STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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E 006 SS=J	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency	E 006		11/13/23

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

Electronically Signed | 11/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 006	Continued From page 1 Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on facility and police record review, observation, staff, and police dispatch interviews the facility failed to enact its emergency procedure for a missing resident (Resident #71), who was severely cognitively impaired, after she was reported missing on 7/26/23. The failure resulted in the police not being notified for over an hour from when the resident was initially discovered to have been missing. The deficient practice was found for 1 of 1 resident investigated for elopement. Failing to enact the emergency procedure plan for a missing resident, including notification of the police within 10 minutes after a resident is reported missing, placed facility	E 006	1) Adress how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Director of Nursing completed a physical assessment on 7/26/23, and no injuries identified for Resident #71. The resident□s psychosocial well -being was not affected as evidenced by the resident laughing upon being found by the DON and police officer, on 7/26/23. On 8/9/23, the in-house psychological provider performed a trauma assessment and resident had no recall of the event of	

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E 006	Continued From page 2 residents with cognitive loss and wandering behavior at a high likelihood of suffering serious harm in the event of an emergency situation. Immediate Jeopardy began on 7/26/23 when Resident #71 was reported missing. Immediate Jeopardy was removed on 10/14/23 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. Findings included: A review of the facility document titled, "Emergency Procedure: Missing Resident" dated 11/2017, last revised 6/2020, and last reviewed on 6/20/23 revealed in part the following: IV. Policy: Resident elopement resulting in a missing resident is considered a facility emergency. V. Policy Interpretation: 1. Residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety. 2. Staff will implement the protocol for missing resident immediately upon discovering that a resident cannot be located. VI. Emergency Procedure: Missing Resident; 8. If the search is unsuccessful after a period of 10 minutes, call the police to report the resident missing." A review of the facility's Emergency Preparedness staff training records on 10/13/23 at 10:00 AM revealed in part documentation that prior to 7/26/23, Nurse Aide (NA) #5 last received	E 006	7/26/23. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Regional MDS Nurse reviewed BIMS scores for all current residents to determine who was classified as cognitively impaired. Of those residents the facility therapy manager identified residents who are able to locomote independently. These residents have been identified as at risk of being behind an unlocked office door to include conference room, therapy gyms, kitchen, and other common storage rooms. This was completed on 10/13/2023. There have been no other incidents of other residents wandering into unlocked doors. 3)A ddress what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A copy of the Missing Resident Policy is available at each nurse□s station for staff to reference, in case of an emergency. The Missing Resident Policy was placed at each facility nurse□s station on 10/13/23 by the Regional Clinical Nurse On 10/13/23, the regional clinical nurse provided education to the DON and facility Administrator on the EP Missing Resident Policy. The facility administrator and DON began education on 10/13/23 with all facility staff including clinical agency/contract (HK/Laundry/rehabilitation) employees on the Missing Resident Policy. This	

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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E 006	Continued From page 3 Elopement/Missing Resident training on 11/29/2011, Nurse #2's General Orientation checklist dated 4/18/23 had no documentation of EP or Elopement/Missing Resident training, NA #4 last received Elopement/Missing Resident training on 11/6/2021, and Nurse #7 had no documentation of EP or Elopement/Missing Resident training. A review of an "Inservice Sign-In Sheet" for an in-service provided by the facility on 10/11/23 revealed the Director of Nursing (DON) provided this in-service training on 7/26/23. The objective of the training was "Administrator and DON notification (incidents requiring contact)". This included a list of incident types which required Administrator and DON notification including elopement/missing resident, and the facility's "Emergency Procedure: Missing Resident" document. This in-service sign in sheet was signed by 20 facility staff. Signatures from NA #5, Nurse #2, NA #4, and Nurse #7 were not present on the document. On 10/13/23 at 11:22 AM an observation at the 700 Hall nurse's station revealed a copy of the facility's EP plan located in a red binder. On 10/13/23 at 12:37 PM an interview with the DON indicated a copy of facility's EP plan book was kept at 3 of 3 nurse's stations for staff to refer to in an emergency. In an interview on 10/18/23 at 12:53 PM the Regional Nurse Consultant stated prior to the event on 7/16/23, folders at 3 of 3 nurse's station included a list of residents who were moderately cognitively impaired and face sheets with a picture of each resident wearing a wander guard	E 006	education included notifying the facility Administrator and DON immediately once it is determined a resident is unable to be located, conducting a facility head count to ensure no other residents are missing, checking all resident rooms/bathrooms/closets/dining room and locked office doors, to include conference room, therapy gyms, kitchen, and other common storage rooms, continue search of the outside property (parking lot, trash dumpster area, surrounding grounds and neighboring community), notification of residents attending physician/Responsible Representative and local police. All newly hired employees, clinical agency personnel, and contract (HK/Laundry/Rehabilitation) personnel, will receive this education from the Director of Nursing and/or designee, prior to being able to work. DON is currently tracking current staff to ensure that education is completed prior to them being able to work. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility will complete Missing Resident drills weekly for 2 weeks, monthly for 3 months then quarterly, these drills will be conducted by the facility Maintenance Director and/or Administrator. The facility Administrator will complete a summary of the results of the facility Missing Resident drills and present at the facility monthly Quality Assurance & Performance Improvement (QAPI) to ensure continued compliance.	

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E 006	Continued From page 4	E 006		

(a type of elopement alarm).

Resident #71 was admitted to the facility on 4/22/22 with diagnoses including dementia, generalized muscle weakness, and unsteadiness on feet.

Resident #71's quarterly Minimum Data Set (MDS) assessment dated 5/4/23 revealed she was severely cognitively impaired. She required set-up assistance for locomotion on and off her unit and used a wheelchair for mobility. Resident #71 had one fall with no injury since her prior assessment.

A quarterly Elopement Risk Tool for Resident #71 dated 7/15/23 completed by the Director of Nursing (DON) revealed Resident #71 was found to be at risk for elopement. It further revealed her wandering behavior had the potential to affect her safety and well-being.

On 10/10/23 a review of the physician's orders for Resident #71 revealed an order dated 7/15/23 for a wander guard to be placed to her right ankle.

A review of the facility's "Timeline of Event {resident's name} Resident #71 7/26/23" regarding the period of time when Resident #71 was unaccounted for, provided by the facility on 10/11/23 revealed in part "Resident (Resident #71) was last seen around 8:30 PM. 8:45 PM- {name of staff} (Nurse Aide (NA) #4) notified {name of staff} (Nurse #7) she was unable to find resident (Resident #71). {name of staff} (Nurse #7) instructed everyone to check the entire facility for the resident (Resident #71). 9:00 PM- still unable to locate the resident (Resident #71) the staff began searching outside the facility (parking

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E 006	Continued From page 5	E 006		

lot, nearby neighborhood, and wooded area near the facility. 9:55 PM- the Admissions Coordinator notifies the Administrator the resident (Resident #71) is missing. 9:57 PM- The Administrator called {name of staff} DON (Director of Nursing) to inform her a resident is missing. {name of staff} (DON) missed the call. 10:03 PM- the Administrator contacted the facility and spoke with {name of staff} (Nurse #2). Administrator provided instructions to call the police. 10:06 PM-DON received call from {name of staff} (Nurse #7) informing her the resident (Resident #71) was missing. DON returned the call of the Administrator, to let her know she had recently been informed of the missing resident and was enroute to the facility." Review of the Timeline of the Event revealed no documentation of enactment or use of the Missing Resident procedure contained within the Emergency Preparedness plan.

A nursing progress note dated 7/27/23 at 7:58 AM written by Nurse #2 revealed in part Resident #71 was reported missing around 9:00 PM to 11:00 PM (7/26/23). All open doors were searched multiple times including outside in the courtyard and around the facility and she was not found. Management and law enforcement were notified (no time documented), and law enforcement came to the facility. She (Resident #71) was found in the MDS (Minimum Data Set) office in the dark seated on the "sofa" facing the door. The door was locked and needed a code to enter. She was assessed for injury at that time with none noted. Review of the progress note revealed no documentation of enactment or use of the Missing Resident procedure contained within the Emergency Preparedness plan.

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E 006	Continued From page 6	E 006		

A review of a written statement dated 7/31/23 from NA #5 (provided by the facility on 10/11/23) revealed in part she spoke with the Admissions Director by phone and told her Resident #71 had been missing for over an hour and a half and neither the Administrator nor the DON had been notified. It further revealed NA #5 told the Admissions Director Nurse #7 had said she was going to drive around the block to look for Resident #71 and if she didn't see her, she would come back and call the Administrator, DON, and the police.

On 10/10/23 at 1:23 PM a telephone interview with NA #5 indicated she participated in looking for Resident #71 from about 8:30 until 10:00 PM.

A review of the written statement provided by the Admissions Director dated 7/31/23 (provided by the facility on 10/11/23) revealed in part that at 9:52 PM she received a call from NA #5 who told her Resident #71 had been missing for about 2 hours. NA #5 told her that the nurse had not called to notify the DON or the Administrator. NA #5 reported staff had been looking for Resident #71 all over the building, in the parking lots, out behind the dumpster and near the woods. NA #5 told her the nurse had said she was going to get in her car and look around the neighborhood and if she still couldn't find Resident #71, she was going to notify the Administrator and DON.

On 10/10/23 at 12:13 PM an interview with the Admissions Director indicated she had been made aware by telephone that Resident #71 was missing at the facility on 7/26/23 around 10:00 PM when NA #5 called her.

On 10/11/23 at 2:43 PM an interview with Police

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E 006	Continued From page 7	E 006		

Dispatch #1 indicated the Fuquay Varina Police Dispatch first received the call for a missing resident at the facility on 7/26/23 at 10:23 PM.

On 10/16/23 a review of the Fuquay Police Department Call for Service report dated 7/26/23 for a missing person revealed the call was initially received from the facility at 10:23 PM. It further revealed on 7/26/23 at 10:42 PM Resident #71 was found.

On 10/10/23 at 11:19 AM a telephone interview was conducted with Nurse #2. Nurse #2 stated around 8:20 PM on 7/26/23 Resident #71 refused her medications and her vital signs, and she told Resident #71 she would try again later. She went on to say around 9:20 PM she went to find Resident #71 in her room, but she wasn't there. Nurse #2 further indicated she found Nurse Aide (NA) #4 to ask her where Resident #71 was. Nurse #2 stated NA #4 had not known and NA #4 went to look for Resident #71. Nurse #2 stated when NA #4 reported back to her that NA #4 was not able to locate Resident #71 after looking on all the halls Nurse #2 let all staff know to begin looking for her. She went on to say after staff searched everywhere they could access inside the facility and outside for about 30 minutes and could not locate Resident #71, she knew it was time to notify her chain of command. She stated when she spoke with the Administrator by telephone, the Administrator told her to call the police. She indicated when the police arrived at the facility, Resident #71 was located inside of the locked MDS office, and the room was accessed through the use of code entered into a keypad on the door. She went on to say Resident #71 had been found seated in the MDS office alone in the dark. In a follow up interview on 10/18/23 at 4:11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 006	Continued From page 8	E 006		

PM Nurse #2 stated Resident #71 had a wander guard in place. She went on to say she assessed this during each shift she worked to make sure it was on and functioning. During the interviews, Nurse #2 did not provide information regarding the facility's failure to enact the emergency preparedness plan for a missing resident.

During a telephone interview on 10/10/23 at 8:36 PM Nurse #7 stated on 7/26/23 around 9:00 PM NA #4 informed her NA #4 could not find Resident #71. Nurse #7 went on to say Resident #71 had a wander guard in place and there were no alarms going off so she really felt Resident #71 must have still been inside the building. Nurse #7 stated she was "fuzzy" about the time, but she thought it was about 10:00 PM when she called the DON. She stated she did not think the DON had known yet about Resident #71 being missing. Nurse #7 went on to say she was "fuzzy" about who called the police or when but the reason the police were not notified sooner was everyone thought Resident #71 would not have been able to get out of the building unless someone let her out. She explained she had wanted to be sure Resident #71 was not in the building first before the police were called. In a follow-up interview on 10/16/23 at 8:16 AM Nurse #7 stated she did not recall receiving any training on the EP program including the procedure for elopement/missing resident since she began work at the facility in June of 2022.

On 10/11/23 at 8:33 AM an interview with the DON indicated she first received notification Resident #71 was missing on 7/26/23 about 10:00 PM. She stated staff should have notified her and the Administrator immediately when they were not able to find Resident #71. She went on

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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E 006	Continued From page 9	E 006		

to say the facility Emergency Preparedness procedure for a missing resident directed staff to notify the administration immediately and the police in 10 minutes if a missing resident could not be found. The DON stated staff had not followed this on 7/26/23. She went on to say she did not consider the hour it took staff to notify administration to be immediately. She further indicated if administration had been notified immediately staff would have been instructed to call the police. She stated when the police came, they instructed staff to open all the locked doors to look for Resident #71 and Resident #71 had been found. She went on to say if the police had been notified when they should have been, Resident #71 would have been found sooner.

On 10/11/23 at 8:47 AM an interview with the Administrator indicated she was not sure exactly what the timeframe was for calling the police when a resident was missing according to the policy and procedure. She stated she would have to look back at the facility's policy and procedure. She went on to say when a resident was missing, staff should follow the facility's emergency policy and procedure.

The Administrator was notified of Immediate Jeopardy (IJ) on 10/11/23 at 1:50 PM.

The facility provided the following credible allegation of IJ removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the non- compliance:

On the evening of 7/26/2023 at approximately 8:30 PM, CNA #4 began looking for Resident #71

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 006	Continued From page 10	E 006		

throughout the facility. At approximately 8:45 PM, CNA #4 notified Nurse #7 that she was unable to locate Resident #71. Nurse #7 initiated a facility wide search for Resident #71 to include the outside building perimeter, nearby neighborhood, and the wooded area by the facility. CNA #5 telephoned the admissions Coordinator, at approximately 9:15PM and informed her that Resident #71 was missing and could not be found in the building. The admissions Coordinator notified the facility Administrator who in turn notified the DON at 9:57 PM. At 10:03, the Administrator called the facility and instructed Nurse #2 to call the police. The facility should have called the Administrator and the DON when the resident was initially reported as missing by the CNA and the police 10 minutes after the resident was not found in the initial search as directed in the Missing Resident Policy. The police were dispatched at 10:23 PM and arrived shortly thereafter. The DON arrived at the facility at 10:32 PM and using her door code unlocked the office doors. Resident #71 was found in the MDS office on 400 hall. When the DON opened the door with the police present, the resident was laughing and said, "Ya'll called the police on me, didn't you?"

The resident was immediately assessed for physical injuries by the Director of Nursing. There were no identified injuries. The resident was laughing when the door was opened. The resident's psychosocial well-being was not affected as evidenced by the resident laughing upon being found and having no recollection of the event on 7/26/2023 as documented in the trauma assessment performed on 8/9/2023 and visits by the inhouse psych provider in August.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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E 006	Continued From page 11	E 006		

On 7/26/23, the evening supervisor conducted a facility head count prior to the resident being located to ensure all other residents were accounted for. All other residents were located in the facility.

The Regional MDS Nurse reviewed BIMS scores for all current residents to determine who was classified as cognitively impaired. Of those residents the facility therapy manager identified residents who are able to locomote independently. These residents have been identified as at risk of being behind an unlocked office door to include conference room, therapy gyms, kitchen, and other common storage rooms. This was completed on 10/13/2023.

Specify action the facility will take to alter the process or system failure to prevent a serious outcome from occurring or recurring and when the action will be completed:

On 10/13/23, the regional clinical nurse provided education to the DON and facility Administrator on the Missing Resident Policy and their responsibilities.

The facility Administrator and DON began education on 10/13/23 with all facility staff including clinical agency/contract (Housekeeping/Laundry/rehabilitation) employees on the Missing Resident Policy. This education included notifying the facility Administrator and DON immediately once it is determined a resident is unable to be located, conducting a facility head count to ensure no other residents are missing, checking all resident rooms/bathrooms/closets/dining room and locked office doors, to include conference room, therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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E 006	Continued From page 12	E 006		

gyms, kitchen, and other common storage rooms, calling the police within 10 minutes, notifying the MD/RP, then begin checking the outside property (parking lot, trash dumpster area, surrounding grounds and neighboring community).

All newly hired employees, clinical agency personnel and contract (HK/Laundry/Rehabilitation) personnel, will receive this education from the Director of Nursing and/or designee, prior to being able to work. The DON is currently tracking current staff to ensure that education is completed prior to them being able to work. A copy of the Missing Resident Policy is available at each nurse's station for staff to reference, in case of an emergency. The Missing Resident Policy was placed at each facility nurse's station on 10/13/23 by the Regional Clinical Nurse.

Date of IJ removal: 10/14/2023

The validation process for the IJ removal plan was completed on 10/18/23. Staff from different departments and who worked different shifts were interviewed and verified they had received training on the "Missing Resident Policy." Review of nursing stations showed the "Missing Resident" policy was printed and available for staff as needed. A review was completed of the audit logs that included educational information provided to staff during the in-service and a review of in-service staff sign-in logs. The in-service logs were reviewed, and staff names randomly selected and verified to have received training. There have been no new hires, the new hire package was reviewed and included the training completed by staff in the in-service. The facility's IJ removal date of 10/14/23 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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E 006	Continued From page 13 validated.	E 006		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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E 037	Continued From page 14	E 037		

hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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E 037	Continued From page 15 *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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E 037	Continued From page 16	E 037		

and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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E 037	Continued From page 17 must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide and maintain documentation of annual staff training on the Emergency Preparedness (EP) Plan. The findings included: A review of the facility's EP Plan revealed no documentation of the annual staff training. An interview was completed with the Corporate Nurse Consultant on 10/13/23 at 11:15 AM and reported that staff received in-service training on the elopement process in May 2023, missing resident in July 2023, and inclement weather in August 2023. The Administrator was interviewed on 10/13/23 at 11:20 AM and stated she had started at the facility in June 2023 and expected the facility to provide EP training to all staff at least annually. She indicated if training was provided, the Staff Development Coordinator (SDC) should have	E 037	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: There was no resident identified with this alleged deficient practice. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected by this alleged deficient practice. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The annual training in emergency preparedness will be scheduled with the facility mandatory educations. The facility administrator will ensure that this education is completed annually and at the time of any reviews and updates of the	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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E 037	Continued From page 18 documentation of the training. The SDC was interviewed on 10/13/23 at 11:34 AM and reported she started at the facility in September 2023 and had not provided any EP training to staff.	E 037	facility emergency preparedness manual. The Staff Development Coordinator will monitor completion of assigned emergency preparedness training. The facility Administrator completed education with the facility Maintenance Director on the annual training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection and where necessary, evacuation of residents, staff and visitors, fire prevention, and cooperation with firefighting and disaster authorities. This training will be completed by 11/13/23. The facility Administrator and/or Maintenance Director have completed training with current staff, including agency clinical staff and contract (Housekeeping/Laundry/Rehab) personnel, on the facility Annual Emergency Preparedness Program. This training will be completed on 11/13/23. All newly hired employees, clinical agency personnel, and contract (Housekeeping/Laundry/Rehabilitation) personnel, will receive this education from the facility maintenance director and/or Administrator, during orientation. Any employee who has not received this education by 11/13/23, will not be allowed to work until they receive this education. DON is currently tracking current staff to ensure that education is completed prior to them being able to work. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 037	Continued From page 19	E 037	The facility Administrator will review the facility emergency training records with the Maintenance Director, monthly for 3 months, then quarterly to ensure training is being completed in a timely manner to ensure staff is prepared for facility emergencies. The facility Administration will complete a summary of these emergency training reviews and present them at the facility monthly QAPI meeting, to ensure continued compliance.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted onsite from 10/09/2023 through 10/13/2023 with additional information obtained remotely 10/14/2023 through 10/17/2023. Onsite validation of Immediate Jeopardy removal was conducted on 10/18/2023. Therefore, the exit date was changed to 10/18/2023. Event ID# 7V1V11. The following intakes were investigated: NC00192768, NC00192831, NC00192993, NC00193416, NC00195613, NC00196542, NC00198410, NC00200237, NC00201577, NC00203209, NC00203975, NC00204930, NC00206183, NC00206892, NC00208073, NC00208202, NC00208258, NC00208482. 31 of the 79 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J)	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 20 CFR 483.73 at tag E0006 at a scope and severity (J) CFR 483.90 at tag F925 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy for E0006 began on 7/26/23 and was removed on 10/14/23 Immediate Jeopardy for F689 began on 7/26/23 and was removed on 10/15/23. Immediate Jeopardy for F925 began on 10/6/23 and was removed on 10/13/23. An extended survey was conducted. The Statement of Deficiencies was amended on 11/3/23 at tag F641.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make	F 561		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 561	Continued From page 21 choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to honor a resident's choice related to showers for 1 of 9 dependent residents reviewed for choices (Resident #29). Findings included: Resident #29 was admitted to the facility on 4/10/2023, and diagnoses included congestive heart failure. The admission Minimal Data Set (MDS) assessment dated 4/15/2023 indicated Resident #29 was cognitively intact and considered choosing a sponge bath or shower very important. The quarterly MDS assessment dated 8/5/2023 indicated Resident #29 required physical assistance of one person with bathing, bed mobility and transfers. Resident #29's care plan dated 5/8/2023 indicated Resident #29 required assistance with grooming, bathing, mobility and transfers due to	F 561	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #29 was showered on her next shower day 10/12/23 and NA #10 was in-serviced by regional clinical nurse, on showering/bathing residents per their request on November 7, 2023. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this practice; therefore, all alert and oriented residents were interviewed by the Director of Social Services on 11/8/23 to determine if their showered/bathed request have been honored. Any non-interviewable residents had their responsible parties was contacted by the Social Service Director to inquire about shower choices and requests,	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 561	Continued From page 22	F 561		

congestive heart failure, reduced mobility, and muscle weakness.

Based on the facility's shower schedule, Resident #29 was scheduled showers on Mondays and Thursdays.

There were no shower sheets for Resident #29 in the facility's shower book.

A review of nursing documentation dated 10/1/2023 to 10/13/2023 recorded Resident #29 receiving sponge baths. There were no showers documented.

In an interview with Resident #29 on 10/13/2023 at 5:36 p.m., she stated Monday 10/9/2023 was one of her scheduled shower days, and she did not get her shower. She said when she asked NA #10 for a shower around 8:30 p.m. on 10/9/2023, NA #10 informed Resident #29 she was reporting to another hall to work. She stated on 10/9/2023 at 9:30 p.m., she asked NA #10 again to help her with a shower, and NA #10 informed her it was too late to get a shower. Resident #29 further stated she did not receive her showers every Monday.

