| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345529 | A. BUILDING _____ B. WING _____ | C 01/18/2023 |

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

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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted on 1/18/2023. Event ID# 08Y011. The following intakes were investigated NC00196914, NC00196403, NC00195879, and NC00196444. 2 of the 5 complaint allegations were substantiated resulting in deficiencies. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. | F 550 | | 2/13/23 |

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

Electronically Signed | 02/09/2023

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| F 550 | Continued From page 1<br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, and resident interviews, the facility failed to treat a resident with dignity by not providing incontinence care when needed for 2 of 2 residents reviewed for incontinence care (Resident #5 and Resident #2).<br><br>Findings included:<br><br>1. Resident #5 was admitted to the facility on 12/15/22 with a diagnosis of stroke with hemiplegia.<br><br>Record review of the MDS Admission Assessment dated 12/20/22 revealed Resident #5 was cognitively intact, was frequently incontinent of bladder, and required extensive assistance x 2 staff members for bed mobility and toileting.<br><br>During an interview on 1/18/23 at 10:30 am Resident #5 revealed that she had not yet been provided or offered incontinence care since approximately 5:45 am. Resident #5 stated she reported she needed to have incontinence care to Nurse Aide (NA) #2 in the early morning when | F 550 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice<br><br>Resident #5 received incontinent care<br>Resident #2 has been discharged from the facility<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice<br><br>All current residents have the potential to be affected by the alleged practice.<br>1/18/2023 rounds were completed for all residents in facility. Rounds revealed all residents had received care.<br>Residents are receiving assistance with ADL's including incontinent care.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur | |

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| F 550 | Continued From page 2<br>breakfast trays were delivered, but she was unable to get back to the room to assist yet. She stated NA #2 had been in the room to let her know that she was assisting several residents get prepared for out of facility appointments and that she would be back as soon as possible to provide care. Resident #5 reported she has waited on several occasions for 2-4 hours to have care provided but she understood the staff was working hard to provide care but did not like sitting in wet brief for that amount of time.<br><br>During a follow-up interview on 1/18/23 at 2:10 pm Resident #5 stated she had received incontinence care from NA #2 between 11:30 am and 12:00 pm. She was unable to remember the exact time but stated it was before her lunch tray arrived. She stated she understood she required more assistance than other residents since she was not able to stand on her own and help as much and the staff would need a significant amount of time to get her care done, but she did not like being in the wet brief for such a long time because it was uncomfortable.<br><br>During an interview on 1/18/23 at 4:54 pm NA #2 reported she was aware that Resident #5 required incontinence care but was unable to complete the care timely because she was the only NA on the hall and had to get several residents ready for appointments. She stated she did go back and notify Resident #5 that she was busy and would be back as soon as possible but was not able to get to her before 11:00 am or so.<br><br>During an interview on 1/18/23 at 5:00 pm the Director of Nursing (DON) stated she was not aware incontinence care was not completed for Resident #5 for several hours. The DON stated | F 550 | On February 3, 2023, education began for all nursing staff in reference to providing assistance with ADL's including incontinent care to be given frequently, as requested by the resident or family member, and as needed for visual signs of soiling.<br><br>The Director of Nursing, Staff Development Coordinator, Unit Coordinator and/or Supervisor will complete walking rounds daily to include off shifts and weekends to ensure that nursing staff are meeting the needs of all residents including incontinent care.<br><br>Walking rounds will continue daily x 4 weeks and weekly thereafter<br><br>Ambassador rounds will continue weekly. Observations during ambassador rounds to include resident dressed appropriately, clean and odor free.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained<br><br>The Director of Nursing will report the summary of walking rounds to the Quality Assurance and Performance Improvement Committee monthly for six months.<br><br>The Administrator will report the findings of the ambassador rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is | |

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| F 550 | Continued From page 3 | F 550 | | |

incontinence care was to be completed as needed and Resident #5 should not have had to wait for 4 hours to have care completed.

2. Resident #2 was admitted to the facility on 12/07/22 with a diagnosis of stroke.

Record review of the Minimum Data Set (MDS) Admission Assessment dated 12/13/22 revealed Resident #2 was cognitively intact and required total assistance x 2 staff members for transfers and toileting.

Resident #2 was discharged from the facility on 1/15/23 and was not available for an interview. A closed record review was utilized for the investigation.

During a telephone interview on 1/18/23 at 11:23 am Resident #2's Responsible Party (RP) revealed on 12/19/22 at 11:25 am the family had visited Resident #2 and found her to be heavily soiled with feces, sitting in her wheelchair in her room. The RP was unable to state how long Resident #2 had been sitting in the soiled brief.

During an interview on 1/18/23 at 12:38 pm the Rehabilitation Manager stated she participated in the therapy session with Resident #2 on 12/19/22 and did not recall her ask for assistance for toileting during the therapy session.

During an interview on 1/18/23 at 12:50 pm the Physical Therapist stated she worked with the Rehabilitation Manager to provide in room therapy session with Resident #2 on 12/19/22. She stated she did not recall Resident #2 ask for assistance with toileting during the therapy session. The Physical Therapist reported she left

achieved.

Include dates when corrective action will be completed
February 13, 2023

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| F 550 | Continued From page 4 | F 550 | | |

Resident #2 in the television room watching television after the therapy session as requested by the resident.

During a telephone interview on 1/18/23 at 4:22 pm Nurse Aide (NA) #1 revealed that she was assigned to Resident #2 on 12/19/22. She stated that Resident #2 had multiple bowel movements that morning and she asked Physical Therapy staff to not take her from bed today due to the increased bowel movements but was told she was scheduled for therapy. She stated she then left the room and continued to complete care for other residents and approximately 1 hour later she observed Resident #2 in the television room. NA #1 stated Resident #2 was soiled with feces which went down her leg and up her back. NA #1 stated Resident #2 waited about 1 hour after she saw her in the television room to obtain incontinence care because she had trouble getting someone to help, so she could have been sitting in the soiled brief for over 2 hours.

During an interview on 1/18/23 at 4:45 pm Nurse #1 revealed she was assigned to Resident #2 on 12/19/22 and that she recalled that NA #1 reported that she was unable to complete care for Resident #2 without assistance and she was soiled with feces and had been sitting for a few hours. Nurse #1 stated she went and spoke to therapy to obtain assistance with incontinence care for Resident #2.

An interview was conducted with the Administrator on 1/18/23 at 5:30 pm and she stated she was not aware of the incident with Resident #2 but stated that no resident should be left for an extended period in need of care.