15/19. She explain hematoma (bruise) with and flank down to the resident was a stated that she 1/15/19. She explain hematoma (bruise) with and flank down to the resident was she with the conducted on 2/1/15 Nurse stated that she 1/15/19. She explain hematoma (bruise) with and flank down to the resident was she with the conducted on 2/1/15 Nurse stated that she 1/15/19. She explain hematoma (bruise) with and flank down to the resident was she with the conducted on 2/1/15 Nurse stated that she 1/15/19. She explain hematoma (bruise) with and flank down to the resident was she with the conducted on 2/1/15 Nurse stated that she 1/15/19. She explain hematoma (bruise) with the conducted on 2/1/15 Nurse stated that she 1/15/19. She explain hematoma (bruise) with the conducted on 2/1/15 Nurse stated that she 1/15/19.	ident. The NA revealed that om the resident while doing the nurse to assess when she turned around, the off the bed. The NA stated the fall. Nurse #1 stated that nitored for any distress 15/19 to make sure the le condition. She stated that ting in bed and the family room the whole time. The 't do a neuro checks because at that time that the resident here were no signs of any nily member was there so sident visually for any  otes on 1/15/19 at 5:37 PM matoma extending from right ss the flank. An abrasion on a salso written in her  e Hospice Nurse was at 3:41 PM. The Hospice e observed Resident # 13 on hed that the resident's was located at the right mid on her right buttock. She stated an abrasion in the resident's	F	589			
	the ADON indicated at 2:40 PM and the at 60% and the puls Minute (BPM) (Norn	1/15/19 at 7:04 PM written by the resident went on distress O2 saturation recorded was e rate was 76 Beats Per nal pulse rate is 60 to 100). that the head of the bed was					

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345529	B. WING			02/01/2019		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	•	32/01/2019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 689	minute via a face marechecked after 15 mafter the continuous the note that the MD notified right around  The Hospice Nurse of 2/1/19 at 3:41 PM that 3:00 PM and saw the head of the bed in himask. The Hospice already expired whe room. She further staresident expired at 3:41 PM that ADON was interested that following day on 1/10 administration that the tothe floor during he that she assisted the without alerting the ronducted on 2/1/19 that the resident was was unable to move contractures of her histated that Resident that needed two persons assist during the roons assist during the roots as a face of the r	as started at 5 liters per ask. The O2 Sat was ninutes and it went up to 78% O2 treatment. She stated in and the Hospice Nurse was 2:40 PM.  Stated during her interview on at she came in the door after e resident in bed with her gh position with oxygen Nurse stated that the resident in she got in the resident's ated that she pronounced the :45 PM.  Viewed on 2/1/ 19 at 11:35 NA #1 confessed the 6/19 with the facility he resident rolled out of bed er ADL care. The NA admitted er resident to bed alone hurse of the fall.  Jursing Assistant (NA) #4 was at 9:45 AM. The NA stated as a total care and the resident by herself due to her lands and her legs. NA #4 #13 was very stiff and solid sons assist with ADL care.  ed on 2/1/19 at 2:44 PM and #13 cannot move herself he resident needed two	F 6	89				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C <b>02/01/2019</b>			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	P CODE	, 02,0			
LININ/EDO	N. 11541 TH 04 DE/NODT			5201 CLARKS FORK DRIVE NW					
UNIVERSA	AL HEALTH CARE/NORT	HRALEIGH		RALEIGH, NC 27616					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BI O THE APPROPRIA		(X5) COMPLETION DATE		
F 689	Continued From page	e 52	F 6	689					
L 009	resident had contract extremities. She also move by herself and in fetal position all the the resident only oper stimulation and moand Interview with the Unit 11:17 AM she stated persons assist with be Interview with the AD the ADON stated that persons assist with be Interview with MDS CPM she stated that the persons assist with be Interview with the MD 4:01 PM. The MD state with no brain function declining health statu was ordered for the renext 6 months. The M fall up until the next dinformed by the facilithe didn't believe the fresident. The MD state was for any distress the Review of the resident indicated the resident	ures on her upper and lower stated the resident cannot the resident was somewhat a time. Nurse #1 also stated in her eyes with verbal is at times.  It Coordinator on 2/1/19 at the resident needed 2 ed mobility and transfers.  ON on 2/1/19 at 11:35 AM at the resident needed 2 ed mobility and transfers.  Coordinator on 2/1/19 at 3:15 er esident needed 2 ed mobility and transfers.  Owas conducted on 2/1/19 at ted that the resident was and on hospice for her s. He stated the hospice esident who could die in the AD did not know about the ay on 1/16/18 when he was sy staff. The MD stated that fall caused the death of the ted that the order to monitor he resident might have.		989					