In a phone interview on 10/13/2023 at 6:00 p.m. with NA #10, she stated she reported to work at 7 p.m. on 10/9/2023 and was assigned to Resident #29 until 11 p.m. She explained when Resident #29 asked for a shower around 8 p.m., she was busy returning residents to bed, providing incontinent care and giving residents bed baths, and she informed Resident #29 she would not be able to give her a shower. NA #10 stated she reported to Medication Aide #2 Resident #29 was not given a shower, and she was told by

3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
Beginning 11/8/2023 all clinical staff including clinical agency personnel (RN, LPN, CNA) were educated by the Staff Development Coordinator and/or administrative nurse on showering residents on their assigned shower days and upon request. The education also included if the CNA is unable to shower the resident upon request for any reason, to notify their charge nurse and the oncoming aide so arrangements can be made to honor the residents shower request. All education will be included in the orientation process for newly hired clinical staff including clinical agency personnel. Effective 11/13/23, any facility or agency clinical staff that has not been educated will not be allowed to work until education is received in- person or via telephone by Director of Nursing and/or administrative nurse. All newly hired nursing staff or clinical agency personnel will receive education during the orientation process by the Staff Development Coordinator (SDC) and/or administrative nurse on providing showers to residents per their request.
4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The Director of Social Services and/or Activities Director will interview 4 residents weekly for 4 weeks, then monthly for 3 months and quarterly thereafter to ensure compliance. The Director of Social

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 561	Continued From page 23 Medication Aide #2 to give Resident #29 a shower. NA #10 reported it was before 11:00 p.m. and informed Medication Aie #2 she was assigned to report to another unit at 11:00p.m. NA #10 further stated did not report to NA #11 (NA assigned to Resident #29 for the 11:00 p.m.- 7 a.m. shift) that Resident #29 did not receive a shower that evening. In a phone interview on 10/16/2023 at 8:31 a.m. with NA #11, she explained she was not aware Resident #29 had not received a shower on the evening on 10/9/2023. She reported she didn't recall Resident #29 asking for a shower or Nurse #7 asking her to give Resident #29 a shower during her 11p.m. to 7 a.m. shift on 10/9/2023. In a phone interview on 10/16/2023 at 8:21 p.m. with Medication Aide # 2 (who was assigned to Resident #29 the 3:00 p.m. to 11 p.m. shift on 10/9/2023), she stated she learned from Resident #29 on 10/9/2023 around 10:00 p.m. during the medication pass, NA #10 had not given Resident #29 a shower that evening, and Resident #29 stated she was told by NA #10 it was too late to receive a shower because she was moving to another unit at 11:00 p.m. Medication Aide #2 reported she did not speak to NA #10 about Resident #29 not getting a shower until 10/10/2023 during the 3 p.m. to 11 p.m. shift when NA #10 reported she did not give Resident #29 a shower on 10/9/2023 as scheduled. In a phone interview with Nurse #7 on 10/16/2023 at 8:16 a.m., she stated she was not aware that Resident #29 did not receive her shower on the evening of 10/9/2023 until the morning of 10/10/2023. She said Resident #29 reported she had asked NA #10 for a shower, and NA #10 did	F 561	Services will complete a summary of the interview results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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F 561	Continued From page 24 not give her a shower before reporting to another unit to work at 11:00 p.m. Nurse #7 stated if she had known Resident #29 had not received her shower on the evening of 10/9/2023, she would have gotten someone to assist Resident #29 with her shower. In an interview with the Regional Nurse Consultant on 10/13/2023 at 6:43 p.m., she stated staff prioritize resident care tasks, and since NA #10 was unable to perform Resident #29's shower on 10/9/2023, NA #10 should have reported Resident #29 needing a shower to the next shift so nursing staff could have helped her with a shower. In an interview with the Director of Nursing on 10/18/2023 at 10:00 a.m., she stated Resident #29 was scheduled showers on the Monday and Thursday evening shift (3:00 p.m. to 11:00 p.m.). She explained the nursing assistant working the 7p.m. to 11p.m. portion of the shift was responsible for assisting Resident #29 with her shower, and NA #10 should have given Resident #29 her shower as requested and documented in the electronic medical record.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at	F 565		11/13/23

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F 565	Continued From page 25 the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to provide the resident council members with a response to grievances reported during the resident council meetings for 3 of 3 resident council grievances reviewed. Findings included: Review of Resident Council minutes dated 8/1/23 revealed resident council members expressed a concern that the council does not get	F 565	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Administrator held a resident council meeting on 11-7-23. The Resident Council received updates on the concerns that were voiced during previous council meetings. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 565	Continued From page 26 "resolutions" to issues from resident council meetings. A resident council grievance dated 8/2/23 stated a concern about "resolutions" to issues from resident council written by the Activities Director. The form reflected it being solely addressed by the Activities Director. The staff response section stated the Activities Director would ensure follow-up with department heads. The form had an area designated for the date on which the resolution was approved by the Resident Council. There was no council approval date, and the area was blank. The implementation date was 8/9/23. Review of Resident Council minutes dated 9/5/23 revealed concerns about showers and timeliness of pain medications. Review of a resident council grievance dated 9/6/23 showed staff response was a shower/bath audit and education for nurse aides. There was no indication on the form on who completed it. The form was given to the Director of Nursing who signed the form. It did not have an implementation date or council approval date. A second resident council grievance dated 9/6/23 referenced pain medication not being received in a "timely" manner. Staff response was nurse education. There was no indication on the form of who completed the form. The form was given to the Director of Nursing who signed the form. The form didn't have an implementation date or council approval date. Observation of a Resident Council Meeting was conducted on 10/10/23 at 11:14 AM and revealed an issue with the resolution of grievances. There	F 565	Any resident had the potential to be affected by the alleged deficient practice. The Administrator completed an audit of resident council meeting minutes, for the last 30 days to identify any unresolved grievances. This audit will be completed by 11/13/23. Any identified unresolved grievances will be investigated by the facility Administrator and/or Social Services Director and the resident and/or resident representative will be notified of resolution. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: During resident council when residents voice a grievance, the activities director and/or social services director will record individual and group grievances on the facility grievance form. The grievance will be given to the facility administrator to distribute to the appropriate department for resolution. The individual and/or group grievance will be investigated, and a written response and resolution will be presented to the resident council present or individual resident. Administrator will in-service department heads on proper follow up to resident council concerns/grievances by 11/13/2023. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility administrator and/or social services director will review resident council grievances daily (M-F) at the facility Morning Meeting, to ensure that	

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F 565	Continued From page 27 were four residents present for the meeting. Residents stated they did not get a response or notice of resolution of grievances reported during the resident council meetings. The residents in the meeting reported not all grievances were resolved by the facility and there were no explanations given as to the reason the grievances were not resolved. The Resident Council president explained that during each meeting the issues from the prior month were discussed by the council members to see if the issues were still a concern. The Resident Council president reported the Activities Director documented the issues and discussed the ongoing concerns during each meeting. Several of the members indicated the Activities Director explained during the meetings that the issues were passed along to the appropriate staff to ensure resolution of the issues. The residents reported after they voiced a grievance or concern to the Activities Director, they frequently were not given a response from the facility. An interview was conducted with the Activities Director on 10/12/23 at 2:05 PM who stated she gave the grievances to the appropriate department heads to follow-up. She stated it was the department heads' responsibility to follow-up with the Resident Council members. The Activities Director stated she only completed grievances for group issues not individual concerns of residents. She reported she would have mentioned the grievances in the daily morning meeting of department heads. During an interview on 10/11/23 at 3:04 PM the Administrator stated she was unaware of the process for Resident Council grievances as she is new to the facility. The Administrator stated	F 565	group and individual grievances are addressed. The administrator will present results of audit to QAPI Committee monthly to ensure continued compliance.	

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F 565	Continued From page 28 she would expect the grievance form to be completed with an outcome relayed to the Resident Council.	F 565		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to inform residents (Resident #4, #59, #24 and #36) of the location of the state inspection results, and failed to display state inspection results in a location	F 577	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #4, #24, and #36 were	11/13/23

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F 577	Continued From page 29 accessible to residents. The findings included: On 10/9/23 at 11:48 am the survey inspection results white binder for the facility was observed on the reception counter, approximately fifty-six inches from the floor with a sign above which said survey inspection results. The binder was two feet from the edge of the counter. Due to other items on the counter in front of the survey binder it could not be reached from the front of the counter. The survey inspection results binder could only reached from inside the reception area. Residents were not permitted in the reception area. Observations revealed no other signs in the building regarding results of state inspection results. On 10/10/23 at 11:15 am during a Resident Council meeting, Resident #4, Resident #59, Resident #24, and Resident #36 stated state inspection results were not made available for residents to read and they did not know the location of the state inspection results. An interview was conducted on 10/10/23 at 3:07 PM with Receptionist #1 who stated she had been employed with the facility for two years and could not recall a resident asking for the survey results. An interview was conducted on 10/10/23 at 3:09 PM with Receptionist #2 who stated she had been employed with the facility for six years and could not recall a resident asking for the survey results.	F 577	informed of the location of the state survey inspection results on 11/7/2023. Resident # 19 discharged. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A survey binder that includes any certifications, surveys, and complaint investigations for the 3 preceding years with the plans of correction, is available to residents, families, and legal representatives at all times. The survey binder is located in the front lobby. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Residents will be notified of the location of the survey binder in each monthly Resident Council meeting. The administrator will be responsible for ensuring that the survey binder is in the correct location for resident and or visitor review weekly times 4 weeks, then biweekly times 4 weeks, then monthly times 4 months. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator will complete a summary of audit/monitoring results and will present results at the monthly QAPI meeting.	

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F 577	Continued From page 30 An interview was conducted with the Administrator on 10/12/23 at 10:30 AM who stated she was unaware the survey inspection results binder should be accessible to residents without assistance. She reported she would have the survey book moved to a lower position so it would be within reach of wheelchair bound residents. The Administrator stated the residents would be educated on the location of the survey inspection results.	F 577		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		11/13/23

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F 578	Continued From page 31 legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure advanced directive information was accurate throughout residents' electronic and paper medical records for 4 of 5 residents (Resident #42, Resident #52, Resident #57, and Resident #76) reviewed for advanced directives. Findings included: 1) Resident #42 was admitted to the facility on 2/14/20. Resident #42's electronic medical record revealed an active physician's order dated 4/8/20 that read "full code." This order was still active on 10/9/23. Resident #42's quarterly Minimum Data Set (MDS) assessment dated 7/2/23 revealed Resident #42 was severely cognitively impaired.	F 578	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Advance Directive orders for Residents #42, #52, #57, #76 were updated to ensure the physician orders, electronic health record (EHR) and code status binders match and are reflective of the residents desired code status. The update was completed on 10/12/23 by the Minimum Data System (MDS) Coordinator. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The code status of all current residents was audited by a Clinical Administrative Nurse (Unit Manager) on 11/7/23, to ensure the code status indicated in the binders, the physician orders and electronic health record were reflective of	

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F 578	Continued From page 32 Review of Resident #42's care conference notes showed a note dated 7/25/23 at 2:00 P.M. read in part "(Guardian) is requesting a letter be written to change the resident code status from CPR (cardiopulmonary resuscitation) to DNR (Do Not Resuscitate) . . . Resident will remain a CPR CODE STATUS until the letter is received and approved by the guardian supervisor." Resident #42's electronic medical chart showed on the communication bar of Resident #42's opened medical chart, a code status icon that read DNR. When the icon was clicked, an "Advanced Directives" tab appeared that showed on 9/1/23 at 6:13 P.M. Resident #42's code status was changed to Do Not Resuscitate (DNR). Review of the DNR binder located at the nurse's station showed Resident #42 had a signed DNR form dated 9/1/23 located in the binder. Review of the Medication Administration Record for October 2023 showed Resident #42 was a full code. An interview was conducted on 10/13/23 at 10:16 A.M. with the Social Worker (SW). During the interview, the SW explained Resident #42's code status was recently changed from a full code to a DNR code status. The SW stated staff received a written statement via email from Resident #42's Guardian which stated Resident #42's code status was to be changed to a DNR. He stated when the physician arrived at the facility, the physician signed the DNR paperwork and returned the paperwork to him. The SW stated his responsibility was to place the paperwork in the DNR book at the nurse's station and make a copy to place in the medical records room so the	F 578	one another. Any discrepancies identified were clarified with the assistance of the social service director and the resident□s attending physician. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Current residents code status will be reviewed at admission, readmission, quarterly and at the time of a significant change by the administrative nurses (includes Director of Nursing, Asst Director of Nursing, Unit Managers and Staff Development Coor) During the facility clinical meeting, the administrative nurses and facility Interdisciplinary team (in addition to the clinical team includes Social Worker, Activity Director, and MDS Coor) will discuss any changes to a resident□s code status to ensure there is an update in the residents□ EHR, physician orders and code status book. Any updated information will be communicated to the facility licensed nurses to ensure they have updated information. The interdisciplinary team was educated by the Regional Nurse Consultant on 11/7/23 on the importance of ensuring that any new changes in a resident□s code status is made known to the administrative nurse management team and medical director to ensure that it is confirmed by a matching advanced directive order, accurately communicated in the resident□s electronic health record and the code status binders at the nursing	

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F 578	Continued From page 33 medical records personnel could upload the document to the resident's medical record. The Social Worker stated when he placed the DNR paperwork into the DNR binder at the nurse's station he made the resident's assigned nurse and/or the Unit Manager aware because they were responsible for updating the physician orders and the code status under the Advance Directors tab where the information was reflected on the communication bar of a resident's chart. An interview was conducted on 10/11/23 at 2:00 P.M. with the Unit Manager. During the interview, the Unit Manager stated when a resident's code status was updated after admission, the assigned nurse was given the signed advanced directive paper. The Unit Manager explained it was the responsibility of the assigned nurse or herself, the Unit Manager if the nurse was busy, to update resident's physician orders and the Advanced Directive tab in the resident's electronic medical record to reflect the change in the code status. The Unit Manager was unsure why Resident's #42's medical record was not accurately updated when his code status changed, and she stated she felt it was an oversight. During the interview, the Unit Manager stated the electronic medical record should be updated with a copy of the newest DNR paperwork and if there was a discrepancy between physician orders, the Advanced Directives tab on the electronic medical chart, and the DNR binder at the nurse's station, she would check the dates and follow the code status of the document with the newest date. An interview was conducted on 10/11/23 at 3:11 P.M. with the Director of Nursing (DON). The DON said the code status for each resident was	F 578	stations. This education will be included in the new hire orientation packet for all newly hired interdisciplinary team members. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or designee will conduct random audits of the code status binder and EHR for accurate code status for 10 residents weekly for 4 (four) weeks, then monthly for 3 (three) months and quarterly thereafter to ensure compliance. Findings will be documented on an audit tool with the results presented at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance. Changes will be made to the plan as necessary to maintain compliance.	

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F 578	Continued From page 34	F 578		

in the DNR binder at the nurse's desk, shown on an icon on the communication bar in the resident's electronic medical records when the chart was open, entered as a physician order, and scanned into the resident's electronic medical record. During the interview, the DON explained the SW helped collect updated code status paperwork and the medical records personnel was responsible for scanning the code statuses into the electronic medical record. The DON explained the medical records position has been vacant for over a month. The DON stated all the code status should have the same information throughout the resident's electronic medical record and in the code status binder at the nurse's desk and she is unsure why Resident #42's code status was not accurate throughout his electronic medical documentation.

An interview was conducted on 10/13/23 at 10:08 A.M. with the Administrator. During the interview, the Administrator stated a resident's code status should be accurate throughout the resident's medical record to include the physician orders, status icon on the communication bar, scanned documents, and the code status binder at the nursing station. The Administrator explained the facility has a medical records position working on an as needed basis and some of the code status documents have not been scanned into resident medical records. The Administrator did not provide a reason for why the code status in Resident #42's medical record was not consistent throughout.

2. Resident #52 was admitted to the facility on 6/18/19.

Review of Resident #52's electronic medical chart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 35	F 578		

revealed on the communication bar a code status icon that read CPR (cardiopulmonary resuscitation). When the icon was clicked, an "Advance Directives" tab appeared which showed on 7/9/21 Resident #52's code status was documented "attempt cardiopulmonary resuscitation."

Review of Resident #52's electronic medical record revealed a scanned Medical Orders for Scope of Treatment (MOST) form dated 5/1/23 showed Resident #52 was a DNR (Do Not Resuscitate).

Review of Resident #52's active physician's order date 9/7/23 read code status DNR.

Review of the DNR binder located at the nurse's station showed Resident #52 had a DNR form dated 9/7/23 located in the binder.

Review of Resident #52's electronic medical records showed the DNR form dated 9/7/23 was not scanned into the electronic medical record.

Resident #52's quarterly Minimum Data Set (MDS) assessment dated 9/14/23 revealed Resident #52 was severely cognitively impaired.

An interview was conducted on 10/13/23 at 10:16 A.M. with the Social Worker (SW). During the interview, the SW explained Resident #52's code status was recently changed. The SW stated his responsibility after the physician signed the DNR paperwork, to place the signed DNR into the DNR binder at the nurse's station. The SW said he copied the DNR and placed the copy with the medical records office to be scanned into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 578	Continued From page 36	F 578		

resident's medical record. The Social Worker stated when he placed the DNR paperwork into the DNR binder at the nurse's station he made the resident's assigned nurse and/or the Unit Manager aware because they were responsible for updating the code status under the Advance Directors tab that shows on the communication bar and updating the physician orders.

An interview was conducted on 10/11/23 at 2:00 P.M. with the Unit Manager. During the interview, the Unit Manager stated when a resident's code status was updated after admission, the assigned nurse was given the signed advanced directive paper. The Unit Manager explained it was the responsibility of the assigned nurse or herself, the Unit Manager if the nurse was busy, to update resident's physician orders and the Advanced Directive tab in the resident's electronic medical record to reflect the change in the code status. The Unit Manager was unsure why Resident's #52's medical record was not accurately updated when his code status changed, and she stated she felt it was an oversight. During the interview, the Unit Manager stated the electronic medical record should be updated with a copy of the newest DNR paperwork and if there was a discrepancy between physician orders, the Advanced Directives tab on the electronic medical chart, and the DNR binder at the nurse's station, she would check the dates and follow the code status of the document with the newest date.

An interview was conducted on 10/11/23 at 3:11 P.M. with the Director of Nursing (DON). The DON said the code status for each resident was in the DNR binder at the nurse's desk, shown on an icon on the communication bar in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 37	F 578		

resident's electronic medical records when the chart was open, entered as a physician order, and scanned into the resident's electronic medical record. During the interview, the DON explained the SW helped collect updated code status paperwork and the medical records personnel was responsible for scanning the code statuses into the electronic medical record. The DON explained the medical records position has been vacant for over a month. The DON stated all the code status should have the same information throughout the resident's electronic medical record and in the code status binder at the nurse's desk and she is unsure why Resident #52's code status was not accurate throughout his electronic medical documentation.

An interview was conducted on 10/13/23 at 10:08 A.M. with the Administrator. During the interview, the Administrator stated a resident's code status should be accurate throughout the chart to include the physician orders, status icon, scanned documents, and the code status binder at the nursing station. The Administrator explained the facility has a medical records position working on an as needed basis and some of the code status documents have not been scanned into resident medical records. The Administrator did not provide a reason for why the code status in Resident #52's medical record was not consistent throughout.

3. Resident #57 was admitted to the facility on 6/1/22.

Resident #57's quarterly Minimum Data Set (MDS) assessment dated 9/1/23 revealed Resident #57 had a moderate cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 578	Continued From page 38	F 578		

Attempts to interview Resident #57 were not successful.

Resident #57's care plan dated 9/5/23 revealed she had a goal status of "do not resuscitate". Review of the DNR binder located at the nurse's station showed Resident #57 had a signed DNR form dated 9/5/23 located in the binder.

Resident #57's electronic medical chart showed on the communication bar of Resident #57's opened medical chart, a code status icon that read full code.

On 10/11/23 at 10:47 AM an interview was conducted with Nurse #12 who stated to locate a resident's code status she would check the chart for the status.

An interview was conducted on 10/11/23 at 2:00 P.M. with the Unit Manager. During the interview, the Unit Manager stated when a resident's code status was updated after admission, the assigned nurse was given the signed advanced directive paper. The Unit Manager explained it was the responsibility of the assigned nurse or herself, the Unit Manager if the nurse was busy, to update resident's physician orders and the Advanced Directive tab in the resident's electronic medical record to reflect the change in the code status. During the interview, the Unit Manager stated the electronic medical record should be updated with a copy of the newest DNR paperwork and if there was a discrepancy between physician orders, the Advanced Directives tab on the electronic medical chart, and the DNR binder at the nurse's station, she would check the dates and follow the code status of the document with the newest date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 39	F 578		

An interview was conducted on 10/11/23 at 3:11 P.M. with the Director of Nursing (DON). The DON said the code status for each resident was in the DNR binder at the nurse's desk, shown on an icon on the communication bar in the resident's electronic medical records when the chart was open, entered as a physician order, and scanned into the resident's electronic medical record. During the interview, the DON explained the SW helped collect updated code status paperwork and the medical records personnel was responsible for scanning the code statuses into the electronic medical record. The DON explained the medical records position has been vacant for over a month. The DON stated all the code status should have the same information throughout the resident's electronic medical record and in the code status binder at the nurse's desk.

An interview was conducted on 10/12/23 at 10:08 A.M. with the Administrator. During the interview, the Administrator stated a resident's code status should be accurate throughout the resident's medical record to include the physician orders, status icon on the communication bar, scanned documents, and the code status binder at the nursing station. The Administrator explained the facility has a medical records position working on an as needed basis and some of the code status documents have not been scanned into resident medical records. The Administrator did not provide a reason for why the code status in Resident #57's medical record was not consistent throughout.

4. Resident #76 was admitted to the facility on 10/18/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 40	F 578		

Review of the DNR binder located at the nurse's station showed Resident #76 had a signed DNR form dated 4/17/23 located in the binder.

Resident #76's quarterly Minimum Data Set (MDS) assessment dated 7/21/23 revealed Resident #76 had a moderate cognitive impairment.

Attempts to interview Resident #76 were not successful.

Resident #76's electronic medical chart showed on the communication bar of Resident #76's opened medical chart, a code status icon that read full code.

On 10/11/23 at 10:47 AM an interview was conducted with Nurse #12 who stated to locate a resident's code status she would check the chart for the status.

An interview was conducted on 10/11/23 at 2:00 P.M. with the Unit Manager. During the interview, the Unit Manager stated when a resident's code status was updated after admission, the assigned nurse was given the signed advanced directive paper. The Unit Manager explained it was the responsibility of the assigned nurse or herself, the Unit Manager if the nurse was busy, to update resident's physician orders and the Advanced Directive tab in the resident's electronic medical record to reflect the change in the code status. During the interview, the Unit Manager stated the electronic medical record should be updated with a copy of the newest DNR paperwork and if there was a discrepancy between physician orders, the Advanced Directives tab on the electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 41	F 578		

medical chart, and the DNR binder at the nurse's station, she would check the dates and follow the code status of the document with the newest date.

An interview was conducted on 10/11/23 at 3:11 P.M. with the Director of Nursing (DON). The DON said the code status for each resident was in the DNR binder at the nurse's desk, shown on an icon on the communication bar in the resident's electronic medical records when the chart was open, entered as a physician order, and scanned into the resident's electronic medical record. During the interview, the DON explained the SW helped collect updated code status paperwork and the medical records personnel was responsible for scanning the code statuses into the electronic medical record. The DON explained the medical records position has been vacant for over a month. The DON stated all the code status should have the same information throughout the resident's electronic medical record and in the code status binder at the nurse's desk.

An interview was conducted on 10/12/23 at 10:08 A.M. with the Administrator. During the interview, the Administrator stated a resident's code status should be accurate throughout the resident's medical record to include the physician orders, status icon on the communication bar, scanned documents, and the code status binder at the nursing station. The Administrator explained the facility has a medical records position working on an as needed basis and some of the code status documents have not been scanned into resident medical records. The Administrator did not provide a reason for why the code status in Resident #76's medical record was not consistent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 578	Continued From page 42 throughout.	F 578		
F 585 SS=B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 585		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 585	Continued From page 43	F 585		

can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 585	Continued From page 44 regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interviews, family interviews, staff interviews, and record review the facility failed to provide a written resolution of grievances for 4 of 4 residents reviewed for grievances (Resident #59. #36, #14, #53). The facility also failed to maintain grievance records as required for a period of no less than 3 years from the issuance of the grievance decision. The findings included: 1. a. Resident #59 was admitted to the facility 10/28/19. Review of an undated grievance form initiated by the resident revealed she expressed nursing concerns during 4/24/23-4/27/23. There was no documentation of resolution of grievance. Review of a letter dated 5/18/23 was attached to	F 585	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Administrator spoke with the person filing the grievance for #36, #14, #53 on 11/9/2023. After discussion the grievance was resolved. #59 is no longer in facility. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of Grievance/Concern forms for thirty days will be completed by Administrator by 11/8/2023 to determine if forms were completed in their entirety and the resolution was presented to the resident or responsible party and a written resolution given to the resident per his/her wishes. 3) Address what measures will be put	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 45 the undated grievance which read in part, "thank you for allowing us to intervene and assist with the formal grievance in which was expressed to our facility". There was no mention of resolution of the grievance. Resident #59's most recent Minimum Data Set assessment, an annual, dated 8/14/23 revealed she was cognitively intact. An interview was conducted with Resident #59 on 10/11/23 at 11:30 AM who stated she had not been notified of any resolution of her grievance. She stated she recalled filing the grievance. During an interview on 10/11/23 at 2:31 PM the Social Worker stated he had been working at the facility for a little over six months. When someone filed a grievance the person who received the grievance gave it to the Administrator and she would then distribute the grievance to the appropriate department. The Administrator kept records of the grievances in her office. He concluded the Administrator would be able to speak to the process of grievance responses to the residents and family. During an interview on 10/11/23 at 3:04 PM the Administrator stated up to 3 weeks ago the grievance was given to the receptionist and then the receptionist would put it in the Administrators box. She stated now the grievances were placed directly into her box. The Administrator stated she will review the grievance and then she will give the grievance to the department the grievance mentions. She stated grievances were completed within 5 days and then the person who made the complaint (resident or resident family) will be notified of the outcome of the grievance. She	F 585	into place or systemic changes made to ensure that the deficient practice will not recur: Staff will be in-serviced by the SDC and/or nursing admin that upon receipt of a written grievance that the appropriate designee will investigate the allegations and submit a written report of such findings to the facility administrator within 72 hours of receiving the grievance. The administrator and interdisciplinary team will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken. The resident, or person filing the grievance/complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The reports will be made in writing by the facility administrator or designee, within five working days of the filing of the grievance or complaint with the facility. The in-service will be completed by 11/13/2023. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility administrator and/or social services director will review resident grievances daily (M-F) at the facility Morning Meeting, to ensure that individual grievances are addressed. The administrator will present results of audit to QAPI Committee monthly to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 46	F 585		

stated the department the grievance was given to was responsible for completing the grievance form. The Administrator stated she would expect the grievance form to be completed with an outcome.

b. Resident #36 was admitted to the facility 4/8/19.

Review of an undated grievance form initiated by the resident revealed he expressed dietary and nursing concerns. There was no documentation of resolution of grievance.

Resident #36's most recent Minimum Data Set assessment dated 5/4/23, an annual assessment revealed he was assessed as cognitively intact.

An interview was conducted with Resident #36 at 12:15 PM and he stated he had not been notified of any resolution to his grievance. He stated he recalled filing the grievance.

During an interview on 10/11/23 at 2:31 PM the Social Worker stated he had been working at the facility for a little over six months. When someone filed a grievance the person who received the grievance gave it to the Administrator and she would then distribute the grievance to the appropriate department. The Administrator kept records of the grievances in her office. He concluded the Administrator would be able to speak to the process of grievance responses to the residents and family.

During an interview on 10/11/23 at 3:04 PM the Administrator stated up to 3 weeks ago the grievance was given to the receptionist and then the receptionist would put it in the Administrator's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 585	Continued From page 47	F 585		

box. She stated now the grievances were placed directly into her box. The Administrator stated she will review the grievance and then she will give the grievance to the department the grievance mentions. She stated grievances were completed within 5 days and then the person who made the complaint (resident or resident family) will be notified of the outcome of the grievance. She stated the department the grievance was given to was responsible for completing the grievance form. The Administrator stated she would expect the grievance form to be completed with an outcome.

c. Resident #14 was admitted to the facility on 2-21-19.

The quarterly Minimum Data Set (MDS) dated 9-13-23 revealed Resident #14 was severely cognitively impaired.

Review of grievances from July 2022 through October 2023 revealed one grievance for Resident #14 dated 3-25-23. The grievance documented a concern that another resident had entered Resident #14's room. Other than the concern documented, there was no further documentation on the grievance form related to the investigation, a resolution or who had accepted the grievance.

An interview with the author of the grievance occurred on 10-11-23 at 2:15pm. The author stated she had filed the grievance for Resident #14 but stated she had not heard of any investigation being completed or the outcome of the grievance.

The facility Social Worker (SW) was interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585	Continued From page 48	F 585		

on 10-11-23 at 2:30pm. The SW explained anyone can file a grievance and the grievance was then given to the Administrator. He stated once the Administrator reviewed the grievance form, the Administrator would then give the grievance form to the department that the grievance mentioned. The SW said he did not handle grievances unless the grievance was about abuse.

During an interview with the Administrator on 10-11-23 at 3:04pm, the Administrator explained she had not been employed at the facility in March 2023 so she could not explain why the grievance for Resident #14 was not completed. The Administrator discussed the facility's current process for grievances. She stated once a grievance was written, the grievance form was placed directly into her mailbox, she would review the grievance with the management team, and the department mentioned in the grievance would receive the form. The Administrator said once the grievance form had been completed with the investigation, the grievance form was brought back to her, and she would notify the author of the grievance form of the investigation outcome. She stated she would expect the staff assigned to the grievance to complete the investigation within 5 days.

The Director of Nursing (DON) was interviewed on 10-13-23 at 10:11am. The DON explained she was not employed by the facility in March 2023 so she could not speak to why the grievance for Resident #14 was not completed. She stated management discussed grievances in their morning meeting and the grievance form was distributed to the correct department to investigate. The DON stated staff try to complete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 585	Continued From page 49	F 585		

their investigation within 48 hours and return the grievance to the Administrator for follow up with the author of the grievance. She stated she expected grievances to be completed with an investigation and follow up.

d. Resident #53 was admitted to the facility on 11/29/22.

Review of a grievance for Resident #53 completed and submitted on 2/27/23 by Family Member #1 revealed there was documentation of the facility follow-up and no resolution of the grievance or concern.

Review of Resident #53's most recent minimum data set assessment dated 7/10/23 revealed he was assessed as severely cognitively impaired.

During an interview on 10/11/23 at 2:15 PM Family Member #1 stated she had not received any response from the facility regarding the grievance she submitted on 2/27/23.

During an interview on 10/11/23 at 2:31 PM the Social Worker stated he had been working at the facility for a little over six months. When someone filed a grievance the person who received the grievance gave it to the Administrator and she would then distribute the grievance to the appropriate department. The Administrator kept records of the grievances in her office. He concluded the Administrator would be able to speak to the process of grievance responses to the residents and family.

During an interview on 10/11/23 at 3:04 PM the Administrator stated up to 3 weeks ago the grievance was given to the receptionist and then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 585	Continued From page 50	F 585		

the receptionist would put it in the Administrators box. She stated now the grievances were placed directly into her box. The Administrator stated she will review the grievance and then she will give the grievance to the department the grievance mentions. She stated grievances were completed within 5 days and then the person who made the complaint (resident or resident family) will be notified of the outcome of the grievance. She stated the department the grievance was given to was responsible for completing the grievance form. The Administrator stated she would expect the grievance form to be completed with an outcome.

2. On 10/10/2023, grievances logs were reviewed from July 2022 to October 2023. There were no grievance logs provided to review for November 2022 and December 2022.

In an interview with Regional Nurse Consultant #1 on 10/10/2023 at 3:15 p.m., she stated the facility was unable to locate the grievance logs for November 2022 and December 2022. She explained the facility was transitioning between social workers and she was not the Regional Nurse Consultant during those months. She said she was unaware if there were any grievances for November 2022 and December 2022.

In an interview with Regional Nurse Consultant #2 on 10/11/2023 at 10:31 a.m., she stated she was the facility's Regional Nurse Consultant in November 2022 and December 2022. She said there were grievances reported during November 2022 and December 2022, and the facility was unable to locate the grievance logs and grievance forms for those two months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 585	Continued From page 51 In an interview with the Administrator on 10/18/2023 at 4:41 p.m., she explained after grievances were investigated and resolved, grievance forms were placed in a grievance book for the reporting year and grievance reports were maintained by the facility for three years. She explained she started at the facility as Administrator in June 2023, and she was unable to answer why the grievance logs and grievance forms for November 2022 and December 2022 were not in the grievance book for 2022.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 609	Continued From page 52 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to submit an initial report to the State Survey Agency within 2 hours of notification of an allegation of involuntary seclusion. This was for 1 of 1 residents (Resident #71) reviewed for involuntary seclusion. Findings included: A review of the facility's policy titled, "Abuse prevention, intervention, reporting and investigation" last revised 2/2021 revealed in part the following: "I. Purpose The purpose of this policy is to ensure all residents have the right to be free from abuse, mistreatment, neglect, exploitation, corporal punishment, involuntary seclusion, and misappropriation of property. The facility will ensure the prevention, protection, prompt reporting, and interventions in response to alleged, suspected, or witnessed abuse, neglect, and exploitation of any resident. III. Definitions 6. Involuntary seclusion is defined as the separation of the resident from other residents or from his/her room (with or without roommate'), against the resident's will or the will of the resident representative. V. Procedure 6. Investigation b. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24	F 609	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Director of Nursing completed a physical assessment on 7/26/23, and no injuries identified for Resident #71. The resident□s psychosocial well -being was not affected as evidenced by the resident laughing upon being found by the DON and police officer, on 7/26/23. On 8/9/23, the in-house psychological provider performed a trauma assessment and residents had no recall of the event of 7/26/23. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Regional MDS Nurse reviewed BIMS scores for all current residents to determine who was classified as cognitively impaired. Of those residents the facility therapy manager identified residents who can locomote independently. These residents have been identified as at risk of being behind an unlocked office door to include conference room, therapy gyms, kitchen, and other common storage rooms. This was completed on 10/13/2023. There have been no other incidents of other residents wandering into unlocked doors. On 11/8/23, the regional clinical nurse	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 609	Continued From page 53 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Executive Director of the facility and to other officials (Including to the State Survey Agency)". Resident #71 was admitted to the facility on 4/22/22 with diagnoses including dementia, generalized muscle weakness and unsteadiness on feet. A review of Resident #71's quarterly Minimum Data Set (MDS) assessment dated 5/4/23 revealed she was severely cognitively impaired. She displayed inattention and disorganized thinking continuously. She displayed no behavioral symptoms, rejection of care or wandering behavior. Resident #71 required the extensive assistance of 2 people for transfers and set-up assistance for locomotion on and off her unit. She did not walk. She was not steady when moving from a seated to standing position and was only able to stabilize with human assistance. She was not steady during transfers from surface to surface (between bed to chair or wheelchair) and was only able to stabilize with human assistance. She had no functional impairment of range of motion in her upper or lower extremities. She used a wheelchair for mobility. She had one fall with no injury since her prior MDS assessment. She did not use a wander/elopement alarm. A nursing progress note dated 7/27/23 at 7:58 AM written by Nurse #2 revealed in part Resident #71 was reported missing around 9:00 PM to 11:00 PM (7/26/23). She was found in the MDS (Minimum Data Set) office in the dark seated on	F 609	provided education to the DON and Administrator on submitting an initial report to the State Survey Agency within 2 hours of notification of an allegation of abuse, including involuntary seclusion. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: At the time there is an allegation of abuse the Administrator will be notified immediately. The Administrator or Social Services Director will report the allegation within 2 hours of notification to NCDHSR. The investigation will be submitted within 5 working days after submission of initial report. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The administrator will review grievances to identify any allegations that should have been reported weekly for four weeks, then biweekly 3 months weeks, then quarterly. The facility administrator will complete a summary of the audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 609	Continued From page 54	F 609		

the "sofa" facing the door. The door was locked and needed a code to enter.

On 10/10/23 at 11:19 AM a telephone interview with Nurse #2 indicated she was familiar with Resident #71. She further indicated when Resident #71 had not been located by staff during the search inside and outside the facility, the police had been called. She stated the Admissions Director had arrived at the facility at about the same time as the police. She went on to say the Admissions Director had gone to the MDS office door, entered the code, opened the door, and Resident #71 was there alone in the dark seated on a couch with her wheelchair facing the door and the brakes to her wheelchair locked. Nurse #2 further indicated when she arrived to work on 7/26/23 at 7:00 PM, she walked past the MDS office and recalled the office door being closed like it usually was in the evening. Nurse #2 stated there was no way Resident #71 could have gotten out of there by herself due to the heavy door, and the codes that were needed.

10/10/23 06:32 PM in an interview the Director of Nursing (DON) stated a reenactment of the incident using Resident #71's wheelchair had been done after the incident on 7/26/23 and they had not been able to get Resident #71's wheelchair to the position where it had been found without pulling it up in the middle. She further indicated she had not thought Resident #71 could have gotten in there by herself.

On 10/11/23 at 11:04 AM a telephone interview with NA #4 indicated she was familiar with Resident #71 and had been assigned to care for her at the time of the incident on 7/26/23. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 609	Continued From page 55 stated Resident #71 was at baseline that night and did not have any behaviors. She stated Resident #71 liked to propel herself around the facility in her wheelchair and everyone kept an eye on her for safety reasons. NA #4 went onto say around 8:30 PM on 7/26/23 she had gone to look for Resident #71 to help her get ready for bed and could not find her. She went on to say the Admissions Director arrived at the facility and had gone straight to the MDS office and opened the door. She went on to say she had no idea how Resident #71 could have gotten locked in the MDS office by herself. On 10/11/23 at 1:50 PM the Administrator was notified of an allegation of involuntary seclusion for Resident #71. On 10/13/23 a review of an "Initial Allegation Report" for an allegation of abuse involving Resident #71 signed by the Administrator on 10/12/23 and provided by the Director of Operational Support revealed the attached "Transaction Report" was submitted to the State Survey Agency on 10/12/23 at 7:25 PM. In an interview on 10/13/23 at 10:35 AM the Director of Operational Support stated the facility submitted the initial report to the State Survey Agency on 10/12/23. She stated she recognized that this report was late.	F 609		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 641	Continued From page 56	F 641		

by:
Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 37 residents reviewed for MDS accuracy (Residents #390 and Resident #30).

Findings included:

1. Resident #390 was admitted to the facility on 8/7/2023, and diagnoses included end stage renal disease. Resident #390 was discharged from the facility to a hospital on 8/21/2023 and re-admitted to the facility on 8/25/2023.

Physician orders dated 8/25/2023 included Resident #390 receiving dialysis on Tuesday, Thursday and Saturday at 12:30 p.m. at a local dialysis center.

The 5-day Minimal Data Set (MDS) assessment dated 8/28/2023 indicated Resident #390 was moderately cognitively impaired and diagnoses included renal insufficiency and end stage renal disease. The MDS indicated Resident #390 received dialysis while not a resident in the facility and was not coded that Resident #390 received dialysis while a resident.

Resident #390's care plan dated 9/5/2023 included a focus for end stage renal disease and indicated Resident #390 required dialysis. Interventions included the facility providing and coordinating transportation to the dialysis center.

In a phone interview with the Dialysis Center Administrator on 10/11/2023 at 11:54 a.m., she stated Resident #390 reported to the dialysis center and received dialysis on Saturday,

1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
MDS assessment for Resident #390 ARD 8/28/2023 and ARD 9/07/2023 were modified on 10/12/2023 to reflect receiving dialysis while a resident in Section O.
MDS assessment for Resident #30 ARD 10/03/2023 were modified on 10/16/2023 to reflect a diagnosis of depression in Section I.

2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
MDS Coordinator will review all active residents with dialysis treatment while a resident for accurate coding in Section O of the MDS assessments for the previous six months. This was completed on 10/10/23.
MDS Coordinator will review all active residents with depression as a diagnosis for accurate coding in Section I of the MDS assessments for the previous six months. This was completed on 11/10/23

3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
MDS Coordinator was educated on accurate coding of section O of the MDS assessment for dialysis while a resident by the MDS Consultant on 10/12/23.
MDS Coordinator was educated on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 641	Continued From page 57 8/26/2023. In an interview with Resident #390 on 10/11/2023 at 1:40 p.m., he stated he received dialysis on Saturday, 8/26/2023, the day after he was re-admitted to the facility from the hospital. Resident #390 stated he had not missed any dialysis appointments since he was admitted to the facility. In an interview with MDS Nurse #1 on 10/10/2023 at 4:12 p.m., she explained Resident #390 had to receive dialysis within the 5-day look back period for the MDS dated 8/28/2023 to be coded receiving dialysis while a resident. She said when completing the MDS assessment, there was no nursing documentation of Resident #390 receiving dialysis while a resident at the facility in the 5-day look back period. She explained she could not code for dialysis while a resident based on physician orders, and she had no proof Resident #390 received dialysis since re-admitted on 8/25/2023. In a follow up interview on 10/13/2023 at 11:42 a.m., MDS Nurse #1 stated since the interview on 10/10/2023, the dialysis center had confirmed Resident #390 received dialysis on Saturday, 8/26/2023 and the MDS dated 8/28/2023 had been modified to reflect Resident #390 received dialysis while a resident. She said she had attempted to call the dialysis center prior to completing the 5-day MDS dated 8/28/2023, and no one answered or called back to clarify if dialysis was received on Saturday 8/26/2023. In an interview with Corporate MDS Consultant on 10/13/2023 at 12:21 p.m., she explained there must be proof of dialysis occurred to code on the MDS assessment. She stated MDS Nurse #1	F 641	accurate coding of section I of the MDS assessment for depression diagnosis by the MDS Consultant on 10/12/23. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will audit MDS assessments for resident receiving dialysis, and those residents with a depression diagnosis, while a resident for accurate coding each week x 4 weeks, then every other week x 2 weeks, then each month x 2 months. The Director of Nursing will present these findingsto monthly QAPI to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 58	F 641		

exalted all efforts for evidence Resident #390 received dialysis on 8/26/2023 in the 5-day look back period for the MDS assessment dated 8/28/2023. She reported the dialysis center didn't like to release their medical records, and the MDs assessment dated 8/28/2023 was modified after she contacted the dialysis center on 10/12/2023 and received a faxed copy of the dates Resident #390 had received dialysis at the dialysis center.

In an interview with the Administrator on 10/18/2023 at 4:41 p.m., she explained information on Resident #390 receiving dialysis would be shared at the interdisciplinary morning meetings. She stated Resident #390's MDS should be accurate and sometimes it's a human oversite why the MDS was not accurate.

2. Resident #30 was admitted to the facility on 4/06/2022, and diagnoses included depression.

Physician orders dated 9/26/2023 included Duloxetine (a medication used to treat depression) 60 milligrams (mg) daily and Trazodone (a medication used to treat major depressive disorders) 50 mg at bedtime daily for depression.

The September 2023 Medication Administration Record (MAR) indicated Resident #30 received Duloxetine 60 mg on 9/27/2023, 9/29/2023 and 9/30/2023 and Trazadone 50mg on 9/28/2023, 9/29/2023 and 9/30/2023. The October 2023 MAR indicated Resident #30 received Duloxetine 60mg and Trazodone 50 mg daily as ordered.

The quarterly Minimal Data Set (MDS) assessment dated 10/3/2023 indicated Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 59 #30 was moderately cognitively impaired and received antidepressant medication (medication used to treat or prevent clinical depression). Depression was not coded as a diagnosis on the MDS assessment. In an interview with MDS Nurse #1 on 10/13/2023 at 11:55 a.m., she stated Resident #30 had a diagnosis of depression and was receiving antidepressant medications. She explained depression should have been marked on the MDS assessment as a diagnosis, and she missed marking the box. In an interview with Corporate MDS Consultant on 10/13/2023 at 12:21 p.m., she explained Resident #30 had a history of depression and had received antidepressants in the 7-day look back period. She stated depression on the MDS should have been coded. In an interview with the Administrator on 10/18/2023 at 4:41 p.m., she stated Resident #30's MDS should be accurate, and sometimes it's a human oversite why the MDS was not accurate.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 655	Continued From page 60 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, interview with a Resident Representative and record reviews, the facility failed to develop a baseline care plan within 48 hours of a resident's	F 655	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 655	Continued From page 61 admission and failed to provide a written summary of the baseline care plan to the Resident or Resident Representative for 4 of 28 sampled residents (Residents #29, #77, #388 and #89). Findings included: 1. Resident #29 was admitted to the facility on 4/10/23 with diagnoses that included, in part, diabetes and congestive heart failure. The admission Minimum Data Set (MDS) assessment dated 4/15/23 revealed Resident #29 was cognitively intact. Resident #29's medical record was reviewed and revealed no evidence a baseline care plan had been completed after the resident's admission. During an interview with Resident #29 on 10/10/23 at 2:08 PM, she said she could not remember if the facility offered her a written summary of the baseline care plan. On 10/10/23 at 9:38 AM an interview was conducted with MDS Nurse #1. She explained the admitting nurse on the hall completed the baseline care plan when a resident was admitted to the facility. The baseline care plan was then reviewed with the resident or Resident Representative during the 72 hour meeting. A telephone interview was conducted with Nurse #16 on 10/13/23 at 10:07 AM. She was an agency nurse who cared for Resident #29 on the day she was admitted to the facility. She was unable to specifically recall Resident #29's admission but shared she followed the facility's	F 655	Resident #29 & #77's resident representative received a copy of the Baseline care plan on by the Social Woker 11/9/23 Resident #388 and Resident #89 are no longer active Residents. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Interdisciplinary Team (including Social Worker, director of nursing, activities, dietary, director of rehabilitation and business office manager) will complete an audit of new admissions for the past 30 days, to ensure that all Resident admissions have a completed baseline care plan within 48 hours of admission and presentation of baseline care plan to Resident or Resident Representative. This will be completed by 11/13/23. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Interdisciplinary Team was educated on Survey tag F655, Baseline Care Plan by the facility Administrator on 11/9/2023. At the time of admission, the admitting nurse will begin the baseline care plan. The baseline care plan will be completed within 48 hours. The baseline care plan will be reviewed by the Interdisciplinary Team during the morning meeting. After review of the baseline care plan by the Interdisciplinary Team, it will be reviewed, and written summary given to the resident or resident representative by the Social	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 655	Continued From page 62 admission paperwork protocol when a new resident came to the facility. She did not remember if a baseline care plan was included in the admission paperwork that she completed for Resident #29. In interviews with the Director of Nursing (DON) and Regional Nurse Consultant on 10/10/23 at 10:03 AM and 10/12/23 at 11:45 AM, the Regional Nurse Consultant stated the baseline care plan was completed within 48 hours of a resident's admission to the facility. She added the baseline care plan information was then reviewed with the resident or Resident Representative during the 72 hour meeting and a copy offered to the resident or Resident Representative. She further explained there had been some staffing turnover and the facility had not consistently completed baseline care plans within 48 hours of a resident's admission. 2. Resident #77 was admitted to the facility on 11/3/22 with a diagnosis that included, in part, dementia. The admission Minimum Data Set (MDS) assessment dated 11/8/22 revealed Resident #77 had severely impaired cognition. Resident #77's medical record was reviewed and indicated a family member was listed as a Resident Representative. The medical record demonstrated a baseline care plan was completed on 11/3/22 and was signed by members of the interdisciplinary team. The baseline care plan included a section titled, "Date reviewed with resident/representative," which was blank. Further review of the medical record	F 655	Services Director. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Baseline care plans will be reviewed by the Interdisciplinary team daily in morning clinical meeting 5 times a week for 4 weeks, then weekly times 3 months, then quarterly. The Social Service Director will complete a summary of the audit results and present these findings to monthly QAPI to ensure continued compliance.	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 655	Continued From page 63	F 655		

revealed no documented evidence that a summary of the baseline care plan was given to Resident #77's representative.

During a telephone interview with Resident #77's representative on 10/12/23 at 11:22 AM, she said the facility had not provided her with a written summary of the baseline care plan or given her a list of medications or goals for Resident #77 after she was admitted to the facility.

On 10/10/23 at 9:38 AM an interview was conducted with MDS Nurse #1. She explained the nurse on the hall completed the baseline care plan when a resident was admitted to the facility. The baseline care plan was then reviewed with the resident or Resident Representative during the 72 hour meeting.

Attempts to interview the Former Social Worker by telephone were unsuccessful.

In interviews with the Director of Nursing (DON) and Regional Nurse Consultant on 10/10/23 at 10:03 AM and 10/12/23 at 11:45 AM, the Regional Nurse Consultant stated the baseline care plan was completed within 48 hours of a resident's admission to the facility. She added the baseline care plan information was then reviewed with the resident or Resident Representative during the 72 hour meeting and a copy offered to the resident or Resident Representative. She further explained there had been some staffing turnover and the facility had not consistently completed baseline care plans within 48 hours of a resident's admission. The Regional Nurse Consultant added she did not know why a summary of the baseline care plan was not offered or provided to Resident #77's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 655	Continued From page 64	F 655		

representative.

3. Resident #388 was admitted to the facility on 10/2/2023, and diagnoses included diabetes mellitus.

Nursing documentation dated 10/3/2023 by Nurse #17 reported Resident #388 was using oxygen at two liter per minute, had a left above the knee amputation and used a walker for mobility.