	was conducted on 2/2	Chief Clinical Officer (CCO) 1/19 at 4:35 PM. The CCO investigated this incident							

PRINTED: 06/17/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CAREINORTH RALEIGH  STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE WR  RALEIGH, NC 27616  SET CLARKS FORK DRIVE WR  RALEIGH, NC 27616  F 689  Continued From page 53 and the NA no longer worked for the company. The written investigation showed by the CCO specified that on 01/15/19 at 11:30 AM, NA #1 left Resident #13 untended while positioned on the side of the bed with the bed in the high position and resident left from bed to the floor and experienced injuries which included bruising from her right mid ribs down to her right buttocks. Skin tear was also noted on the right buttocks. Skin tear was also noted on the right buttocks. Skin tear was also noted on the right buttocks. Skin tear was also noted on the right buttocks. The also stated that they implemented a corrective action plan for this incident and provided a binder for their plan of correction.  The facility provided the following plan of corrections that had been completed on 1/19/19.  Corrective action accomplished for those residents found to have been affected by the deficient practice. Resident #13 was admitted on thospice services while in the facility and coded on section "O' of MDS with ARD 11/1/2018. Review of facility most recent minimum data set, with Assessment reference date 11/1/2018 section G indicated Resident #13 requires extensive assistance. Resident #13 coded in section J. to have no falls since the entryfive-entry and/or last assessment.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARENORTH RALEIGH    (X4)   ID   SUMMARY STATEMENT OF DEFICIENCIES   S201 CLARRIS FORM DRIVE NW RALEIGH, NC 27618			345529	B. WING				
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 53 and the NA no longer worked for the company. The written investigation showed by the CCO specified that on 01/15/19 at 11:30 AM, NA #1 left Resident #13 unattended while positioned on the side of the bed with the bed in the high position and resident fell from bed to the floor and experienced injuries which included bruising from her right mid ribs down to her right buttocks. Skin tear was also noted on the right buttocks. He also stated that they implemented a corrective action plan for this incident and provided a binder for their plan of correction:  The facility plan of correction: The facility provided the following plan of corrections that had been completed on 1/19/19.  Corrective action accomplished for those residents found to have been affected by the deficient practice. Resident #13 was admitted to the facility on 07/07/2017 for long term care services. On 7/27/2018 resident #13 was admitted on Hospice services while in the facility and coded on section "O" of MDS with ARD 11/1/2018. Review of facility most recent minimum data set, with Assessment reference date 11/1/2018 section G indicated Resident #13 requires extensive assistance with bed mobility with two assists, transfer with one assistance, Resident #13 coded in section J. to have no falls					5201 CLARKS FORK DRIVE NW	02	2/01/2019	
and the NA no longer worked for the company. The written investigation showed by the CCO specified that on 01/15/19 at 11:30 AM, NA #1 left Resident #13 unattended while positioned on the side of the bed with the bed in the high position and resident fell from bed to the floor and experienced injuries which included bruising from her right mid ribs down to her right buttocks. Skin tear was also noted on the right buttocks. He also stated that they implemented a corrective action plan for this incident and provided a binder for their plan of correction.  The facility plan of correction: The facility provided the following plan of correctives that had been completed on 1/19/19.  Corrective action accomplished for those residents found to have been affected by the deficient practice. Resident #13 was admitted to the facility on 07/07/2017 for long term care services. On 7/27/2018 resident #13 was admitted on Hospice services while in the facility and coded on section "O" of MDS with ARD 11/1/2018. Review of facility most recent minimum data set, with Assessment reference date 11/1/2018 section G indicated Resident #13 requires extensive assistance with bed mobility with two assists, transfer with one assistance, and tolleting with one assistance. Resident #13 coded in section J. to have no falls	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION	