A review of Resident #388's baseline care plan dated 10/9/2023 at 4:57 p.m. completed by Nurse #17 included the following information: Resident #388 was on a diabetic diet, physical and occupational therapy was needed, Resident #388 used of a wheelchair and needed assistance with transfers, toileting and bathing.

In an interview with the Minimum Data Set (MDS) Nurse #1 on 10/13/2023 at 11:42 a.m., she stated nursing staff were responsible for completing Resident #388's baseline care plan on admission.

In an interview with MDS Nurse #2 on 10/13/2023 at 11:52 a.m., she stated Resident #388's baseline care plan was completed four days ago on 10/9/2023.

In an interview with Nurse #17 on 10/13/2023 at 1:00 p.m., she explained she served as a nurse manager and admitted Resident #388 on 10/2/2023 to the facility at the end of her shift. She stated she was responsible for checking baseline care plans were completed daily for new admissions and missed Resident #388 having a baseline care plan. She said she completed Resident #388's baseline care plan on 10/9/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 65	F 655		

when she discovered Resident #388 did not have a baseline care plan.

In an interview with the Director of Nursing on 10/13/2023 at 12:57 p.m., she stated the unit manager or admitting nurse were responsible for completing the baseline care plan within twenty-hours of Resident #388's admission, and the baseline care plan dated 10/9/2023 was completed late.

In an interview with the Administrator and Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., they stated they thought the facility had a system of monitoring completion of baseline care plan. They explained baseline care plans were a component of the admission checklist reviewed by nurse managers, and all components including the baseline care plan were to be completed when discussed at the interdisciplinary team meeting.

4) Resident #89 was admitted to the facility on 3/17/23 and discharged home on 3/22/23. Her diagnoses included pneumonia due to COVID-19, hypertension, and muscle weakness.

Resident #89's medical record revealed no baseline care plan.

An interview occurred with the Minimum Data Set (MDS) Nurse #1 on 10/10/23 at 9:38 AM, who explained the admitting nurse initiated the baseline care plan.

The Director of Nursing (DON) was interviewed on 10/10/23 at 10:03 AM and explained the admitting nurse completed the baseline care plan and was aware that one was required within 48

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 655	Continued From page 66 hours of admission. The DON stated there had been some staff turnover which may have contributed to the deficient practice. On 10/11/23 at 9:55 AM, the Regional Nurse Consultant stated she was unable to locate a baseline care plan for Resident #89 and that the admitting nurse generated the baseline care plan. On 10/12/23 at 1:28 PM, a phone message was left for Resident #89's admitting Nurse #1. A return call was not received during the time of the survey.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 656	Continued From page 67 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to develop a comprehensive care plan which addressed wandering behavior and the use of a wander/elopement alarm for 1 of 33 residents (Resident #71) whose comprehensive care plans were reviewed. Findings included: Resident #71 was admitted to the facility on 4/22/22 with diagnoses including dementia, generalized muscle weakness and unsteadiness on feet.	F 656	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Comprehensive Care Plan for Resident #71 was updated to reflect wandering behavior, including the use of wanderguard on 10/12/23 by the MDS Coordinator. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: MDS Coordinator reviewed current resident medical records for presence of	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 656	Continued From page 68 A review of an Elopement Risk Tool for Resident #71 dated 7/15/23 completed by the Director of Nursing (DON) revealed Resident #71 was found to be at risk for elopement. It further revealed her wandering behavior affected her safety and well-being. A review of the physician's orders for Resident #71 revealed an order dated 7/15/23 for a wander guard (a type of elopement alarm) to be placed to her right ankle. A nursing progress note dated 7/27/23 at 7:58 AM written by Nurse #2 revealed in part Resident #71 was reported missing around 9:00 PM to 11:00 PM (7/26/23). All open doors were searched multiple times including outside in the courtyard and around the facility and she was not found. Management and law enforcement were notified, and law enforcement came to the facility. Resident #71's family was notified. Resident #71 was found in the MDS (Minimum Data Set) office in the dark seated on the "sofa" facing the door. A review of Resident #71's quarterly Minimum Data Set (MDS) assessment dated 7/28/23 revealed she was severely cognitively impaired. She did not exhibit wandering behavior. Resident #71 used a wander/elopement alarm daily. A review of Resident #71's care plan revealed it was last reviewed on 8/23/23. There was no care plan focus area for wandering or the use of a wander/elopement alarm. A review of the Medication Administration Records for Resident #71 from 7/16/23 through 10/13/23 revealed documentation Resident #71's wander guard was in place and checked by staff	F 656	wandering behavior. If wandering behavior was identified a new care plan was updated with appropriate intervention, including wander guards (if applicable), in the facility on 10/10/23. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: MDS Coordinators were educated by MDS Consultant on 10/12/23 for care planning of wandering behavior and intervention of wander guards, if applicable. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: MDS Coordinator will audit care plans for residents with wander guards for presence of wanderguard care plans for the previous six months. This will be completed on 10/12/23. MDS Coordinator will audit care plans for Residents with wander guards for presence of wanderguard care plans each week x 4 weeks, then every other week x 2 weeks, then each month x 2 months. Audit will be reviewed in monthly QAPI meeting by IDT (Interdisciplinary Team).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 69	F 656		

each shift.

On 10/10/23 at 11:19 AM a telephone interview with Nurse #2 indicated she was familiar with Resident #71. She stated Resident #71 often self-propelled herself round in the facility by wheelchair. In a follow-up interview on 10/18/23 at 4:11 PM Nurse #2 stated Resident #71 wore a wander guard. She went on to say she assessed this device during each shift she worked to make sure it was on Resident #71 and functioning.

On 10/10/23 at 5:28 PM Resident #71 was observed up in her wheelchair. A wander guard was observed in place on her right ankle.

On 10/10/23 at 8:36 PM a telephone interview with Nurse #7 indicated she was very familiar with Resident #71. She stated Resident #71 liked to self-propel herself around the facility in her wheelchair and so everyone kept an eye on her for safety. Nurse #7 reported on 7/26/23 around 8:30 PM she saw Resident #71 near the nurse's station. She stated at that time she told Resident #71 to head back towards her hall which she usually did when you told her to. She stated around 9:00 PM that night NA #4 came to her and told her they had been looking for Resident #71 and could not find her. Nurse #7 went on to say she had become very concerned and immediately got all the staff together to begin looking for Resident #71. She stated Resident #71 was not steady enough to transfer herself without falling. She went on to say Resident #71 had a wander guard and there were no alarms going off so everyone really felt she must still be in the building.

On 10/12/23 at 11:23 AM an interview with MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 70 Nurse #1 indicated she did not see a care plan focus area for wandering or the use of a wander/elopement alarm on Resident #71's care plan. She stated she completed the section of Resident #71's MDS assessment dated 7/28/23 which documented Resident #71's use of a wander/elopement alarm daily. She went on to say she would have been responsible for including Resident #71's wandering and the use of a wander/elopement alarm in her care plan. MDS Nurse #1 stated she did not know how this had gotten missed. She stated she normally put this in the care plan when the physician's order was entered. On 10/12/23 at 11:37 AM an interview with the Director of Nursing (DON) indicated Resident #71's wandering behavior and the use of a wander/elopement alarm were things that should have been included in Resident #71's care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 71 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure an interdisciplinary team reviewed and revised a resident's comprehensive care plan and failed to ensure the resident's representative was involved in care planning after a quarterly Minimum Data Set (MDS) assessment for 1 of 33 residents (Resident #71) whose care plans were reviewed. Findings included: Resident #71 was admitted to the facility on 4/22/22 with diagnoses including dementia, generalized muscle weakness and unsteadiness on feet. A review of a progress note for Resident #71 dated 5/4/23 2:11 PM written by the Social Worker (SW) revealed the SW mailed an invitation to Resident #71's care conference to Resident #71's representative. A review of Resident #71's care plan revealed the following focus areas and their last reviewed dates: discharge, 5/27/23; activity, 8/23/23; falls,	F 657	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Care plan meeting for Resident #71 was held on 10/12/23, with the resident representative and facility social worker. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: MDS Coordinator will audit care plan meetings for current residents to identify those residents not having a care plan meeting at least once every ninety-two days. Those identified as not having a timely meeting will have a meeting scheduled. The schedule will be completed by 11/13/23. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Resident care plans will be revised quartely and with any significant change of status. A monthly calendar will be	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 657	Continued From page 72 11/14/22; respiratory, 11/14/22; pain, 11/14/22; nutrition, 11/12/22; communication, 11/14/22; cognition, 11/14/22; advanced directives, 11/14/22; and blood pressure, 11/14/22. A review of Resident #71's quarterly Minimum Data Set (MDS) assessment dated 7/28/23 revealed she was severely cognitively impaired. On 10/10/23 a review of Resident #71's record revealed her last documented care conference was on 5/23/23. On 10/12/23 at 11:02 AM an interview with the SW indicated Resident #71's representative was hard to get by phone. He went on to say he was responsible for scheduling care conferences, notifying the interdisciplinary team of the conference so they could participate, and inviting residents and/or their representatives to the meetings. He stated the last time he mailed an invitation to Resident #71's representative was for Resident #71's care conference that was held on 5/23/23. The SW went on to say he had not mailed another invitation to Resident #71's representative since then. He further indicated he kept copies of all the invitations he sent out. The SW stated care conferences were supposed to be held at least every 3 months. He went on to say because Resident #71's last care conference was on 5/23/23 she would have next been due for a care conference in August 2023. The SW further indicated because Resident #71's last quarterly MDS assessment was completed on 7/28/23, and this was not 3 months since her last care conference, she was not due for another care conference at that time. He stated Resident #71 would next be due for a care conference in October 2023, as this was 3 months after her	F 657	developed by the MDS Coordinator of all assessments due each month. The social worker will send letter of invitation to the resident representative and or resident of scheduled care plan meeting. IDT was educated on scheduling care plan meetings at least every 3 months by Regional Nurse Consultant on 11/6/23. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: MDS Coordinator will audit Resident care plan meetings each week x 4 weeks, then every other week x 2 weeks, then each month x 2 months. Audit will be reviewed in monthly QAPI meeting by IDT.	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 657	Continued From page 73 MDS assessment on 7/28/23. The SW went on to say he was getting ready to send out the invitation for this. He further indicated if Resident #71 had an MDS assessment in August 2023, he would have set-up a care conference for her then. The SW stated this was how he had always done things, and no one had ever questioned him about it before. Multiple attempts were made to contact Resident #71's representative for a telephone interview. These were not successful. On 10/12/23 at 11:23 AM an interview with MDS Nurse #1 indicated the SW was responsible for scheduling care conferences with the interdisciplinary team and sending invitations to residents and/or their representatives. She stated resident care conferences were supposed to be held at least every 3 months regardless of the timing of the MDS assessment. On 10/12/23 at 11:57 AM an interview with the Director of Nursing (DON) indicated resident's care conferences were supposed be held at least every 3 months. She stated these conferences should include members of the interdisciplinary team and the resident, and/or their representative.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		11/13/23

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 677	Continued From page 74 Based on record review and staff and family interviews the facility failed to change a resident's soiled brief due to meal trays being passed on the halls for 1 of 8 resident reviewed for activities of daily living care (Resident #53). Findings included: Resident #53 was admitted to the facility on 11/29/22. Review of Resident #53's most recent Minimum Data Set assessment dated 7/10/23 revealed he was assessed as severely cognitively impaired. He had no moods or behaviors. He was totally dependent on staff for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. He had an indwelling urinary catheter and was always incontinent of bowel. His active diagnoses included anemia, coronary artery disease, heart failure, hypertension, peripheral vascular disease, obstructive uropathy, and diabetes mellitus. Review of Resident #53's care plan dated 9/28/23 revealed he was care planned to require assistance for eating, mobility, transfers, dressing, grooming, toileting and bathing related to cerebrovascular accident and contractures in both elbows. The interventions included to refer to Physical Therapy for evaluation and treatment, refer to Occupational Therapy for evaluation, use a mechanical lift for all transfers, encourage good oral care, keep call light within arm's length and teach how to use call light to request assistance, shower or bath twice a week and as needed, catheter care every shift, and provide nail care as needed and oral care daily. Review of Resident #53's progress notes	F 677	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 9/29/23 resident #53 was provided incontinence care by nursing assistant (NA) #6. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/12/23, observation rounds were initiated during mealtimes of cognitively impaired incontinent residents to ensure briefs are being changed timely and they were not being left soiled by the clinical administrative team. No additional concerns were identified. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A 100% inservice was initiated by the Staff Development Coordinator (SDC) on 11/7/23 with all licensed nurses, med aides and nursing assistants which included agency clinical personnel on providing incontinence care when rising/awaking, upon request even during mealtime and assisting one another with 2-person assistance residents. Effective 11/12/23, any facility or agency clinical staff that has not been educated will not be allowed to work until education is received in- person or via telephone by Director of Nursing or designee. All newly hired nursing staff or clinical agency personnel will receive education during the orientation process by the Staff Development Coordinator (SDC) and/or	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 677	Continued From page 75 revealed there were no notes about Resident #53's activities of daily living care on 9/29/23. During an interview on 10/9/23 at 12:49 PM Resident #53's family member stated on 9/29/23 she came to the facility around 9:30 AM and found Resident #53 in a soiled brief did and he did not appear to have been checked on and cleaned that morning prior to her getting to the facility and finding NA #6 and asking them to change the resident. During an interview on 10/10/23 at 1:41 PM NA #6 stated she remembered in September 2023 she once was Resident #53's nurse aide during 1st shift. She stated she checked him when she started her shift around 7:30 AM and he needed his brief changed at that time because it was soiled with stool. She further stated Resident #53 needed two-person assistance. She stated at that time she was unable to find someone to assist her with his brief change, so she provided the needed activities of daily living care to her dependent residents who required only one person assistance. She stated he did not get a breakfast tray due to having tube feeding but other staff were assisting with meal pass and she was unable to find someone to help her as nurse aides had to finish passing trays before they could then stop and change the residents. She stated around 9:30 AM Resident #53's family members approached her and indicated Resident #53 needed to be changed. She stated she was going to get to it and Resident #53's family reminded her to find another nurse aide to complete his brief change after breakfast trays were passed. She again reiterated that staff could not stop and change a resident's brief during tray pass.	F 677	administrative nurse on providing residents ADL care. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing and/or administrative nurse will conduct random observation audits of 10 residents during mealtimes who are incontinent weekly for 4 weeks then monthly for 3 months and quarterly thereafter to ensure compliance. The Director of Nursing will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 677	Continued From page 76 During an interview 10/10/23 at 2:12 PM Nurse #15 stated nurse aide staff were not allowed to stop passing trays during mealtimes to change a resident's brief. She further stated she may have been notified by the nurse aide that she was behind in completing Resident #53's morning care but could not remember. During an interview on 10/10/23 at 3:06 PM NA #7 stated if a resident needed to have their brief changed and meal trays were being passed, the nurse aides were to complete passing meal trays first and then return and complete a brief change. During an interview on 10/10/23 at 3:15 PM NA #8 stated if a resident needed their brief to be changed during meal pass, she would have to finish passing trays to prevent cross contamination. She concluded she would of course let the resident know she needed to finish passing trays and then would return to provide incontinent care. During an interview on 10/11/23 at 9:20 AM the Director of Nursing stated staff should stop passing trays and provide activities of daily living care including changing resident's briefs instead of making the resident wait until after tray pass.	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		11/13/23

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 686	Continued From page 77 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and Physician interviews, the facility failed to follow physician orders for pressure ulcer dressing changes, compete wound care as ordered, and set an alternating pressure mattress according to the resident's weight. This occurred for 3 of 3 residents (Resident #1, Resident #81, and Resident #32) reviewed for wound care. Findings included: 1. Resident #1 was admitted to the facility on 3-30-23 with multiple diagnoses that included paraplegia, stage 4 pressure ulcer to right buttocks, stage 4 pressure ulcer to left buttocks, stage 4, pressure ulcer to left lower back. The quarterly Minimum Data Set (MDS) dated 8-31-23 revealed Resident #1 was cognitively intact and did not exhibit any behaviors. The MDS also documented Resident #1's pressure ulcers. Physician order dated 9-14-23 read clean stage 4 wound to right buttocks with wound cleanser, apply silver alginate, and cover with a foam dressing daily. Physician order dated 9-14-23 read clean stage 4 wound to left buttocks with wound cleanser, apply	F 686	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #1, #32 and #81 were reassessed by DON and Attending Physician on 10/12/23, no negative outcomes noted. No new orders were provided by the attending Physician. Nurses #4 will be educated by 11/13 /23 by the Staff Development Coordinator, on signing TAR after completion of treatment, and following physician orders for treatment. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of Treatment Administration Records (TAR)s was completed to ensure all treatment orders on the TARs are signed off by the Licensed Nurses for the month of October by Director of Nursing (DON) and administrative nurses on 11/1/23. Any other identified missing documentation was reviewed by the DON and the resident's attending physician to continue current treatments orders.	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 78 silver alginate, and cover with a foam dressing daily. Physician order dated 9-14-23 read clean wound to lower back with wound cleanser, apply silver alginate, and cover with a foam dressing daily. A review of Resident #1's Treatment Administration Record (TAR) for September and October 2023 revealed Resident #1 did not have documentation of his wound care being completed on the following days. - September: 16, 17, 23, 24 - October: 7, 8 A review of Resident #1's wound measurements for September and October 2023 regarding his right buttocks, left buttocks, and lower back revealed no deterioration. Resident #1 was interviewed on 10-9-23 at 12:15pm. The resident discussed not receiving wound care on the weekends. Resident #1 stated his wound care was to be completed daily. Resident #1's care plan dated 10-10-23 revealed goals and interventions for his pressure ulcers to include providing treatments as ordered. An observation of Resident #1's wound care occurred on 10-11-23 at 11:05am with Nurse #4. The pressure ulcer to Resident #1's right buttock was observed to be bright red with moderate drainage. No signs or symptoms of infection. Resident #1's left buttocks pressure ulcer tunneled, bleeding and a slight odor and the wound to the lower back had no redness and minimal drainage with no odor. There were no signs or symptoms of infection observed.	F 686	3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 11/7/23, education was initiated with current licensed nursing staff including agency, regarding completion and signing of treatment orders and following the physician treatment orders by the DON or designee. The education will be completed by 11/13/23. Any facility or agency licensed nurse that has not received this education by 11/13/23, will not be allowed to work until education is completed in person or via telephone by the Director of Nursing and/or administrative nurse. All newly hired licensed nursing staff or clinical agency personnel will receive education during the orientation process by the Staff Development Coordinator (SDC) and/or administrative nurses on providing wound treatment care per the physician order and signing the TAR. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing (DON) and/or administrative nurses will audit TARs weekly x 2 months, then monthly for 3 months and quarterly thereafter to ensure compliance. A summary of these audits will be completed by the Director of Nursing and presented at the facility monthly QAPI meeting to ensure continued compliance.	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 686	Continued From page 79	F 686		

Nurse #4 was interviewed on 10-11-23 at 11:39am. Nurse #4 explained she was the designated wound care nurse Monday through Friday. She stated the floor nurses were responsible for completing wound care on Resident #1 on the weekends.

A telephone interview occurred with Nurse #11 on 10-11-23 at 12:45pm. Nurse #11 confirmed she had been assigned to Resident #1 on 9-17-23. She discussed not performing wound care on Resident #1 on 9-17-23 because she stated, "I was unaware he needed wound care completed." Nurse #11 said she was aware she was responsible for resident wound care on the weekends but was unaware of Resident #1's wounds.

During an interview with Nurse #12 on 10-11-23 at 1:47pm, the nurse confirmed she had been assigned to Resident #1 on 9-23-23, 9-24-23, 10-7-23, and 10-8-23. Nurse #12 explained the only day she had not performed wound care was 10-8-23 for Resident #1. She stated she had fallen behind in her assignment and did not have time to perform the needed wound care. Nurse #12 also said she had not informed the on-coming shift that the wound care had not been completed.

Attempts were made to contact the other nurses but were unsuccessful.

The facility's wound care Physician was interviewed on 10-12-23 at 11:17am. The Physician discussed Resident #1's wounds as chronic and stated the resident had entered the facility with the wounds. He said Resident #1's wounds were getting better each week but had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 686	Continued From page 80	F 686		

not been progressing as well as he would like to see. The wound care Physician discussed being unaware that the wound care was not being completed on the weekends consistently and explained there was a possibility of wound deterioration if the wound care orders were not followed. He stated he expected staff to follow his orders and complete Resident #1's wound care daily.

The Director of Nursing was interviewed on 10-12-23 at 3:51pm. The DON stated she was not aware of Resident #1's wound care not being completed on the weekends. She said she expected staff to follow Physician orders and complete wound care as ordered.

2. Resident #81 was admitted to the facility on 5-5-23 with multiple diagnoses that included stage 4 pressure ulcer to the sacrum, stage 4 pressure ulcer to left heel, stage 4 pressure ulcer to right heel, stage 4 pressure ulcer to right lateral foot, and stage 3 pressure ulcer to left shin.

The quarterly Minimum Data Set (MDS) dated 8-29-23 revealed Resident #81 was cognitively intact with no rejection of care. The MDS also documented Resident #81's pressure ulcers.

Resident #81 did not have any goals or interventions for his pressure ulcers.

The Physician order dated 9-7-23 read clean pressure wound to right lateral foot with wound cleanser, apply silver alginate and cover with a foam dressing daily.

Physician order dated 9-7-23 read clean left lateral shin with wound cleanser, apply Santyl,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 81	F 686		

silver alginate, and cover with a foam dressing daily.

The Physician order dated 9-21-23 read clean stage4 wound to left heel with wound cleanser, apply silver alginate, and cover with a foam dressing daily.
Physician order dated 9-21-23 read clean sacral wound with Dakin's, apply silver alginate, and cover with a foam dressing daily.

Physician order dated 9-22-23 read clean stage 4 wound to right heel with Dakin's, apply silver alginate, cover, and wrap with gauze daily.

Resident #81's Treatment Administration Record (TAR) for September and October 2023 revealed there was no documentation that wound care was completed on the following days.
- September: 9, 10, 16, 17
- October: 7, 8

Review of Resident #81's wound measurements for September and October 2023 revealed there was no deterioration in his wounds.

Resident #81 was interviewed on 10-9-23 at 12:36pm. The resident discussed not receiving his daily wound care over the weekend (10-7-23, 10-8-23). The resident voiced concern that his wounds may become infected if his wound care was not completed.

Observation of Resident #81's wound care occurred on 10-10-23 at 10:39am with Nurse #4. The right heel wound was observed to have eschar with no open areas. No drainage observed or signs and symptoms of infection. The lateral foot wound had minimal drainage, no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 82	F 686		

bleeding and the skin was red. There were no signs or symptoms of infection. The left heel wound was observed to be closed with the surrounding tissue within normal limits. Resident #81's left shin wound was observed to be beefy red with surrounding pink tissue surrounding it. There was slight drainage with no signs or symptoms of infection. The sacral wound was observed to have heavy drainage with tunneling. There were no signs or symptoms of infection.

Nurse #4 was interviewed on 10-10-23 at 11:57am. The nurse confirmed Resident #81's wound care was to be completed daily. She stated she worked Monday through Friday and that the floor nurses were responsible for Resident #81's wound care on the weekends.

During a telephone interview with Nurse #11 on 10-11-23 at 12:45pm, Nurse #11 confirmed she had been assigned to Resident #81 on 9-17-23. She stated she was aware Resident #81 had wounds and that she had changed his sacral dressing due to the dressing being soiled but had not performed wound care per the Physician orders. Nurse #11 said she was aware she was to perform wound care on Resident #81 on the weekends but stated "I just did not do it."

An interview with Nurse #12 occurred on 10-11-23 at 1:47pm. The nurse confirmed she had been assigned to Resident #81 on 9-9-23, 9-10-23, 10-7-23, and 10-8-23. Nurse #12 stated the only day she had not performed wound care on Resident #81 was 10-8-23. She stated she had fallen behind in her assignment and did not have time to perform the needed wound care. Nurse #12 also said she had not informed the on-coming shift that the wound care had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 686	Continued From page 83	F 686		

completed.

The Director of Nursing (DON) was interviewed on 10-11-23 at 4:44pm. The DON discussed not being aware of Resident #81 not receiving wound care on the weekends. She stated she expected staff to complete wound care as ordered.

The facility's wound care Physician was interviewed on 10-12-23 at 11:24am. The wound care Physician discussed Resident #81 being motivated to have his wounds healed and stated the resident's wounds have improved each week. He stated he was not aware wound care was not being completed on the weekends and said there was a possibility for Resident #81's wounds to deteriorate if the wound care was not being completed daily as ordered. The wound care Physician stated he expected staff to complete wound care as he had ordered.

3) Resident #32 was admitted to the facility on 8/30/23 with diagnoses that included osteomyelitis (inflammation or swelling that occurs in the bone) of the vertebra/sacral region and diabetes type 2.

An admission Minimum Data Set (MDS) assessment dated 9/1/23 indicated Resident #32 was cognitively intact and was coded with one stage 4 pressure ulcer and one unstageable pressure ulcer. A pressure reducing device was coded for the bed.

a) A review of Resident #32's active care plan, dated 9/7/23, included a focus area for the resident having an unstageable pressure ulcer to the right buttock and a stage 4 to the left buttock that were both present on admission. One of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 686	Continued From page 84	F 686		

interventions included wound care as ordered.

A review of Resident #32's September 2023 and October 2023 active physician orders included the following orders for wound care:
- Cleanse left ischium with wound cleanser. Pat dry. Apply silver alginate to wound bed and cover with foam dressing daily.
- Cleanse right buttock with wound cleanser. Pat dry. Apply silver alginate to wound bed and cover with foam dressing daily.
- Apply betadine to left heel blister daily.

A review of the September 2023 Treatment Administration Record (TAR) revealed wound care had not been signed off as completed on 9/24/23.

A review of the October 2023 TAR revealed wound care had not been signed off as completed on 10/8/23.

A phone interview occurred with Nurse #6 on 10/11/23 at 1:40 PM. She was assigned to care for Resident #32 on 10/8/23 (Sunday) from 7:00 AM to 7:00 PM and explained that on the weekends the 7:00 AM to 7:00 PM floor nurses were responsible for wound care. She stated she went to do wound care for Resident #32 on 10/8/23 but he asked if she could come back later. She became busy with an emergency and did not make it back to perform wound care for Resident #32.

An interview was completed with the Wound Physician on 10/12/23 at 10:25 AM and stated he was unaware Resident #32 did not receive wound care on 9/24/23 or 10/8/23 but would expect it to be completed daily as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 686	Continued From page 85	F 686		

On 10/12/23 at 11:31 AM, a phone interview was completed with Nurse #7 who was assigned to care for Resident #32 on 9/24/23 (Sunday) from 7:00 AM to 7:00 PM. She stated she could not recall completing wound care for Resident #32 on that day.

The Director of Nursing was interviewed on 10/12/23 at 3:15 PM and stated she would expect wound care to be completed as ordered for Resident #32.

b) A review of Resident #32's active physician orders included an order dated 8/31/23 to cleanse the right buttock with wound cleanser. Pat dry. Apply silver alginate (an antimicrobial dressing) to the wound bed. Cover with a foam dressing and change daily.

A review of Resident #32's active care plan, dated 9/7/23, included a focus area for the resident having an unstageable pressure ulcer to the right buttock and a stage 4 to the left buttock that were both present on admission. One of the interventions included wound care as ordered.

An initial Wound Evaluation and Management Summary report from the Wound Physician dated 10/5/23 indicated to change the treatment for the sacrum/right buttock area- to Santyl (a prescription ointment that removes dead tissue from wounds) with alginate calcium covered with a foam dressing daily.

A review of the October 2023 Treatment Administration Record (TAR) included cleanse the right buttock with wound cleanser. Pat dry.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 686	Continued From page 86	F 686		

Apply silver alginate to the wound bed and cover with a foam dressing daily.

A wound care observation occurred on 10/10/23 at 2:07 PM with Resident #32 and Nurse #4. She indicated she was the facility wound care nurse during the weekday. There was an open wound to the sacrum-right buttock area with a pink wound bed. Nurse #4 was observed putting Santyl in the wound bed followed by alginate calcium and a foam dressing.

On 10/10/23 at 3:36 PM, an interview occurred with Nurse #4. She reviewed Resident #32's active physician orders and confirmed that Santyl was not listed to be used on the sacrum/right buttock pressure wound. She explained that Resident #32 had been seen by the Wound Physician on 10/5/23 with changes made to the wound care order but she had not had an opportunity to update the active physician orders or TAR.

The Director of Nursing was interviewed on 10/12/23 at 3:15 PM and stated she would expect the wound care orders to be updated within a day of the changes and for the nurses to follow the active physician orders for wound care.

c) A review of Resident #32's active care plan, dated 9/7/23, included a focus area for the resident having an unstageable pressure ulcer to the right buttock and a stage 4 to the left buttock that were both present on admission. One of the interventions included provide pressure reducing surfaces on the bed and chair.

A review of Resident #32's medical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 686	Continued From page 87	F 686		

revealed from 8/31/23 to 10/13/23 wound care was completed daily to the right buttock and left ischium (the bones that comprise either half of the pelvis).

Resident #32's weight on 10/4/23 was 230.8 pounds (lbs.).

An interview and observation were conducted with Resident #32 on 10/9/23 at 12:10 PM. He was lying in bed watching TV. The alternating pressure mattress reducing machine was set at 660-750 lbs. per weight setting. The machine had settings of 90 lbs., 150 lbs., 220 lbs., 290 lbs., 350 lbs., 420 lbs., 490 lbs., 550 lbs., 620 lbs., and 660-750 lbs. Resident #32 made the comment, "It feels like I'm lying on a bed of rocks".

Resident #32 was observed lying in bed watching TV on 10/10/23 at 10:20 AM. The alternating pressure reducing mattress was set at 660-750 lbs.

On 10/10/23 at 2:07 PM, an observation was made with Nurse #4 of Resident #32's alternating pressure reducing mattress machine, confirming it was set at 660-750 lb. setting. Nurse #4 stated she checked the functionality of the mattress when she was performing wound care daily. She was unsure why the mattress was not set according to the resident's weight as stated on the machine.

The Wound Physician was interviewed on 10/12/23 at 10:25 AM and stated he expected the alternating pressure reducing mattress machine to be set according to the resident's weight as stated on the machine. He added large gaps between the resident's weight and the weight on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 686	Continued From page 88 the machine would not be a useful intervention. On 10/12/23 at 3:15 PM, an interview was held with the Director of Nursing, who stated they expected the alternating pressure reducing mattress machine to be set according to the resident's weight as stated on the machine.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, police dispatch, physician, and responsible party (RP) interviews the facility failed to prevent a severely cognitively impaired resident (Resident #71) with known wandering behaviors and poor safety awareness from becoming trapped alone in a locked administrative staff's office with the lights off without staff's knowledge. The facility also failed to provide evidence that a thorough investigation of the incident was conducted and to put corrective measures in place after the incident to prevent a potential recurrence. This deficient practice had a high likelihood of causing Resident #71 serious physical and psychosocial harm. Resident #71 did not have the cognitive capacity to express an adverse outcome. A reasonable person would have suffered feelings of fear, anxiety, and/or helplessness from the	F 689	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #71 was located in the MDS office on 7/26/23 by the DON and local police. There were no identified injuries. Resident was laughing when the door was opened. Her psychosocial well-being was assessed by the in-house mental health provider, on 8/14/23. The facility social worker completed a trauma informed assessment on 8/9/23. The resident's psychosocial well-being was not affected and is still at baseline. Resident #71 is still a resident at the facility and continues to be at her baseline with no physical or psychological issues	11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 689	Continued From page 89	F 689		

incident. This was for 1 of 11 residents reviewed for the provision of supervision to prevent accidents.

Immediate Jeopardy began on 7/26/23 when Resident #71 became trapped alone in a staff office. Immediate Jeopardy was removed on 10/15/23 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective.

Findings included:

Resident #71 was admitted to the facility on 4/22/22 with diagnoses including dementia, generalized muscle weakness and unsteadiness on feet.

A review of the Physical Therapy discharge summary for Resident #71 dated 6/21/22 completed by Physical Therapist (PT) #1 revealed the discharge recommendation was for staff to continuously monitor Resident #71 and to keep Resident #71 in line of sight of staff due to her high fall risk.

A review of a nursing progress note for Resident #71 dated 11/21/22 at 6:36 PM revealed in part she was found on the floor in the hallway. She had no injuries.

A review of a nursing progress note for Resident #71 dated 11/27/22 at 12:59 PM revealed in part she was found on the floor in a kneeling position.

noted.

To keep, Resident #1 and other identified residents safe and to allow them to maintain their independence in the facility. The Regional Clinical Nurse has educated administrative staff on 10/12/2023 to lock unoccupied offices, to include, conference room, therapy gyms, kitchen, and other common storage rooms, implemented nightly security checks by the receptionist, to assure all doors are secured. This is the systemic change and corrective action to keep cognitively impaired residents safe.
Department heads and administrative personnel with an office were educated regarding- making sure your office door is closed and locked when leaving the facility for the day by the DON and Administrator beginning on 8/1/2023 and again on 10/11/2023

2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected by this alleged deficient practice of not completing a thorough investigation.
The Regional Clinical Nurse and facility Director of Nursing completed a review of facility investigations, including incident logs and state reportable, for the past 30 days, to ensure an investigation was completed for each occurrence. This was completed on 10/13/23. As a result of this review, 1 investigation was re-opened by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 689	Continued From page 90 She had no injuries. A review of a nursing progress note for Resident #71 dated 12/2/22 at 6:56 PM revealed in part she was found sitting on the floor in the dining room. She had no injuries. A review of a nursing progress note for Resident #71 dated 4/13/23 at 6:23 PM revealed in part Resident #71 was found on the floor in the dining room. She had no injuries. A Fall Risk Assessment for Resident #71 dated 4/14/23 revealed in part she had a history of falls. It further revealed she overestimated her abilities and forgot her limitations. It concluded Resident #71 was at high risk for falls. Resident #71's comprehensive care plan revealed in part a focus area last updated on 4/22/23 of at risk for further falls and injury related to weakness, impaired mobility, potential side effects of medication, poor safety awareness and history of falls. It further revealed Resident #71 had actual falls with no injury on 7/29/22, 8/12/22, 8/17/22, 8/19/22, 11/21/22, 11/27/22, 12/2/22 and 4/13/23. The goal was for Resident #71 to remain free from falls with injury through the next review. Interventions included the following: 8/12/22 referral to Occupational Therapy for wheelchair positioning, 8/17/22 a non-slip mat to seat of wheelchair, 8/19/22 staff education to ensure resident is wearing non skin {sic} footwear when OOB (out of bed), 12/2/22 anti-tippers to wheelchair, and 4/13/23 frequent monitoring during mealtimes. There was no care plan focus area in place for wandering. A review of Resident #71's quarterly Minimum	F 689	the facility administrator related to a state reportable. No other issues were identified. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The evening receptionist will be responsible for the security of administrative office doors nightly, prior to the end of their shift, to ensure all office doors are closed and locked. The receptionist will notify the charge nurse and facility Administrator, immediately, of any unlocked doors noted during her rounds. The BOM educated the evening receptionists on 10/12/2023 on the door security observational rounds and how to document these rounds. The receptionist will give the completed round sheet to the facility administrator. The security round results will be reviewed by the facility Administrator during the morning meeting. The Regional Clinical Nurse completed education with the facility Administrator, DON and Administrative Team (admissions, business office, MDS Nurses, activities, and social services, maintenance staff, housekeeping/laundry, dietary, payroll/scheduler, medical records, central supply, rehabilitation director, administrative nurses, administrator on completing a timely and thorough investigation. This training was completed on 10/13/23. All current licensed nurses, nursing assistants, including agency staff, and administrative staff, were educated by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 689	Continued From page 91 Data Set (MDS) assessment dated 5/4/23 revealed she was severely cognitively impaired. She displayed inattention and disorganized thinking continuously. She displayed no behavioral symptoms, rejection of care or wandering behavior. Resident #71 required the extensive assistance of 2 people for transfers and set-up assistance for locomotion on and off her unit. She did not walk. She was not steady when moving from a seated to standing position and was only able to stabilize with human assistance. She was not steady during transfers from surface to surface (between bed to chair or wheelchair) and was only able to stabilize with human assistance. She had no functional impairment of range of motion in her upper or lower extremities. She used a wheelchair for mobility. She had one fall with no injury since her prior MDS assessment. She did not use a wander/elopement alarm. A review of an Elopement Risk Tool for Resident #71 dated 7/15/23 completed by the Director of Nursing (DON) revealed Resident #71 was found to be at risk for elopement. It further revealed her wandering behavior affected her safety and well-being. On 10/10/23 a review of the physician's orders for Resident #71 revealed an order dated 7/15/23 for a wanderguard (a type of elopement alarm) to be placed to her right ankle. A nursing progress note dated 7/27/23 at 7:58 AM written by Nurse #2 revealed in part Resident #71 was reported missing around 9:00 PM to 11:00 PM (7/26/23). All open doors were searched multiple times including outside in the courtyard and around the facility and she was not found.	F 689	DON, Regional Nurse Consultant and administrative nurses, that all office doors must be closed, locked, and secured when not occupied in order to keep all residents safe. This education included education on “residents who are cognitively impaired and move independently about the facility are at increased risk of entering into unsupervised, unsecured areas”. “When a resident is identified in one of these areas, the resident will be encouraged to go to a more common, higher trafficked area to increase supervision “. This education was completed on 10/14/2023. Any employee who does not receive this education by 10/14/23 will not be able to work until education is completed by DON and/or Administrative Nurse. The DON and/or administrative nurses will be responsible for ensuring that the employees receive this required education, prior to working. Regional Clinical Nurse completed education with the facility Administrator, DON and Administrative Team (admissions, business office, MDS Nurses, activities, social services, maintenance staff, housekeeping/laundry, dietary, payroll/scheduler, medical records, central supple, rehabilitation director, administrative nurses, administrator), on completing a timely and thorough investigation. This training was completed 10/13/2023. The Regional Clinical Nurse will complete a weekly review of the facility investigations to ensure they are timely and thorough.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 689	Continued From page 92 Management and law enforcement were notified, and law enforcement came to the facility. Resident #71's family was notified. She was found in the MDS (Minimum Data Set) office in the dark seated on the "sofa" facing the door. The door was locked and needed a code to enter. She was assessed for injury at that time with none noted. Her family was notified that she had been found safe. On 10/10/23 at 11:19 AM a telephone interview with Nurse #2 indicated she was familiar with Resident #71. She stated Resident #71 often self-propelled herself round in the facility by wheelchair. She stated she was assigned to care for Resident #71 from 7:00 PM to 7:00 AM on 7/26/23. She went on to say about 7:30 PM to 8:00 PM on 7/26/23 she had some residents including Resident #71 gathered around her medication cart in the hallway. She further indicated around 8:20 PM Resident #71 refused her medications and her vital signs, and she told Resident #71 she would try again later. Nurse #2 stated this was the last time she had seen Resident #71 herself prior to her being identified as missing. Nurse #2 stated around 9:20 PM she went to find Resident #71 in her room, but she wasn't there. She went on to say she found Nurse Aide (NA) #4 to ask her where Resident #71 was. She stated NA #4 had not known and NA #4 went to look for Resident #71. Nurse #2 stated when NA #4 reported back to her that NA #4 was not able to locate Resident #71 after looking on all the halls Nurse #2 let all staff know to begin looking for her. She went on to say they searched everywhere inside the facility and outside that they could access for about 30 minutes but could not locate Resident #71. She further indicated at that point she knew it was time to notify her chain	F 689	4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility Administrator and/or DON will review facility investigations, including incident logs and state reportable at the morning clinical meeting to ensure that each occurrence is investigated, including an analysis of the facts and evidence gathered and is finalized with a comprehensive report which compiles relevant statements and evidence obtained. The corporate support team, including Regional Clinical Nurse and/or Regional Director of Operations will be completing a random review of the facility incident logs and state reportable to ensure investigations are completed within the 2 hr/24 hour and 5 day reporting time. This review will be weekly for 4 weeks, then monthly for 3 months, then quarterly. The facility Administrator will complete a summary of these review results and present at the facility monthly QAPI committee to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 93	F 689		

of command and the police. She stated when she spoke with the Administrator by telephone, the Administrator told her to call the police, so she did. She went on to say the Director of Nursing, the Admissions Director, and the police had all arrived at the facility about the same time Nurse #2 further indicated the police asked for the codes to the locked doors in the facility. She went on to say the Admissions Director then went to the MDS office door, entered the code, opened the door, and Resident #71 was there alone in the dark seated on a couch with her wheelchair facing the door and the brakes to her wheelchair locked. She stated Resident #71 was smiling and asked if the police were going to arrest her. She further indicated when she arrived to work on 7/26/23 at 7:00 PM she walked past the MDS office and recalled the office door being closed like it usually was in the evening. Nurse #2 stated there was no way Resident #71 could have gotten out of there by herself due to the heavy door, and the codes that were needed. She stated Resident #71 was thin, not very strong, and could not walk. She further indicated she had assessed Resident #71 for injuries and there had been none.

On 10/11/23 at 2:43 PM an interview with Police Dispatch #1 indicated the Fuquay Varina Police Dispatch first received the call for a missing resident at the facility on 7/26/23 at 10:23 PM.

A review of the local Police Department Call for Service report dated 7/26/23 for a missing person verified the call was initially received from the facility at 10:23 PM.

On 10/10/23 12:00 PM an observation of the MDS office was conducted with MDS Nurse #2. She stated she had been working in this MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 689	Continued From page 94	F 689		

office for over a year. She went on to say she was not working on 7/26/23. She stated the current arrangement of the MDS office was the same as it had always been. On entrance to the office there was observed to be one desk to the right of the door facing towards the back of the room. There was a second desk on left of the office which faced the door. There was a short, narrow Z shaped path between the opposing corners of desks leading to the back wall of the office. There were 2 chairs at the front of the desk on the right which were pushed together and facing the desk on the left. The door to the office did not atomically shut and had to be manually pushed to close.

On 10/10/23 at 5:21 PM an observation was conducted with the Director of Nursing (DON) of the MDS office including the key code door locking mechanism. The MDS office was observed to be at the end of the 400 Hall past where resident rooms were located. A numerical push button keypad was located on the outside of the door below the door handle which required entering the correct numerical code to open the door if it were locked. There was also a keyhole. The interior aspect of the locking mechanism on the inside of the office door was observed to have a knob. If this knob was turned one way, it disabled the need to enter a numerical code to unlock the door if the door were closed. When this knob was turned the opposite way it enabled the keypad lock which locked the door requiring the correct keypad code be entered to unlock the door if it were closed.

On 10/11/23 at 11:04 AM a telephone interview with NA #4 indicated she was familiar with Resident #71 and had been assigned to care for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 689	Continued From page 95	F 689		

her at the time of the incident on 7/26/23. She stated Resident #71 was at baseline that night and did not have any behaviors. She stated Resident #71 liked to propel herself around the facility in her wheelchair and everyone kept an eye on her for safety reasons. NA #4 went onto say around 8:30 PM on 7/26/23 she had gone to look for Resident #71 to help her get ready for bed and could not find her. She stated she notified Nurse #7 who was the Supervisor that night. NA #4 stated Nurse #7 said she had seen Resident #71 earlier and Nurse #7 instructed everyone to keep looking. NA #4 stated when Resident #71 could not be found, the DON, Administrator and police were notified. She stated the police arrived and wanted all the locked doors opened. She went on to say the Admissions Director arrived at the facility and had gone straight to the MDS office and opened the door. She went on to say she had no idea how Resident #71 could have gotten locked in the MDS office by herself.

A review of a written statement from Nurse #7 dated 7/26/23 (provided by the facility on 10/11/23) revealed in part she last saw Resident #71 at around 8:30 PM in the facility. Around 9:00 PM NA #4 reported to her she could not find Resident #71 after she looked everywhere in the facility. All staff were notified of the situation, and they began to look for Resident #71.

On 10/10/23 at 8:36 PM a telephone interview with Nurse #7 indicated she was very familiar with Resident #71. She stated Resident #71 liked to self-propel herself around the facility in her wheelchair and so everyone kept an eye on her for safety. Nurse #7 stated the last time she saw Resident #71 on 7/26/23 was around 8:30 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 96	F 689		

near the nurse's station. She reported she told Resident #71 to head back towards her hall which she usually did when you told her to. She stated around 9:00 PM that night NA #4 came to her and told her they had been looking for Resident #71 and could not find her. Nurse #7 went on to say she had become very concerned and immediately got all the staff together to begin looking for Resident #71. She stated Resident #71 was not steady enough to transfer herself without falling. She went on to say Resident #71 had a wanderguard and there were no alarms going off so everyone really felt she must still be in the building. Nurse #7 stated she was "fuzzy" about the time, but she thought it was about 10:00 PM when she called the DON. She stated she did not think the DON had known yet about Resident #71 being missing. She went on to say she was "fuzzy" about who called the police or when but the reason the police were not notified sooner was everyone thought Resident #71 would not have been able to get out of the building unless someone let her out and there were no alarms going off, so she had wanted to be sure Resident #71 was not in the building before the police were called. She went on to say it took time to look everywhere. Nurse #7 stated she got in her car and began driving around to look for Resident #71. She went on to say when she got back to the facility the Admissions Director was there getting out of her car. She stated she followed the Admissions Director into the building and the Admissions Director went straight to the MDS Office. Nurse #7 stated the Admissions Director, the DON, and the police were all there at the same time, the Admissions Director put the key code in and opened the MDS office door and found the resident. She further indicated that door had been checked during the search earlier and it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 97	F 689		

had been locked. She went on to say when the door was opened initially, the room was dark. She stated Resident #71 had been sitting in a chair and her wheelchair was in the back of the room facing the door.

In an interview on 10/10/23 at 12:06 PM MDS Nurse #1 stated she left for the day on 7/26/23 between 3:00 PM and 4:00 PM. She went on to say she had locked the office door when she left like she always did and checked to make sure it was locked. She stated the last thing she did every day was make sure the lights in the office were off and the door was locked. MDS Nurse #1 stated she had never shared the door code with anyone. On 10/12/23 at 8:28 AM MDS Nurse #1 stated the only thing in the MDS office at the time of the incident she could think of that would have posed any risk to Resident #71 would have been a bottle of hand sanitizer.

A review of a written statement dated 7/31/23 from NA #5 (provided by the facility on 10/11/23) revealed in part she spoke with the Admissions Director by phone and told her Resident #71 had been missing for over an hour and a half and neither the Administrator nor the DON had been notified. It further revealed NA #5 told the Admissions Director Nurse #7 had said she was going to drive around the block to look for Resident #71 and if she didn't see her, she would come back and call the Administrator, DON, and the police.

On 10/10/23 at 1:23 PM a telephone interview with NA #5 indicated she was familiar with Resident #71. She stated Resident #71 was confused and did not walk. She went on to say Resident #71 required 1 person to assist her with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 98	F 689		

standing and transferring to the wheelchair. NA #5 stated Resident #71 liked to self-propel herself throughout the facility in her wheelchair. She went on to say everyone knew this and kept an eye on her to ensure Resident #71 stayed safe. She further indicated Resident #71 had a couple of favorite places she liked to sit which included the glass door at the end of the 400 Hall where Resident #71 liked to look out. NA #5 stated she had been working on the 400 Hall on 7/26/23 from 3:00 PM until 11:00 PM. She further indicated Resident #71 had been at baseline that evening with no unusual behaviors. She stated she had last seen Resident #71 about 7:00 PM looking out the 400 Hall exit door with another resident when she was picking up supper trays. She went on to say she recalled the MDS office door being shut during her shift that evening. NA #5 stated about 8:30 PM she came in from her break and NA #4 told her they couldn't find Resident #71. She went on to say she participated in looking for Resident #71 from about 8:30 until 10:00 PM. She further indicated she had been present when the police arrived about 10:00 PM. NA #5 stated when she had been on her break that evening, the Admissions Director called her about an issue with another resident in the facility. She went on to say when she called the Admissions Director back that evening, she told her she couldn't talk because Resident #71 was missing, and they were looking for her. She stated she had no idea how Resident #71 could have gotten locked into the MDS office.