Review of fall incident log from 7/7/2017 up to 1/15/2019 indicated Resident #13 had one fall dated 1/15/2019.  On 1/15/2019 during AM care resident #13 rolled off the bed onto the floor. The nursing aide	F 689	and the NA no longer. The written investigated specified that on 01/Resident #13 unatter side of the bed with and resident fell from experienced injuries her right mid ribs do tear was also noted stated that they imply plan for this incident their plan of corrections. The facility plan of corrections that had a corrective action acresidents found to have deficient practice. Resident #13 was a 07/07/2017 for long 7/27/2018 resident #3 was a 07/07/2017 for long 7/27/2018 resident #3 with AR most recent minimular reference date 11/1/Resident #13 require bed mobility with two assistance, and toile Resident #13 coded since the entry/re-er Review of fall incided 1/15/2019 indicated dated 1/15/2019 during On 1/15/2019 durin	er worked for the company. Action showed by the CCO (15/19 at 11:30 AM, NA #1 left anded while positioned on the the bed in the high position in bed to the floor and which included bruising from and provided a binder for on.  Orrection:  The following plan of been completed on 1/19/19.  Complished for those ave been affected by the dimitted to the facility on term care services. On the facility and coded on section Din 11/1/2018. Review of facility in data set, with Assessment 2018 section Gindicated as extensive assistance with assists, transfer with one assistance.  In section J. to have no falls and one fall of AM care resident #13 rolled and AM care resident #13 rolled.	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C <b>02/01/2019</b>	
	ROVIDER OR SUPPLIER	ORTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP 6 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	CODE	02/01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	status charge reganursing aide exited from bed to the floposition.  C.N.A. failed to report control of the position.  C.N.A. failed to low to leaving bed side resident was assect. C.N.A. failed to posafely on the bed. resident from the falerting a nurse to contrary to the fact Nurse aide number notified a nurse of right buttock skin that she noticed that turning resident #1 reported to licensed nurse #1 assessed the resident right rib discoloration scratch. Licensed supervisor who was licensed nurse #1 Unit supervisor incompleted on 1/1 she did not report physician, attendir within 30 minutes completed.  Address how correactions and corresponding to the complete of the corresponding suspended on 1/1 she did not report physician, attendir within 30 minutes completed.	age 54 e door to alert the nurse of a arding's right eye. Before the difference of the room, resident #13 fell or while the bed was in high  cort timely and accurately.  Were bed to lowest position prior e. C.N.A moved resident before essment by a licensed nurse.  Sition resident properly and Nurse aide #1 assisted loor back to bed without assess the resident which is elity standards and expectation.  If one then exited the room and the right ribs discoloration and ear with a scratch and claimed ose injuries when she was 3 in bed. Nurse aide #1 also and nurse #1 the discoloration walked to resident room and then while in bed and noticed on and right buttock skin tear a nurse #1 notified unit alked to resident's room with the and reassessed resident #13. Iticated that resident shown note of destress. Nurse aide #1 acare for resident #13 was 5/2019 pending investigation as resident fall. Attending and physician called the facility and ordered X-rays to be excited by the same deficient	F	389			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C <b>02/01/2019</b>	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		02/01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	1/18/2018 by the factor manager #2 to ensure transfer is document resident identified wore-assessed and me care. Measures will systematic changes the deficient practice Effective 1/19/2019 resident's care card resident to ensure a used during ADL car resident's care card the appropriate numbence ensure resident from the ensure and the appropriate numbence any resident from the trained personurses. Nursing assattempts possible to while waiting for assattempts possible to while waiting for assattempts on the floo are completed by the personnel (licensed following resident's I reviewing each resided education will be connursing assistant no not be allowed to wore care.	are cards audit completed on cility unit manager #1 and Unit re each resident means of ted in a care card. Any ithout directives was tans of transfer added on the be put into place or what will be made to ensure that will be made to ensure that will not occur. In the providing care for any appropriate number of staff is the as indicated on each. Nursing assistants will utilize ber of staff during care and tent safety.  In the providing care and the providing care and tent safety.  In the providing care and tent safety.	F 6	89			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTR IG	UCTION	(X3) DATE COMP	SURVEY LETED
		345529	B. WING _			C 02/01/2019	
	ROVIDER OR SUPPLIER	ΓΗ RALEIGH		5201 CLAF	DDRESS, CITY, STATE, ZIP CODE RKS FORK DRIVE NW I, NC 27616	1 02	01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	for all new facility nureducation will also be facility staff to include The facility plans to make sure that soluti Effective 1/19/2019 tl (DON), Assistant Diresupervisors and/or S Coordinator (SDC) in residents' transfer candmission/readmission acard immediately. By will ensure each residented in place and services to attain and practicable wellbeing Effective 01/19/19, D Director of Nursing, a Coordinator, will monupodates of each residented in place and services to attain and practicable wellbeing that occurred from the any admission/readmictinical meeting and/or clinical	whires orientation education asing assistants. This approvided annually for all anusing assistants.  Inonitor its performance to one are sustained.  The Director of Nursing (ADON), RN at the description of the process to review pabilities on on and/or with resident's care updating the care card, it dent has a correct transfer thence receive appropriate and the process to review the process to review pabilities on the process to review pabilities on the process to review pabilities on the process to review the process to review pabilities on the process to review p	F	889	DEFICIENCY)		
	validated whether resupdated. Any issues monitoring process we findings from this meadaily clinical report meeting binder in Dir proper follow ups are will review the complete.	sident's care card was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
	345529	B. WING		C 02/01/2019		
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/NORTH RALI			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	02/01/2019		
(X4) ID SUMMARY STATEMENT REFIX (EACH DEFICIENCY MUST IN REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
Effective 01/19/19, Resident ADL care bed is in the lowes resident is positioned correct DON/ADON/Unit Managers, Weekend Supervisor. Audit residents daily x 2 weeks, 5 monthly x 3 months Effective 01/19/19, Director findings of this monitoring propality Assurance and Performantering or modification of months, or until the pattern of maintained. The QAPI complant of ensure the facility recompliance.  The title of the person responsible for the implement correction to ensure the facility responsible for the implement correction to ensure the facility and the facility was validated. The confirmed the facility address involved and acted to mitigate residents. The facility residents. The facility residents. The facility residents. The facility residents and the edu policy to call and report to the assessment before moving a The facility implemented an care card. The facility initiate review resident's transfer cathe care card of all residents.	at position and tly and safely in bed. 3-11 Supervisor and s will include 15 days x 1 weeks, and of Nursing will report ocess to the facility ormance any additional of this plan monthly X3 of compliance is nittee can modify this mains in substantial on sible for a plan of correction. The plan of this plan of ity attains and ance.  an of correction of this plan of ity attains and ance.  an of correction of the survey team sed the resident the ten is the other ocated all staff of cation included the enurse for any resident from fall. The audit to update alled a process to pabilities and update	F 6	39			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	IPLE CONSTRUCTION NG	(X3) E	(X3) DATE SURVEY COMPLETED	
	345529 B. WING			C <b>02/01/2019</b>			
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	H RALEIGH	1	STREET ADDRESS, CITY, STATE, ZIP CO 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		02/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	admission. The facility monitoring process an Quality Assurance an	y also implemented the nd to be included in the d Performance tee meeting. The facility's	F6	689			