A review of the written statement provided by the Admissions Director dated 7/31/23 (provided by the facility on 10/11/23) revealed in part that at 9:52 PM she received a call from NA #5 who told her Resident #71 had been missing for about 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 99	F 689		

hours. NA #5 told her that the nurse had not called to notify the DON or the Administrator. NA #5 reported staff had been looking for Resident #71 all over the building, in the parking lots, out behind the dumpster and near the woods. NA #5 told her the nurse had said she was going to get in her car and look around the neighborhood and if she still couldn't find Resident #71, she was going to notify the Administrator and DON. The Admissions Director told NA #5 she would call the Administrator herself immediately. At approximately 10:35 PM the Admissions Director arrived at the facility. There were 3 police cars at the facility. The DON provided her with the code to unlock the MDS office door. Initially she entered the wrong code and was unable to open the door. When she opened the door, the lights were off, and it was totally dark in the office. She flipped on the lights due to not being able to see clearly without the lights on and saw Resident #71 sitting on the edge sofa chair. To prevent Resident #71 from being scared or upset, the Admissions Director spoke with her. Resident #71 noticed the police officers in the hallway and muttered something about being arrested and going to jail. The Admissions Director sat down beside Resident #71 and told her the police had not come because of her. Resident #71's wheelchair was not extended all the way out (the seat was pulled up in the middle). The wheelchair was beside Resident #71 facing the door. The Admissions Director assisted with getting Resident #71's wheelchair out of the very small office space between the desks. She noticed Resident #71 had her bedroom shoes under a file cart near the door. At 10:43 PM she sent the Administrator a text to let her know the resident had been located.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 100	F 689		

On 10/10/23 at 12:13 PM an interview with the Admissions Director indicated she had been made aware by telephone that Resident #71 was missing at the facility on 7/26/23 around 10:00 PM when NA #5 called her. She went on to say NA #5 told her the nurse had tried to give Resident #71 her medication but Resident #71 had refused. She went on to say NA #5 reported that the nurse had gone back to try again, and they couldn't find Resident #71. The Admissions Director stated she immediately went to the facility to assist with the search. She went on to say when she arrived at the facility, the police were there. She further indicated the Director of Nursing (DON) gave her the code for the MDS office and she went there while the DON went to open the beauty shop door. She stated she initially entered the wrong code to the MDS office, and the door wouldn't open but she tried again and was able to open the door. She went on to say the lights were off in the office and when she flipped on the lights, she saw Resident #71 seated in a chair. The Admissions Director further indicated when Resident #71 saw the police standing in the open doorway Resident #71 asked her if the police were there to arrest her. She stated she reassured Resident #71 the police were not.

On 10/10/23 at 2:04 PM an interview with the DON indicated she received a telephone call about 10:00 PM on 7/26/23 from the facility saying that Resident #71 was missing, staff had looked in all the rooms in the facility and outside and still couldn't find her. She stated she told staff to keep looking. She went on to say the police had already been called. She further indicated she had the code to the office doors, and she immediately went to the facility. The DON stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 101	F 689		

when she arrived at the facility, she checked the beauty salon and then opened the door to the MDS office. She went on to say when she opened the MDS office door the lights were off. She further indicated she flipped on the lights and saw Resident #71 seated on a chair in the office. She stated Resident #71 was calm, kind of laughed because she could see the police and said, "Y'all call the police on me?". The DON went on to say Resident #71 was assessed for injury and none was found. On 10/10/23 at 5:22 PM a follow-up interview with the DON she stated other staff had already tried to open the MDS office door earlier when looking for the resident on 7/26/23 and found it to be locked. She further indicated the door had been locked when she first tried it.

In an interview on 10/10/23 at 2:41 PM the Regional Nurse Consultant #1 stated there were no cameras and there was no video footage or any pictures from the incident on 7/26/23 to be reviewed.

On 10/10/23 at 5:51 PM an interview with the Maintenance Director indicated he received a call in the evening on 7/26/23 regarding a missing resident. He stated he could not recall who called him or the exact time. He further indicated he thought it was from the DON. He went on to say by the time he arrived at the facility the resident had been found. The Maintenance Director stated it was reported to him that Resident #71's wheelchair had been backed into the MDS office. He stated he was familiar with Resident #71 because he often saw her in the halls. He went on to say at times he would see Resident #71 with her wheelchair brakes locked but she wouldn't realize it and she would be just rocking the wheelchair back and forth trying to get it to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 102	F 689		

move and he would have to go over and help her unlock them. He went on to say he immediately changed all the door codes that night. He stated he felt like if that was the issue, he would fix that. The keypad code locking mechanism on the MDS office door was discussed with the Maintenance Director. He confirmed if the door's inner knob was turned one way when the office door was closed, the door would not be locked and no keycode would be required to open the closed door. He further confirmed if the inner knob was turned the opposite way when the door was closed, the entry of the correct code on the keypad would be required to open the door. He stated there was no physical key for the keyhole in the MDS office door.

On 10/11/23 at 8:33 AM an additional interview with the DON indicated an investigation of the incident had been conducted which included interviews with the staff present in the facility at the time of the incident. She went on to say the investigation was inconclusive regarding how it could have occurred. She further indicated education had been provided to staff that they were to immediately notify administration when a resident was missing. She stated if administration had been immediately notified, staff would have been instructed to call the police then. She went on to say she did not consider an hour to be immediately and felt staff should have notified administration and the police sooner than they did. She went on to say staff had been educated on the missing resident policy and all the door codes had been changed to ensure only certain people had access.

On 10/11/23 Regional Nurse Consultant #1 provided the investigation information of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 103	F 689		

7/26/23 event which did not include written statements from Nurse #2, MDS Nurse #1, or therapy staff.

On 10/13/23 at 10:22 AM a follow-up interview with the Regional Nurse Consultant #1 indicated she was not aware of any written statement from MDS Nurse #1 or therapy staff.

As of this survey's exit (10/18/23) the facility provided no written statements from Nurse #2, MDS Nurse #1, or therapy staff.

On 10/11/23 at 8:47 AM an interview with the Administrator indicated she received a phone call from the Admissions Director between 9:30 PM and 10:00 PM on 7/26/23 letting her know that Resident #71 was missing. She stated she immediately called Nurse #2 who told her they were looking for Resident #71. She went on to say she immediately called the DON who went to the facility and found Resident #71 in the locked MDS office. The Administrator stated when she came to the facility the next day (7/27/23), they did an investigation by talking to the people familiar with the incident to see if they could determine how Resident #71 was able to get into the office. She went on to say their investigation had been inconclusive. She further indicated because Resident #71 could have a conversation with her some days and somedays not she felt that maybe the door to the MDS office had been unlocked and Resident #71 had been able to get herself in there.

On 10/12/23 at 10:27 AM an interview with Physical Therapist (PT) #1 indicated he was familiar with Resident #71 from treating her in PT. He stated Resident #71 was a high fall risk due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 104	F 689		

her impaired safety awareness. He went on to say being unsupervised in a locked office alone would place Resident #71 at high risk for a fall and injury.

On 10/12/23 at 2:57 PM an interview with the Therapy Manager indicated she was familiar with Resident #71 from treating her in speech therapy. She stated Resident #71 was severely cognitively impaired as the result of her dementia. She went on to say while there had been a telephone in the administrative office, she would not think Resident #71 would have the cognitive ability to use the phone to call for help. The Therapy Manager stated she had never seen Resident #71 use a telephone. She went on to say based on what she knew of Resident #71, one of her biggest concerns was the simple fact that Resident #71 did not have the cognitive ability to move about in the space and she would just be sitting there.

On 10/13/23 at 10:03 AM the Corporate MDS Consultant discussed reviewing the event of 7/26/23 involving Resident #71 this week. She stated in thinking about things, she recalled Resident #71 visited the MDS office at times before the event. She stated she felt this made it very plausible Resident #71 entered the MDS office herself on 7/26/23.

On 10/13/23 at 10:31 AM in an interview Occupational Therapist (OT) #1 stated she was familiar with Resident #71. She went on to say residents with dementia had fluctuating cognition and while on one day they might not be able to do something, another day they could. She further indicated for residents with dementia, while their short-term memory might be impaired their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 689	Continued From page 105	F 689		

long-term memory could be intact. OT #1 stated she felt that given enough time Resident #71 could have wiggled herself into the MDS office and done a squat pivot transfer. She stated she felt Resident #71 would have the cognition to try to move something that was in her way.

On 10/12/23 at 3:15 PM a telephone interview with the Medical Director indicated he was familiar with Resident #71 and had been notified of her being missing on 7/26/23. He stated for residents with advanced dementia like Resident #71 it was common for them to go in and out of rooms. He stated the same way that these residents did not recognize family members anymore he did not think Resident #71 knew which room was hers and which room was not. He stated because Resident #71 would not have known the difference regarding whether she was in an office or her room, he did not feel it would have been psychologically upsetting for her. He stated his biggest concern was that staff had been unaware of where Resident #71 was. He stated this would not have been safe for Resident #71. The Medical Director further indicated because staff had been unaware of Resident #71's location, anything could have happened to Resident #71 including falls and other injuries.

On 10/16/23 at 8:43 AM a telephone interview with Resident #71's Responsible Party (RP) indicated the facility had notified her on 7/26/23 that Resident #71 was missing. She stated they called her back later that evening to let her know Resident #71 had been found safe. She further indicated it was very upsetting for her to find out that Resident #71 had been locked in an office. She stated Resident #1 did not have the ability to lock or unlock doors and would not have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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F 689	Continued From page 106	F 689		

able to get out. The RP went on to say this would not have been safe for Resident #71 to be trapped alone where staff were not monitoring her.

The Administrator was notified of Immediate Jeopardy (IJ) on 10/13/23 at 12:40 PM.

The facility provided the following credible allegation of IJ removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the non- compliance:

Resident #71 was found in the MDS office on 400 hall behind a locked door at 10:45 PM on 7/26/23 by the DON and local police.

The facility administrator and Director of Nursing (DON) began an investigation into this incident on 7/26/23. Upon review by the Regional Clinical Nurse on October 11, 2023, this investigation was missing statements from MDS Nurse and Physical Therapist, Occupational Therapist, and Therapy Manager. These statements were obtained on 10/13/23. The results of this re-investigation concluded that the MDS door was not secured, and the resident did have the physical ability to enter the unlocked office.

The resident was immediately assessed for physical injuries by the Director of Nursing. There were no identified injuries. Resident was laughing when the door was opened. Her psychosocial well-being was assessed by the in-house mental health provider, on 8/14/23. The facility social worker completed a trauma informed assessment on 8/9/23. The resident's

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F 689	Continued From page 107	F 689		

psychosocial well-being was not affected and is still at baseline.

The Regional Clinical Nurse and DON completed a review of facility investigations to ensure that the investigation was thorough on 10/13/23. This included a review of the incident logs and state reportables for the past 30 days.

The facility administrator re-opened 1 investigation, 10/13/23 related to a reportable, as a result of the review. No other issues were identified.

The Regional MDS Nurse reviewed Brief Interview of Mental Status (BIMS) scores for all current residents to determine who was classified as cognitively impaired. Of those residents, the facility therapy manager identified residents who are able to locomote independently. These residents have been identified as at risk of being behind an unlocked office door to include conference room, therapy gyms, kitchen, and other common storage rooms. This was completed on 10/13/2023.

The facility licensed nurses, Nurse Aides, including agency, and administrative staff were educated on 10/13/23 by the Staff Development Coordinator and the DON that all office doors must be closed, locked, and secured when not occupied, in order to keep residents who are cognitively impaired safe. They were also educated on "residents who are cognitively impaired and move independently about the facility are at increased risk of entering into unsupervised, unsecured areas." "When a resident is identified in one of these areas, the resident will be encouraged to go to a more

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F 689	Continued From page 108	F 689		

common, higher trafficked area for increased supervision."

A review of the incident log for the last 30 days on 10/13/2923 by the Regional Clinical Nurse revealed no similar incidents in the facility.

Specify action the facility will take to alter the process or system failure to prevent a serious outcome from occurring or recurring and when the action will be completed:

The resident's responsible party and attending physician were notified of theincident on 7/26/23 after the resident was found safe by the facility charge nurse on duty.

The care plan for Resident #71 was updated by the facility MDS Nurse on 10/12/23 to include wandering behaviors. The intervention included, "When Resident #71 is noted to be entering into an unsupervised, unsecured area the facility staff will redirect Resident #71 to go to a more common, higher trafficked area for increased supervision." The facility social worker mailed a care plan letter on 10/12/2023 to the responsible party to schedule a care plan meeting.

An incident report and post incident follow up were completed by the Regional Clinical Nurse on 10/13/2023 for Resident #71. The facility Administrative Nurses were educated by the Regional Clinical Nurse on completing an incident report and gathering the initial information about the incident and documenting on the post incident form.

The evening receptionist will be responsible for the security of administrative office doors nightly,

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F 689	Continued From page 109	F 689		

prior to the end of their shift, to ensure all office doors are closed and locked. The receptionist will notify the charge nurse and facility Administrator immediately of any unlocked doors noted during her rounds. The Business Office Manager educated the evening receptionists on 10/12/2023 on the door security observational rounds and how to document these rounds. The receptionist will give the completed round sheet to the facility administrator. The security round results will be reviewed by the facility Administrator during the morning meeting.

The Regional Clinical Nurse educated the Maintenance Director on 10/12/2023 to change door codes to every office monthly to deter accessibility to locked offices. The Administrator, DON, and Maintenance Director will have access to the door codes.

All current licensed nurses, nursing assistants, including agency staff, and administrative staff, were educated by the DON, Regional Nurse Consultant, and administrative nurses, that all office doors must be closed, locked, and secured when not occupied in order to keep all residents safe. This education included education on "residents who are cognitively impaired and move independently about the facility are at increased risk of entering into unsupervised, unsecured areas". "When a resident is identified in one of these areas, the resident will be encouraged to go to a more common higher trafficked area for increased supervision ". This education was completed on 10/14/2023. Any employee who does not receive this education by 10/14/23 will not be able to work until education is completed by DON and/or Administrative Nurse. The DON and/or administrative nurses will be responsible

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F 689	Continued From page 110	F 689		

for ensuring that the employees receive this required education prior to working.

To keep Resident #71 and other identified residents safe and to allow them to maintain their independence in the facility the Regional Clinical Nurse completed education with the facility administrative staff on 10/12/2023 to lock unoccupied offices to include the conference room, therapy gyms, kitchen, and other common storage rooms, and implemented nightly security checks by the receptionist to assure all doors are secured. This is the systemic change and corrective action to keep cognitively impaired residents safe.

Department heads and administrative personnel with an office were educated regarding- making sure your office door is closed and locked when leaving the facility for the day by the DON and Administrator beginning on 8/1/2023 and again on 10/11/2023.

The Regional Clinical Nurse completed education with the facility Administrator, DON and Administrative Team (admissions, business office, MDS Nurses, activities, social services, maintenance staff, housekeeping/laundry, dietary, payroll/scheduler, medical records, central supple, rehabilitation director, administrative nurses, administrator) on completing a timely and thorough investigation. This training was completed 10/13/2023. The Regional Clinical Nurse will complete a weekly review of the facility investigations to ensure they are timely and thorough.

The Administrator and/or DON will bring facility investigations, including state reportables, to the

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F 689	Continued From page 111	F 689		

morning clinical meeting to ensure investigations are complete. The investigation into the event for resident #71 was completed on 10/13/2023 by the administrative nurses led by the DON.

The Administrator and DON will be ultimately responsible for ensuring a complete investigation occurs into this incident and all others going forward. The Regional Clinical Consultant will review all investigations prior to closing to ensure the investigations are complete.

Alleged date of IJ removal: 10/15/2023

The validation process for the IJ removal plan was completed on 10/18/23. Review of Resident #1's medical records showed Resident #71's care plan was updated on 10/12/23 to include wandering behaviors and a care plan meeting letter was mailed to Resident #71's responsible party. An interview conducted with the evening receptionist showed she had been educated and she had used the security round log after she completed nightly checks. An interview conducted with the Maintenance Director revealed he had received education to change the codes on office locks immediately and monthly. The Maintenance Director confirmed the codes were changed last week. Staff from different departments and who worked different shifts were interviewed and verified they had received training on ensuring office doors were locked and shut when the room was unoccupied and increasing supervision for cognitively impaired residents. Interviews with the Administrative Team verified they had received training on completed a timely and thorough interview, in addition to ensuring their office doors were shut and locked when their rooms were unoccupied. A review was completed that

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F 689	Continued From page 112 included educational information provided to staff during the in-service and a review of in-service staff sign-in logs. The in-service logs were reviewed, and staff names randomly selected and verified to receive training. The facility's IJ removal date of 10/15/23 was validated.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to assess the resident's left upper arm shunt site upon returning to the facility after dialysis for 1 of 1 resident reviewed for dialysis. (Resident #390). The findings included: Resident #390 was admitted to the facility on 8/7/2023, and diagnoses included end stage renal disease. Resident #390 was discharged from the facility on 8/21/2023 and was re-admitted to the facility on 8/25/2023. Physician's orders dated 8/25/2023 included dialysis on Tuesday, Thursday, and Saturday at a local dialysis center. There were no other orders for Resident #390 related to dialysis care.	F 698	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #390 was assessed by the assigned charge nurse with no negative outcomes. Nurses #18 and #19 were educated on assessing dialysis residents' shunt site upon return from dialysis by the Staff Development Coordinator on 11/8/23. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 11/8/23, all dialysis resident's physician orders were reviewed to ensure orders were in place to assess the dialysis shunt once the resident returned to the	11/13/23

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 698	Continued From page 113 The 5-day Minimum Data Set (MDS) dated 8/28/2023 indicated Resident #390 was cognitively intact. The MDS reflected Resident #390 had received dialysis while not residing in the facility and had not received dialysis while a resident in the facility for the 5-day look back period. The care plan dated 9/5/2023 stated Resident #390 had end stage renal disease and required dialysis. Interventions included monitoring Resident #390's shunt (a hole or a small passage that moves or allows movement of fluid from one part of the body to another) for patency (a condition of being open, expanded or unobstructed). There was no nursing documentation of Resident #390's left upper arm shunt site after receiving dialysis treatments on the following dates: 8/8/2023, 8/10/2023, 8/15/2023, 8/17/2023, 8/19/2023, 8/26/2023, 8/29/2023, 9/2/2023, 9/5/2023, 9/7/2023, 9/9/2023, 9/12/2023, 9/16/2023, 9/19/2023, 9/21/2023, 9/23/2023, 9/26/2023, 9/30/2023, 10/3/2023, 10/5/2023, 10/7/2023, 10/10/2023. There was no documentation of an assessment of Resident #390's shunt site on the Medication Administration Records and Treatment Administration Records for August 2023, September 2023, and October 2023 On 10/10/2023 at 9:09 a.m., a purplish-blue discoloration was observed covering three-fourths of the skin underneath Resident #390's left upper arm. Resident #390 stated that was where his shunt for dialysis was located.	F 698	facility by the administrative nurses. Any variances were discussed with the attending physician and corrected. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Unit Manager will review shunt site assessment documentation completed by assigned nurse when the resident returns from dialysis. On 11/7/23, education was initiated by the SDC with all licensed nurses and agency clinical licensed nurses on assessing dialysis resident shunt site upon return to the facility and ensuring there is a physician order to monitor the site for all admission/readmission dialysis residents. The education was completed on 11/13/23. Effective 11/14/23, any facility or agency licensed nurse that has not been educated will not be allowed to work until education is received in- person or via telephone by the Director of Nursing and/or administration nurse. All newly hired nursing staff or clinical agency personnel will receive education during the orientation process by the Staff Development Coordinator (SDC) and/or administrative nurse on assessing/monitoring residents who receive dialysis shunt site and documenting their findings. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing (DON) and/or	

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F 698	Continued From page 114 On 10/12/2023 at 4:00 p.m., Resident #390 had returned from his dialysis treatment and was observed sitting in his wheelchair in his room. On 10/12/2023 at 5:39 p.m., Resident #390's shunt site (left upper arm) was observed with a clean white dressing intact. There was no bleeding and Resident #390 did not complain of any pain at the shunt site. In an interview with Nurse #18 on 10/12/2023 at 5:28 p.m., he stated he was new to the facility and was assigned with another nurse (Nurse #19) to Resident #390, who was receiving dialysis treatments. He explained other nurses on the unit had taught him to monitor vital signs, give Resident #390's his medications and know what time Resident #390 was to leave the facility for dialysis. He stated he went into Resident #390's room when transport returned Resident #390 to his room and asked him if he needed anything. He stated he had not assessed Resident #390's shunt site. In an interview with Nurse #19 (the nurse working with Nurse #18) on 10/12/2023 at 5:32 p.m., she explained after returning from the dialysis center, nurses were to review vital signs and any medications given on Resident #390's dialysis communication sheet and assess Resident #390's shunt site. She stated she was on her lunch break when Resident #390 returned from the dialysis center, and she had not assessed Resident #390's shunt site. She stated Resident #390's shunt site should be assessed for pain, bleeding, swelling and irritation, and the assessment was to be documented in the nurse's notes. Nurse #19 further reported Resident #390 returned to the facility without his dialysis	F 698	administrative nurses will audit all dialysis resident shunt site assessment/monitoring documentation weekly x 2 months, then monthly for 2 months and quarterly thereafter to ensure compliance. Findings will be presented at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 698	Continued From page 115	F 698		

communication book and she would need to call the dialysis center for a report.

In a phone interview with Nurse #20 on 10/16/2023 at 11:26 a.m., she explained Resident #390's dialysis communication sheet was reviewed on returned from dialysis treatments, and Resident #390's shunt site was to be checked for bleeding and documented in the nursing notes. She further stated Resident #360's shunt site should be documented each shift and had not noticed the skin discoloration underneath his left upper arm. She explained Resident #390 returned from dialysis on the day shift (7:00 a.m. -7:00 p.m.) and she usually reported to work at 7:00 p.m.

In an interview with the Director of Nursing on 10/13/2023 at 12:59 p m., she stated nursing staff should assess Resident #390's shunt to check for bruit and thrills (a vibration caused by blood flowing through the dialysis shunt felt by placing your fingers just above the incision line) on the days Resident #390 received dialysis and every shift daily. She explained she was unsure if care of a dialysis shunt was part of the facility's standing orders. She said nurses were to document shunt assessments in the nursing notes, and the facility was not monitoring documentation of dialysis care.

In an interview with Regional Nurse Consultant on 10/13/2023 at 3:24 p.m., she stated nurses were to assess Resident #390's shunt site before and after dialysis treatments and to report any concerns with the shunt site to the physician. She further stated dialysis shunt site assessments were to be documented in the nursing notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 727	Continued From page 116	F 727		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have 8 consecutive hours of Registered Nurse (RN) coverage for 7 of 120 days reviewed. Findings included: Review of punch in times (times recorded by digital timecards) for 4/8/23, 4/9/23, 5/6/23, 5/7/23, 5/20/23, 5/21/23, and 6/17/23 at the facility revealed there was no RN working during these days. During an interview on 10/13/23 at 11:33 AM the Scheduler stated she took the position of scheduler on June 3rd. She further stated she was not trained in the position, and she was unaware that there was a requirement for an RN to be on the schedule for 8 hours. She concluded she had heard the term 'RN coverage' but was	F 727	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were named in this alleged deficient practice. Staff schedules were adjusted 10/31/23, by DON to ensure that proper RN coverage is in place. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit was completed by Assistant Director of Nursing on 11/7/2023 of the current staffing schedule to ensure that proper RN coverage is maintained. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 727	Continued From page 117 told by the administrator not to use agency RN for coverage and did not know there needed to be 8 hours for coverage due to lack of training. During an interview on 10/13/23 at 11:39 AM the Director of Nursing stated she was aware of the regulation that facilities needed 8 hours of RN coverage per 24 hours. She concluded there was no monitoring in place to review for 8 hours RN coverage of the schedule and this was why she was unaware of the lack of RN coverage on 4/8/23, 4/9/23, 5/6/23, 5/7/23, 5/20/23, 5/21/23, and 6/17/23. The Director of Nursing confirmed there was no RN coverage on these dates.	F 727	recur: Director of Nursing and Assistant Director or Nursing were educated by Administrator on 8 hour per day RN coverage on 11/8/2023. A copy of the daily schedule will be brought to morning meeting for daily RN coverage review. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will audit daily schedules 5 days 4 week, then weekly for 12 weeks to ensure proper coverage is maintained. DON will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to ensure a resident attended a medical appointment for 1 of 1 sampled resident reviewed for medically related social services (Resident #88). The findings included: Resident #88 was admitted on 6/7/23 with	F 745	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #88 was discharged on 6/23/23. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Transportation Scheduler & Admissions	11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 745	Continued From page 118 diagnoses that included reduced mobility and gait abnormality. Review of Resident #88's hospital discharge summary dated 6/7/23 revealed an orthopedic appointment scheduled 6/19/23. Resident #88's admission Minimum Data Set (MDS) assessment dated 6/12/23 revealed she was cognitively intact with no behaviors or refusals of care. There was no evidence in the medical record that Resident #88 attended her 6/19/23 outpatient orthopedic appointment scheduled for 6/19/23 as noted on the hospital discharge summary. The medical record indicated Resident #88 was discharged from the facility on 6/23/23. The resident was unavailable for interview. A phone interview was conducted on 10/11/23 at 11:26 AM with Resident #88's responsible party who stated she informed staff of the appointment scheduled for 6/19/23 when Resident #88 was admitted to the facility. The responsible party stated she was informed by Resident #88 she had missed the 6/19/23 appointment. She reported the nursing staff she spoke with were unable to give a reason the appointment was missed. An interview was conducted with Transportation Scheduler #1 on 10/11/23 at 4:00 PM who stated Resident #88's appointment was on her transportation schedule and she verified the appointment was missed. She reported she was	F 745	Director will complete an audit of all current resident□s consultations and new admission discharge summaries for the past 30 days by 11/13/2023 to ensure appointments are scheduled timely. Any identified missed appointments will be scheduled. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Hospital discharge summaries for new admissions will be brought to the morning clinical meeting to be reviewed by the DON and/or administrative nurses to ensure follow up appointments are scheduled timely. The transportation scheduler will review the scheduled appointments during the morning clinical meeting, to include resident name, place and time of appointment. If the appointment must be rescheduled or missed, it will be discussed with the Administrator. The Administrator will educate the transportation scheduler and Admissions Director on scheduling appointments by 11/13/2023. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Transportation scheduler and/or Admissions director will meet weekly for 4 weeks, then bi-weekly for 3 months, then quarterly, to review the appointment schedule to ensure residents did attend scheduled appointments. The Admission director will complete a summary of audit results and present at	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 745	Continued From page 119 unsure why Resident #88 was not transported to her appointment. Transportation Scheduler #1 stated she was responsible for gathering appointment information from hospital discharge summaries. She reported she arranged transportation with an outside vendor. Transportation Scheduler #1 stated the appointment was crossed out on her transportation schedule but was unsure why it was cancelled and not rescheduled. An interview was conducted with the Administrator of the facility on 10/12/23 at 10:15 AM who stated Resident #88 should have been transported to her appointment on 6/19/23. She indicated she was new to the facility and was unsure the reason transportation was not provided.	F 745	the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		11/13/23

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F 758	Continued From page 120 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and Medical Director, and staff interviews, the facility failed to ensure an as needed (PRN) psychotropic medication was time limited in duration for 1 of 5 residents reviewed for unnecessary medications (Resident #17). The findings included:	F 758	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #17 order was updated on 10/12/23 by the Director of Nursing to reflect an appropriate stop date for the PRN Lorazepam.	

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F 758	Continued From page 121 Resident #17 was admitted to the facility on 9/15/20 with diagnoses that included muscle spasms and convulsions. Resident #17 had a physician's order dated 5/8/23 for Lorazepam (an antianxiety medication) 0.5 milligrams (mg) one tablet by mouth every six hours as needed for muscle spasms or convulsions. The order for the Lorazepam PRN was entered into the Electronic Medical Record (EMR) by Nurse #9 and did not have a stop date. A quarterly Minimum Data Set (MDS) assessment dated 8/7/23 indicated Resident #17 was cognitively intact and received one day of an antianxiety medication during the assessment period. The August 2023, September 2023, and October 2023 Medication Administration Records (MARs) revealed Resident #17 had received as needed dosages of the Lorazepam seven times in August, three times in September and none in October. An interview occurred with the Medical Director on 10/12/23 at 3:08 PM, who stated he was aware of the regulation that required all PRN psychotropic medications to be time limited in duration, but he wrote Resident #17's order the way it was because of her convulsions. The Director of Nursing (DON) was interviewed on 10/12/23 at 3:15 PM and reviewed Resident #17's medical record. She explained that Nurse #9 was no longer employed at the facility but that she was aware of the need for a stop date to provide reassessment of the medication and felt	F 758	Nurse #9 is no longer employed at the facility. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current residents with PRN psychotropic medication orders were reviewed by the facility's Consulting Pharmacist on 10/31/23 for an appropriate stop date with corrections made if indicated. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Administrative nurses will review new physician orders including those for new admissions during the morning clinical meeting, to ensure that any PRN psychotropic medication has a 14-day stop date. On 11/8/23, the Staff Development Coordinator began education with all licensed nurses, including agency clinical licensed nurses on obtaining an order for a 14-day stop date for all PRN psychotropic medications. The education was completed on 11/13/23. Effective 11/14/23, any facility or agency licensed nurses that have not been educated will not be allowed to work until education is received in- person or via telephone by the Director of Nursing and/or administrative nurse. All newly hired licensed nursing staff and clinical licensed agency personnel will receive education during the orientation process by the Staff Development Coordinator (SDC) and/or	

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F 758	Continued From page 122 the order dated 5/8/23 was an oversight. Multiple phone calls were placed to Nurse #9 during the course of the survey with a message received that the phone number was no longer in service.	F 758	administrative nurse. The SDC will be tracking this educational process to ensure licensed nurses, including agency licensed nurses receive this education. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Regional Nurse Consultant will conduct audits of 5 residents with PRN psychotropic medication orders for 14-day stop dates weekly for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure compliance. The Regional Nurse Consultant will complete a summary of these audits and present findings at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and Physician interviews, the facility failed to have a medication error rate less than 5% as evidenced by 15 medication errors out of 33 opportunities, resulting in a medication error rate of 45.45% for 2 of 4 residents (Resident #14, and Resident #7) observed during the medication administration observation.	F 759	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #14 and #7 were assessed by the Director of Nursing on 10/10/23 with no negative outcomes. Nurse #3 and MA	11/13/23

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 759	Continued From page 123 Findings included: 1a. Resident #14 was admitted to the facility on 2-21-19 with multiple diagnoses that included cerebral infarction and gastrostomy status. Observation of medication administration through a gastro tube occurred on 10-10-23 at 8:00am with Nurse #3. The nurse was observed checking the manufacturers instructions regarding if Resident #14's medication could be crushed. Nurse #3 contacted the Nurse Practitioner informing him some of Resident #14's medications were not allowed to be crushed (Duloxetine, and Memantine). The Nurse Practitioner instructed Nurse #3 to call the pharmacy. The nurse was observed and heard talking to the Pharmacist who informed Nurse #3 that it was alright to crush the medication. Nurse #3 was observed crushing/opening the following medications. - Duloxetine (antidepressant). The manufacturer's instructions for administration read in part "administer duloxetine delayed release capsule orally and swallow whole. Do not chew or crush, and do not open the capsule." - Memantine (for dementia). The manufacturer's instructions for administration read in part "can be taken with or without food, whole or sprinkled on applesauce, do not divide, chew or crush." 1b. The nurse was observed crushing the medications and placing all the following medications into one medicine cup. - Lasix (diuretic) - Plavix (blood thinner) - Duloxetine (antidepressant) - Memantine (for dementia)	F 759	#1 were educated by the Assistant Director of Nursing on 10/10/23 regarding medication administration with residents who have a gastro tube (following the manufacturer□s instructions), obtaining a physician order to administer all the medication together for residents with gastro tubes, following physician orders, and waiting at least 2 minutes between eye drops when administrating 2 different prescribed eye medications. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Consultant Pharmacist completed a medication review as of 11/9/23, of all gastro tube feeding residents to clarify wither the medication could be crushed. Any identified issues were discussed with the resident□s attending physician. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 11/8/23, the SDC began education with current licensed nurses, certified medication aides and agency clinical licensed nurses and certified medication aides on medication administration with residents who have a gastro tube (following the manufacturer□s instructions), obtaining an physician order to administer all the medication together for residents with gastro tubes, following physician orders, and waiting at least 2 minutes between eye drops when administrating 2 different prescribed eye medications. All licensed nurses and	

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F 759	Continued From page 124 - Lisinopril (high blood pressure) - Norvasc (high blood pressure) - Metoprolol (high blood pressure) - Januvia (diabetes) - Baclofen (muscle relaxant) - Lamotrigine (seizures) - Augmentin (antibiotic) Nurse #3 then proceeded to provide the medications to Resident #14 through her gastro tube. Nurse #3 was interviewed on 10-10-23 at 8:20am. The nurse discussed being "uncomfortable" crushing medication when the manufacturers instructions were not to crush but stated she thought it was "ok" since the Pharmacist told her she could. Nurse #3 confirmed there was not a Physician order to mix Resident #14's medication together and stated she was unaware there needed to be an order. Review of Resident #14's physician orders revealed no order for the resident's medications to be mixed. The facility's Medical Director was interviewed by telephone on 10-11-23 at 4:12pm. The Medical Director stated he was familiar with Resident #14. He stated he was unaware the nurses were crushing medication that should not be crushed per the manufacturer's instructions. The Medical Director discussed the manufacturers instructions should be followed and it was the responsibility of the Pharmacist to recognize medications that could not be crushed. He further stated the Pharmacist should have recommended a comparable medication that could be crushed or be provided in a liquid form. The Medical Director	F 759	medication aides received the in service and an observed medication pass by the administrative nurses. The education was completed on 11/13/23. Effective 11/14/23, any facility or agency licensed nurses/certified medication aide that have not been educated will not be allowed to work until education is received in- person or via telephone by the Director of Nursing or designee. All newly hired nursing staff or clinical agency personnel will receive education during the orientation process by the Staff Development Coordinator (SDC) and/or administrative nurses. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Monitoring of medication pass observations will be performed Staff Development Coor, Asst Director of Nursing, Unit Manager or Contracted Pharmacist Consultant with 5 random licensed nurses/medication aides based on the daily scheduled employees/agency clinical personnel each week. These observations will continue weekly x 8 (eight) weeks, then monthly for 2 months and quarterly thereafter to ensure compliance. The error rate must not exceed five percent (5%) during any observation that takes place. If the error rate of a medication administration pass exceeds five percent (5%) immediate education will be provided and another medication pass will be observed. Any error rate that exceeds 5% will be reported to the Administrator and Director of Nursing. The DON and/or administrative nurses will	

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F 759	Continued From page 125	F 759		

stated he would have expected Nurse #3 to call him or the Nurse Practitioner back once the Pharmacist had told her to crush the medication. He also explained he was unaware the nurses were mixing all of Resident #14's medication together. The Medical Director stated there are some medications that when mixed could cause an adverse reaction. He said he expected the nurses to prepare Resident 14's medication separately and administer them separately.

The Director of Nursing (DON) was interviewed on 10-11-23 at 4:23pm. The DON stated there was a lack of education with staff on administering medication through a gastro tube and said she felt Nurse #3 had provided Resident #14 her medications as she was instructed by the Pharmacy. The DON stated she expected staff to provide medication per protocol and Physician orders.

During a telephone interview with the Nurse Practitioner (NP) on 10-12-23 at 12:15pm, the NP discussed the Pharmacy should have provided a list of medications to the facility that were not allowed to be crushed. He further stated he would have expected Resident #14's medication not to be crushed per the manufacturer's instructions and that Nurse #3 should have called him back with the Pharmacy information and not crushed the medication.

The Pharmacy Director of Clinical Services for the facility was interviewed by telephone on 10-12-23 at 12:53pm. The Pharmacy Director of Clinical Services explained even if the manufacturer's instructions were not to crush a medication, she would instruct the facility staff to crush the medication anyway depending on

complete a summary of these observation results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 126	F 759		

where the medication was going to be absorbed in the body. She further explained she did not follow manufacturer's instructions because "most manufacturer's instructions are out of date" and stated she relied on the recent clinical trials to determine product instructions. The Pharmacy Director of Clinical Services also stated the Pharmacy Consultant was responsible for looking at Resident #14's medications and determining what medications could be crushed.

The facility's Pharmacy Consultant was not available for an interview.

2a. Resident #7 as admitted to the facility 9-26-18 with multiple diagnoses that included Parkinson's and cerebral infarction.

Resident #7 was ordered the following medications.
- Refresh eye drops 1%. 1 drop left eye.
- Artificial Tears 1 drop both eyes.

Observation of medication pass occurred on 10-10-23 at 9:45am with Medication Aide (MA) #1. MA #1 was observed to place the Refresh eye drops in both eyes of Resident #7.

2b. Further observation of the medication pass revealed after MA #1 placed the Refresh eye drops into Resident #7's eyes, she immediately placed the Artificial Tears eye drops into both eyes of Resident #7.

MA #1 was interviewed on 10-10-23 at 10:25am. The MA confirmed she had placed the Refresh eye drops into both eyes of Resident #7. After re-reading the order, MA #1 stated "I didn't read the whole order. I just read eye drops and thought

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F 759	Continued From page 127 it was for both eyes." The MA also discussed not being aware that there needed to be a 3-5-minute lapse between each different eye drop. The Director of Nursing (DON) was interviewed on 10-12-23 at 3:51pm. The DON stated she expected staff to read the whole order prior to administering medications and wait the allotted time frame between administering each different eye drop.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		11/13/23

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F 761	Continued From page 128 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired medications for 1 of 2 medication storage rooms observed (station 1 medication room), failed to keep unattended medications in a locked medication cart for 1 of 5 medication carts observed (700-hall medication cart), and failed to keep unattended medications in a locked treatment cart for 2 of 3 treatment carts observed (station 1 treatment cart and station 2 treatment cart). Findings Included: 1. During observation of the station 1 medication room 10/13/23 at 8:34 AM with the Director of Nursing, the station 1 medication room was observed to contain six bottles of simethicone 125 milligrams which had an expiration date of 9/2023, one bottle of simethicone 80 milligrams which had an expiration date of 8/2023, and one bottle of simethicone 80 milligrams which had an expiration date of 9/2023. During an interview on 10/13/23 at 8:34 AM the Director of Nursing stated the simethicone 125 milligrams, and 80 milligrams were passed their expiration dates and still in the medication storage room and available for use. She stated the night supervisor was responsible for rotating the medication storage room inventory and she was unsure why the six bottles of simethicone 125 milligrams and two bottles simethicone 80 milligrams were not discarded. She concluded expired medications should be discarded. 2. During observation on 10/10/23 at 8:22 AM the 700-hall medication cart's lock was observed in	F 761	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: There was no resident identified in this alleged deficient practice. On 10/12/23, the Director of Nursing audited the medications in station 1 medication room to ensure medications were not stored beyond their expiration date. Any medications discovered were discarded immediately. Nurses #4 and #17 were educated on ensuring their medication and treatment carts are locked when unattended by the Staff Development Coordinator on 11/9/23. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected by this alleged deficient practice. The Director of Nursing audited the medications in station 2 medication room to ensure medications were not stored beyond their expiration date. Any medications discovered were discarded immediately. The Director of Nursing inspected treatment and medication carts on hallways to ensure they were locked when unattended. 3) 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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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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F 761	Continued From page 129 the unlocked position and the medication cart was unattended on the 700-hall. A nurse aide was on the 700-hall two rooms away from the unlocked medication cart. At 8:24 AM Nurse #17 returned to the unlocked medication cart. During an interview on 10/10/23 at 8:25 AM Nurse #17 stated the medication cart was unlocked and she should have locked medication cart before leaving it unattended. During an interview on 10/11/23 at 9:18 AM the Director of Nursing stated medication carts were to be locked when unattended. 3. During observation on 10/10/23 at 7:56 AM the station 1 treatment cart's lock was observed in the unlocked position and the unlocked treatment cart was unattended. At 7:56 AM a maintenance staff member walked past the unlocked treatment cart, at 7:57 AM a housekeeping staff member walked past the unlocked treatment cart, at 7:58 AM a nurse aide walked past the unlocked treatment cart, and at 7:59 AM a nurse aide walked past the unlocked treatment cart. At 8:00 AM Nurse #4 approached the unlocked treatment cart. During an interview on 10/10/23 at 8:00 AM Nurse #4 stated it was easier to get supplies from the supply room with the station 1 treatment cart unlocked. She stated this was why she left it unlocked while grabbing supplies in the supply room. She concluded treatment carts were to be locked when unattended. On 10/10/23 at 8:01 AM the station 1 treatment cart contents were observed with Nurse #4. The station 1 treatment cart contained skin prep, no	F 761	The Unit Managers will inspect the medication rooms weekly to ensure that all expired medications are discarded. The Unit Managers will monitor the medication and treatment carts daily while rounding to ensure that the medication and treatment cart are locked while unattended. The night shift supervisor and night shift nurses were educated on rotating and monitoring the medication inventory in the medication storage room on 11/9/23 by the Staff Development Coordinator. On 11/9/23, education was initiated by the SDC with all licensed nurses, medication aides and agency clinical licensed nurses, medication aides on ensuring medication and treatment carts are locked when unattended. The education was completed on 11-13-23. Any facility or agency licensed nurses/medication aides that have not been educated will not be allowed to work until education is received in- person or via telephone by the Director of Nursing and/or administrative nurse. All newly hired licensed nursing or medication aide staff or clinical agency personnel will receive education during the orientation process by the Staff Development Coordinator (SDC) and/or administrative nurse on ensuring their medication/treatment carts are locked when not attended. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing (DON) will review inspections completed by the Unit	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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F 761	Continued From page 130 sting barrier film, povidone-iodine prep pads, medihoney, calcium alginate, silver alginate, xeroform petrolatum dressing, lidocaine HCl jelly USP 2% 120 milligrams per 6 milliliter, zinc oxide ointment 20% antimicrobial skin and wound gel, moisture barrier cream, nystatin topical powder USP 100,000 USP units per gram, gentamicin sulfate ointment 0.1% USP, Santyl ointment 250 units/gram, mupirocin ointment USP 2%, PeriGuard ointment, ammonium lactate 12%, Calmoseptine ointment, Silvasorb gel silver antimicrobial wound gel, triamcinolone acetonide cream USP 0.1%, Collagen Hydrogel Wound Dressing, and wound cleanser. During an interview on 10/11/23 at 9:18 AM the Director of Nursing stated treatment carts were to be locked when unattended. 4. During observation on 10/10/23 at 8:10 AM station 2 treatment cart's lock was observed in the unlocked position and the unlocked treatment cart was unattended. Three nurse aides were observed to pass the unlocked station 2 treatment cart at 8:10 AM. During an interview on 10/10/23 at 8:11 AM Medication Aide #1 stated she had not accessed the treatment cart on station 2 that morning and the other medication aide working station 2 had not accessed the station 2 treatment cart either as medication aids did not have access to the treatment carts. During an interview on 10/10/23 at 8:12 AM Nurse #4 stated she was responsible for maintaining both the station 2 and station 3 treatment carts but the station 1 treatment cart was her primary cart. She stated the station 2	F 761	Managers of the medication storage room for expired medications and compliance to medication and treatment carts being locked while unattended twice a week for 4 weeks, then once a week for 8 weeks and quarterly thereafter to ensure compliance. The DON will complete a summary of these inspection results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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F 761	Continued From page 131 treatment cart was maintained so that when she was not working, the nurses on station 2 would access the treatment cart to provide wound care. She concluded she had accessed it one day last week putting supplies in it and did not know who had accessed the station 2 treatment cart last. On 10/10/23 at 8:13 AM treatment cart #2's contents were observed with Nurse #4. The station 2 treatment cart contained hydrocortisone 0.5% cream, nystatin ointment 100,000 USP, hydrocortisone cream 1%, Biofreeze gel, Medihoney gel, xeroform petrolatum non adhering dressing, diclofenac sodium topical gel 1%, mupirocin ointment USP 2%, ammonium lactate 12%, ketoconazole shampoo 2%, calmoseptine ointment, desitin zinc oxide, clotrimazole and Betamethasone dipropionate cream USP 1%/0.05%, poly bacitracin zinc USP, chlorhexidine gluconate solution 4.0% w/v, and Betadine solution 10% povidone-iodine. During an interview on 10/11/23 at 9:18 AM the Director of Nursing stated treatment carts were to be locked when unattended.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		11/13/23

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 132 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to 1) label/date opened food items stored in 1 of 1 one of one walk-in freezer and 2) label/date food items stored in 1 of 1 dry goods storage area. These practices had the potential to affect food served to all residents. Findings included: 1. Accompanied by the Dietary Manager, an initial tour of the kitchen was conducted on 10/9/23 at 10:59 A.M. Observations made of the walk-in freezer identified the following: - 1 opened clear plastic bag filled halfway with shrimp, no open date or use by date on the package - 1 opened clear plastic bag with 19 beef hot dogs, no open date or use by date on the package - 1 opened clear plastic bag fille halfway with chicken patties, no open date or use by date on the package - 1 large Styrofoam cup with a red straw sticking out of the plastic lid on top, the contents were frozen, no label or date on the cup An interview was conducted with the Dietary Manager during the tour of the walk-in freezer on	F 812	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident was named in this alleged deficient practice. All undated items were removed and discarded by the Dietary Manager and Assistant Dietary Manager on 10/19/23. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected by this deficient practice. An observation audit was conducted by the Dietary Manager to ensure there were no other open items that were not labeled and dated in the dry storage room, walk-in refrigerator, and walk-in freezer. This observation audit was conducted on 10/19/23. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: At the time that a food item is opened and	

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F 812	Continued From page 133 10/9/23 at 10:59 A.M. At that time, the Dietary Manager indicated he was unsure how long the food items had been in the freezer or when the items had been opened. During the interview, he stated all the opened food items in the freezer needed to be dated with an opened date before being placed back into the freezer. The Dietary Manager was observed as he removed the undated foods from the walk-in freezer. An interview was conducted on 10/13/23 at 10:08 A.M. During the interview, the Administrator stated the dietary staff were responsible for following policy and all opened food items should be dated when placed in storage. The Administrator was unable to provide a reason the food items were not labeled with a date when they were opened and returned to the walk-in freezer. 2. Accompanied by the Dietary Manager and the Assistant Dietary Manager, an initial tour of the kitchen on 10/9/23 at 11:05 A.M. of the kitchen's dry goods storage area identified the following: - 1 opened 64-ounce package of min chocolate chips, approximately 1/4 full, no open or use by date on the package - 1 package of flack potatoes, approximately 1/3 full. The package was rolled up with clear plastic wrap around the package, there was no open date and a "use by" date was not visible - 1 package of brown sugar, approximately 1/3 full. The package was rolled up with clear plastic wrap around the package, there was no open date and a "use by" date was not visible An interview was conducted with the Assistant Dietary Manager during the tour of the kitchen's	F 812	is being stored for re-use, the dietary employee will completely seal the food item then provide the date and label prior to storage. The dietary manager began education for Dietary staff, including cooks and aides, on ensuring that items are to be labeled and dated in the dry storage, walk-in refrigerator, and walk-in freezer. This education was completed on 11/13/23 by the dietary manager. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility Administrator will conduct an observation audit to ensure that items that are opened are appropriately labeled and dated in the dry storage, walk-in refrigerator, and walk-in freezer. This audit will be conducted 5x per week x 4weeks, 3x per week x 4 weeks and weekly 4 weeks. The facility administrator will complete a summary of the results of these audits and present them at the QAPI committee to ensure continued compliance.	

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F 812	Continued From page 134 dry storage area on 10/9/23 at 11:07 A.M. The Assistant Dietary Manager stated when a dry goods food item was used during meal preparation, the staff were responsible to properly seal the item and write an open date on the outside of the package. The Assistant Dietary Manager explained a food truck arrives twice a week to the facility and when food items are restocked, opened items should be checked and verified to have an open date written on the package. The Assistant Dietary Manager stated she was unsure who had placed the opened items in the dry storage area without a date or when the items had been placed into the dry storage area. An interview was conducted on 10/13/23 at 10:08 A.M. During the interview, the Administrator stated the dietary staff were responsible for following policy and all opened food items should be dated when placed in storage. The Administrator was unable to provide a reason the food items were not labeled with a date when they were opened and returned to the dry storage area.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain the area surrounding the dumpsters free of debris for 2 of 2 dumpsters observed. Findings included:	F 814	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident was named in this alleged deficient practice.	11/13/23

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F 814	Continued From page 135 During an observation of the dumpster area with the Dietary Manager and the Assistant Dietary Manager on 10/9/23 at 11:15 A.M., debris was found next to and behind the back of the right and left dumpsters. Debris included 11 disposable gloves, 4 plastic lids used on disposable Styrofoam cups/bowls, 1 plastic knife, 4 plastic spoons, 1 plastic bowl, 1-8ounce empty bottle of water, one baseboard, and three pieces of damp crumbly cardboard. An interview was conducted on 10/9/23 at 11:15 A.M. with the Dietary Manager. The Dietary Manager confirmed there were items laying around the dumpster and stated the area should be free from debris. During the interview, he stated he had been employed at the facility for approximately three weeks and had not cleaned the area around the dumpsters during his period of employment. The Dietary Manager further explained he was unsure who was responsible for maintaining the area around the dumpsters. An interview was conducted on 10/9/23 at 11:17 A.M. with the Assistance Dietary Manger. During the interviews, the Assistance Dietary Manager stated she had not cleaned the area around the dumpster and explained she thought it was the maintenance department's responsibility to keep the area around the dumpster clean. A second observation of the dumpster area was conducted on 10/10/23 at 7:45 A.M. revealed the dumpster area was in the same condition. An interview was conducted on 10/12/23 at 9:10 A.M. with the Maintenance Director. During the interview, he stated the dietary staff were	F 814	Debris was immediately removed from around the dumpster area by the Dietary Manager on 10/9/23. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected by this alleged deficient practice. The Dietary manager will educate staff on properly keeping the dumpster area clean and free from debris by 11/8/23. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: When trash is disposed of at the dumpster area the doors will be closed and any debris on the ground will be picked up and disposed of properly The dietary manager and/or facility maintenance director will be responsible for ensuring that the dumpster area is free of debris. The Dietary manager will educate staff, including dietary, housekeeping, and maintenance on properly disposing of trash in the dumpster and ensuring that the dumpster area clean and free from debris. This education will be completed by 11/8/23. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Maintenance Director or Maintenance Assistant will complete observation audit of the dumpster area 5 times per week for	

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F 814	Continued From page 136 responsible for maintaining the cleanliness of the area around the dumpsters. An interview was conducted on 10/13/23 at 10:08 A.M. with the Administrator. The Administrator stated the area around the dumpster should be free from debris. She further explained if debris had been observed around the dumpsters, then her staff needed more education on the importance of keeping the area clean. During the interview, she stated the dietary staff were responsible for maintaining the cleanliness around the dumpsters and without speaking with the Dietary Manager, she was unable to state why the dumpster area had not been maintained free from debris.	F 814	2weeks, then 3 times per week for 2 weeks, then monthly for 2 months. The Maintenance Director will complete a summary of the audit results and present at the facility at the monthly QAPI committee to ensure continued compliance.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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F 842	Continued From page 137	F 842		

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 842	Continued From page 138 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain complete and accurate medical records in the areas of wound care (Residents #32, #58, #1 and #81) and splint management (Resident #53). This was for 5 of 32 resident records reviewed. The findings included: 1) Resident #32 was admitted to the facility on 8/30/23 with diagnoses that included osteomyelitis (an inflammation of the bone caused by an infection) of the vertebra and sacral region and diabetes type 2. The physician orders included orders dated 8/31/23 for the following: - Cleanse the right buttock with wound cleanser. Pat dry. Apply silver alginate (an antimicrobial dressing) to the wound bed and cover with a foam dressing daily. - Cleanse the left ischium (either half of the pelvis) with wound cleanser. Pat dry. Apply silver alginate to the wound bed and cover with a foam dressing daily. A review of the September 2023 and October 2023 Treatment Administration Records (TARs) revealed no wound care had been signed off as completed to Resident #32's right buttock and left ischium wounds on 9/2/23, 9/9/23, 9/23/23,	F 842	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #1, #32, #58 and #81 were assessed by DON and attending Physician with no negative outcomes noted. The attending physician was notified on 10/12/23 by Director of Nursing (DON) of the omissions for residents #1, #32, 58 and #81 and the treatment error for resident #32. All residents are receiving appropriate treatment currently. Resident #53 is wearing splint per physician order. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of current residents TARs will be completed to ensure all orders on the TARs were signed off by the Licensed Nurses for the month of October by Director of Nursing (DON) or designee on 11/1/23. Any variances were discussed with the attending physician by the DON or designee. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 11/7/23, education was initiated to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 842	Continued From page 139 9/24/23, 9/30/23, 10/1/23, 10/4/23, 10/5/23, 10/6/23, 10/7/23 and 10/8/23 at 7:00 PM. An interview occurred on 10/11/23 at 2:06 PM with Nurse #4. She explained she was the wound care nurse and responsible for completing wound care during the weekday and floor nurses completed wound care on the weekends. Nurse #4 would have been responsible for Resident #32's wound care on 10/4/23, 10/5/23 and 10/6/23. She reviewed the October 2023 TAR and confirmed she had not signed off Resident #32's wound care had been completed. Nurse #4 stated she was certain the treatments were completed as ordered but forgot to initial the TAR. The Director of Nursing was interviewed on 10/12/23 at 3:15 PM and stated it was her expectation for Resident #32's TAR to be complete and accurate regarding his wound care. A phone interview was completed with Nurse #8 on 10/13/23 at 9:51 AM. She was assigned to care for Resident #32 on the 7:00 AM to 7:00 PM shift on 10/7/23. She explained she completed wound care as ordered for Resident #32 but forgot to sign off on the TAR. Multiple phone attempts were made to Nurse #10 with no answer or return call. She was assigned to care for Resident #32 on the 7:00 AM to 7:00 PM shift on 9/23/23 and 10/1/23. 2) Resident #58 was admitted to the facility on 3/17/23 with diagnoses that included a stroke, dementia and osteoarthritis. A review of the physician orders included orders	F 842	current licensed nursing staff including agency clinical licensed personnel regarding completion and signing of treatment orders and following the physician treatment orders by the DON or designee. The education was completed 11/13/23. Effective 11/14/23, any facility or agency licensed nurse that has not been educated will not be allowed to work until education is received in- person or via telephone by the Director of Nursing or designee. All newly hired nursing staff or clinical agency personnel will receive education during the orientation process by the Staff Development Coordinator (SDC) or designee on providing wound treatment care per the physician order and signing the TAR 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing (DON) or designee will audit TAR documentation weekly x 2 months, then monthly for 2 months and quarterly thereafter to ensure compliance. Findings will be presented by DON at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance. Changes will be made to the plan as necessary to maintain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 842	Continued From page 140	F 842		

dated 8/24/23 for the following wound care:
- Dakin's (a medical bleach like solution) solution 0.5% to the right posterior heel and cover with a foam dressing daily.
- Skin prep (a liquid that forms a protective film) to the right lateral foot daily.

A review of the September 2023 and October 2023 Treatment Administration Records (TARs) revealed no wound care had been signed off as completed to Resident #58 on 9/2/23, 9/3/233, 9/9/23, 9/10/23, 9/16/23, 9/17/23, 9/23/23, 9/24/23, 9/30/23, 10/6/23, 10/7/23, 10/8/23 and 10/9/23.

A phone interview was completed with Nurse #6 on 10/11/23 at 1:40 PM. She was assigned to care for Resident #58 on the 7:00 AM to 7:00 PM shift on 9/3/23, 9/16/23 and 10/8/23. The September 2023 and October 2023 TARs were reviewed, and she stated that she completed the wound care for Resident #58 as ordered but forgot to sign off on the TAR that it was completed.

Nurse #12 was interviewed on 10/11/23 at 1:52 PM. She was assigned to care for Resident #58 on 9/9/23, 9/10/23, 9/23/23, and 9/24/23. After reviewing the September 2023 TAR, she stated that she always completed wound care for Resident #58 but must have forgotten to sign the TAR.

An interview occurred on 10/11/23 at 2:06 PM with Nurse #4. She explained she was the wound care nurse and responsible for completing wound care during the weekday and floor nurses completed wound care on the weekends. Nurse #4 would have been responsible for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 842	Continued From page 141	F 842		

#58's wound care on 10/6/23 and 10/9/23. She reviewed the October 2023 TAR and confirmed she had not signed off Resident #58's wound care had been completed. Nurse #4 stated she was certain the treatments were completed as ordered but forgot to initial the TAR.

A phone interview was conducted with Nurse #11 on 10/12/23 at 11:36 AM, who was assigned to care for Resident #58 on 9/2/23 and 9/17/23. The September 2023 TARs were reviewed, and Nurse #11 stated she was sure she completed wound care for Resident #58 but must have forgotten to sign off on the TAR.

The Director of Nursing was interviewed on 10/12/23 at 3:15 PM and stated it was her expectation for Resident #58's TAR to be complete and accurate regarding his wound care.

A phone interview was completed with Nurse #8 on 10/13/23 at 9:51 AM. She was assigned to care for Resident #58 on the 7:00 AM to 7:00 PM shift on 10/7/23. She explained she completed wound care as ordered for Resident #58 but forgot to sign off on the TAR.

Multiple phone attempts were made to Nurse #10 with no answer or return call. She was assigned to care for Resident #58 on the 7:00 AM to 7:00 PM shift on 9/30/23.

3. Resident #1 was admitted to the facility on 3-30-23 with multiple diagnoses that included stage 4 pressure ulcer to right buttocks, stage 4 pressure ulcer to left buttocks, stage 4, pressure ulcer to left lower back.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 842	Continued From page 142	F 842		

The quarterly Minimum Data Set (MDS) dated 8-31-23 revealed Resident #1 was cognitively intact.

Physician order dated 9-14-23 read clean stage 4 wound to right buttocks with wound cleanser, apply silver alginate, and cover with a foam dressing daily.

Physician order dated 9-14-23 read clean stage 4 wound to left buttocks with wound cleanser, apply silver alginate, and cover with a foam dressing daily.

Physician order dated 9-14-23 read clean wound to lower back with wound cleanser, apply silver alginate, and cover with a foam dressing daily.

A review of Resident #1's Treatment Administration Record (TAR) for September and October 2023 revealed Resident #1 did not have documentation of his wound care being completed on the following days.
- September: 16, 17, 23, 24
- October: 7, 8

Nurse #4 was interviewed on 10-11-23 at 11:39am. Nurse #4 explained she was the designated wound care nurse Monday through Friday. She stated the floor nurses were responsible for completing wound care on Resident #1 on the weekends. Nurse #4 discussed as wound care was completed, the nurses were responsible for documenting on the TAR.

A telephone interview occurred with Nurse #11 on 10-11-23 at 12:45pm. Nurse #11 confirmed she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 842	Continued From page 143	F 842		

had been assigned to Resident #1 on 9-17-23. Nurse #11 said she was aware she was responsible for resident wound care on the weekends but was unaware that she needed to document in the medical record that the wound care was completed.

During an interview with Nurse #12 on 10-11-23 at 1:47pm, the nurse confirmed she had been assigned to Resident #1 on 9-23-23, 9-24-23, 10-7-23, and 10-8-23. Nurse #12 explained she often forgets to document when she has completed wound care on Resident #1. She explained she becomes "busy" and forgets. Nurse #12 discussed completing Resident #1's wound care on all the dates except 10-8-23 which she stated on 10-8-23 she had become behind in her assignment and was unable to complete the care.

Attempts were made to contact the other nurses but were unsuccessful.

The Director of Nursing was interviewed on 10-12-23 at 3:51pm. The DON stated she was not aware the nurses were not documenting the completion of Resident #1's wound care. She said she expected the nursing staff to document on the TAR each time Resident #1's wound care had been completed.

4. Resident #81 was admitted to the facility on 5-5-23 with multiple diagnoses that included stage 4 pressure ulcer to the sacrum, stage 4 pressure ulcer to left heel, stage 4 pressure ulcer to right heel, stage 4 pressure ulcer to right lateral foot, and stage 3 pressure ulcer to left shin.

The quarterly Minimum Data Set (MDS) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 144	F 842		

8-29-23 revealed Resident #81 was cognitively intact.

The Physician order dated 9-7-23 read clean pressure wound to right lateral foot with wound cleanser, apply silver alginate and cover with a foam dressing daily.

Physician order dated 9-7-23 read clean left lateral shin with wound cleanser, apply Santyl, silver alginate, and cover with a foam dressing daily.

The Physician order dated 9-21-23 read clean stage4 wound to left heel with wound cleanser, apply silver alginate, and cover with a foam dressing daily.

Physician order dated 9-21-23 read clean sacral wound with Dakin's, apply silver alginate, and cover with a foam dressing daily.

Physician order dated 9-22-23 read clean stage 4 wound to right heel with Dakin's, apply silver alginate, cover, and wrap with gauze daily.

Resident #81's Treatment Administration Record (TAR) for September and October 2023 revealed there was no documentation that wound care was completed on the following days.
- September: 9, 10, 16, 17
- October: 7, 8

Nurse #4 was interviewed on 10-10-23 at 11:57am. The nurse confirmed Resident #81's wound care was to be completed daily. She stated she worked Monday through Friday and that the floor nurses were responsible for Resident #81's wound care on the weekends.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 842	Continued From page 145	F 842		

Nurse #4 also discussed documentation of Resident #81's wound care should occur on the TAR.

During a telephone interview with Nurse #11 on 10-11-23 at 12:45pm, Nurse #11 confirmed she had been assigned to Resident #81 on 9-17-23. She stated she was aware Resident #81 had wounds but said she was unaware that she was responsible for documenting Resident #81's wound care in the medical record.

An interview with Nurse #12 occurred on 10-11-23 at 1:47pm. The nurse confirmed she had been assigned to Resident #81 on 9-9-23, 9-10-23, 10-7-23, and 10-8-23. Nurse #12 stated she often forgets to document the completion of Resident #81's wound care. She explained she will often get "busy" and forget to document. Nurse #12 discussed completing Resident #1's wound care on all the dates except 10-8-23 which she stated on 10-8-23 she had become behind in her assignment and was unable to complete the care.

The Director of Nursing (DON) was interviewed on 10-11-23 at 4:44pm. The DON discussed not being aware the nurses were not documenting Resident #81's wound care. She said she expected nursing staff to document in the resident's TAR each time his wound care was completed.

5. Review of the medication administration record on 10/10/23 at 4:03 PM revealed the nurse documented Resident #53's multipodus boots (multi-purpose boots designed to use for plantar flexion contracture, decubitus heel and toe ulcers,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 146	F 842		

hip rotation) were in place on 10/10/23 at 7 PM.

During observation on 10/10/23 at 4:05 PM Resident #53 was observed to not have his boots in place.

During an interview on 10/10/23 at 4:05 PM the family member stated to her knowledge PT #1 was the only one who knew how put on Resident #53's ankle splints and that therapy was placing them currently and not nursing staff. She stated she had been told that therapy wished to monitor the splints while he was still on their caseload and the splints would be on when therapy worked with Resident #53. She stated he had no ankle splints on at that time and no staff had offered to place the boot splints on his feet.

During observation on 10/11/23 at 8:01 AM Resident #53's multipodus boots were observed to not be placed on Resident #53 and were in his closet.

During an interview on 10/11/23 at 9:31 AM PT #1 stated therapy was currently working with Resident #53 and his new multipodus boots. He stated the current expectation was the multipodus boots would not be placed daily like his wrist splints. He stated the multipodus boots were only placed on Resident #53 when physical therapy worked with Resident #5 as tolerated. He stated Resident #53 did not have his multipodus boots put on him yesterday 10/10/23 and would not have them on today 10/11/23.

Review of the medication administration record on 10/11/23 at 12:54 PM revealed the nurse documented Resident #53's boots were in place on 10/11/23 at 7 AM as well as 10/11/23 at 7 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 147 During an interview on 10/11/23 at 1:04 PM Nurse #15 stated she only knew he had wrist splints. She further stated when she noted his wrist splints were on, she would document his splints were on and did not know he had boot splints not put on. Stated when she sees the wrist, she knows the boots are there she never lifts the sheets to see if they were on. Stated she documented about 7 PM today even though it had not happened yet. During an interview on 10/11/23 at 1:13 PM the Director of Nursing stated nursing documentation should accurately reflect the care the resident received, and the nurse should not have assumed the splints were in place when documenting on the medication administration record.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 148 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 867	Continued From page 149	F 867		

level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 150 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident, family, responsible party, physician, police dispatch, and staff, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint investigation survey of 6/11/2021, the revisit survey of 8/6/21, the complaint investigation survey of 9/20/2021, and the recertification and complaint investigation survey of 6/17/2022. This was for nineteen recited deficiencies on the current recertification and complaint investigation survey of 10/18/2023. The deficiencies included: Self Determination (F561), Request/Refuse/ /Discontinue Treatment/Formulate Advance Directive (F578), Grievances (F585), Reporting of Alleged Violations (F609), Accuracy of Assessments (F641), Baseline Care Plan (F655), Develop and Implement Comprehensive Care Plan (F656), Care Plan Timing and Revision (F657), Activities	F 867	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: There was no resident identified with this alleged deficient practice. Administrator reviewed current prior citations of F561, F578, F585, F609, F641, F655, F656, F657, F677, F686, F689, F727, F758, F761, F812, F814, F842, F880 and F947, as of 11/13/23. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected by this alleged deficient practice. The facility Administrator has completed a 3-year review, as of 11/13/23 of the facilities surveys and identified areas of repeat non-compliance. The areas identified as repeat non-compliance will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 867	Continued From page 151 of Daily Living Care Provided for Dependent Residents (F677), Treatment and Services to Prevent/Heal Pressure Ulcers (F686), Free of Accident Hazards/Supervision/Devices (F689), Registered Nurse 8 hour/7 days/week (F727), Free from Unnecessary Psychotropic Medication/PRN (as needed) Use (F758), Label/Store Drugs and Biologicals (F761), Food Procurement /Store/Prepare/Serve-Sanitary (F812), Dispose Garbage and Refuse Properly (F814), Resident Records- Identifiable Information (F842), Infection Control and Prevention (F880), and Required In-Service Training for Nurse Aides (F947). The continued failure during two or more federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross-referenced to: F561: Based on record review, resident interview and staff interviews, the facility failed to honor a resident's choice related to showers for 1 of 9 dependent residents reviewed for choices (Resident #29). During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to honor a resident's choice to get out of bed. In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Administrator stated residents receiving showers had not been identified as a concern with the QAA committee, and the QAA was not monitoring resident showers currently.	F 867	be reviewed by the Administrator and the Quality Assurance Performance Improvement (QAPI) committee and Action Plans developed to ensure continued compliance. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: At the time of an identified area of non-compliance brought up during the facility monthly QAPI meeting, the facility administrator will ensure that a QAPI Action plan is implemented, to include changes to current facility systems to ensure that deficient practice will not recur and monitoring to ensure continued compliance. Regional Director of Operations (RDO) has re-educated Administrator and Director of Nursing on the QAPI process. The facility administrator completed training, as of 11/13/23 with the QAPI committee, which includes Social Services, Dietary Manager, Housekeeping/laundry manager, maintenance director, business office manager, therapy manager, staff development coordinator , medical records, admissions, activities director and medical director, to include implementation of action plans, monitoring tools, the evaluation of the QA process, and modification and if correction is needed to prevent the recurrence of deficient practice. The in-service also included identifying issues that warrant development and establishing a system to	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 152 F578 : Based on record review and staff interviews the facility failed to ensure advanced directive information was accurate throughout residents' electronic and paper medical records for 4 of 5 residents (Resident #42, Resident #52, Resident #57, and Resident #76) reviewed for advanced directives. During the recertification and complaint survey of 6/11/2021, the facility was cited for failure to obtain a physician's order and maintain an accurate Advance Directive. During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to accurately document advance directives (code status) throughout the medical record. In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Administrator stated Advance Directive data shared by the Social Services department in the October 2023 QAA Committee meeting addressed the concern of no physician order to reflect a residents' Do Not Resuscitate (DNR) status on the medical record. She explained there were changes made in the process for obtaining and documenting an Advance Directive in residents' medical record and stated DNR orders were obtained for residents needing a DNR order with an Advance Directive stating DNR status. She said it was the social services department to report Advance Directive data to the QAA committee and there was no performance improvement plan developed for continue monitoring Advance Directives. F585: Based on resident interviews, family	F 867	monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. This education was completed as of 11/13/23. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The administrator will complete a summary of monitoring results to include honoring resident choices, ensure accuracy of advanced directives information, provide written resolution to grievances, maintain grievance records, report allegations of involuntary seclusion to state agency within 2 hours, accurately code MDS, develop baseline care plan within 48 hours of admission and present written summary, develop comprehensive care plan to address wandering behavior and use of wander guard, ensure interdisciplinary team review resident's comprehensive care plan and involve resident representative in care planning, provide ADL assistance, follow physician orders for pressure ulcer changes, maintain 8 hours of consecutive RN coverage, ensure PRN psychotropic medication is time limited , label and store drug biologicals, label and date food items in freezer and dry storage, remove debris around dumpsters, maintain complete and accurate medical records , implement infection control practices for hand hygiene during meals, provide 12 hours of training to certified nursing assistant that will be presented at the monthly Quality Assurance Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 867	Continued From page 153 interviews, staff interviews, record review the facility failed to provide a written resolution of grievances for 4 of 4 residents reviewed for grievances (Resident #59. #36, #14, #53). The facility also failed to maintain grievance records as required for a period of no less than 3 years from the issuance of the grievance decision. During the recertification and complaint survey of 6/11/2021, the facility was cited for failure to make prompt efforts to resolve grievances. In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Administrator stated grievances were placed in her box mail to review. She explained interventions were discussed with the department head investigating the grievance and resolutions were verbally discussed with resident or family members in person or by phone and signed. She stated grievances have been logged, signed as completed and filed since her employment in June 2023. F609: Based on record review and staff interviews the facility failed to submit an initial report to the State Survey Agency within 2 hours of notification of an allegation of involuntary seclusion. This was for 1 of 1 residents (Resident #71) reviewed for involuntary seclusion. During the complaint survey of 9/20/2021, the facility was cited for failure to send an initial report to the State Agency within the required timeframe. F641: Based on record review and staff	F 867	(QAPI) committee to ensure continued compliance. RDO will review QAPI notes bi-weekly for 3 months, then monthly to ensure continued compliance of previous identified areas of non-compliance to ensure there is an effective plan of correction in place and continuous monitoring is being reviewed. The administrator will have QAPI meeting bi-weekly for 3 months to ensure areas of non-compliance are being monitored and corrective actions are being completed as assigned.	

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 867	Continued From page 154	F 867		

interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 37 residents reviewed for MDS accuracy (Residents #390 and Resident #30).

During the recertification and complaint survey of 6/11/2021, the facility was cited for failure to code the MDS assessment accurately in the areas of medication, mental health illness and diagnoses.

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to code the MDS assessments accurately for falls.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Administrator stated the Minimum Data Set (MDS) staff attended and received information at the clinical morning meetings for changes in residents MDS. She stated the QAA committee was not monitoring accuracy of MDS assessments.

F655: Based on resident and staff interviews, interview with a Resident Representative and record reviews, the facility failed to develop a baseline care plan within 48 hours of a resident's admission and failed to provide a written summary of the baseline care plan to the Resident or Resident Representative for 4 of 28 sampled residents (Residents #29, #77, #388 and #89).

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to complete or formulate a baseline care plan within 48 hours and failed to provide a summary of the baseline care plans to residents or their representatives.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 867	Continued From page 155 In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Regional Nurse Consultant stated the facility thought they had a system in place (baseline care plans were on the admission checklist that the nurse manager reviews) for monitoring completion of baseline care plans within 48 hours of admission. She also stated if the baseline care plan was not completed at the interdisciplinary team (IDT) meeting, the IDT would complete the baseline care plan. She stated the system of completing baseline care plans would need re-evaluated. F656: Based on observations, record review and staff interviews, the facility failed to develop a comprehensive care plan which addressed wandering behavior and the use of a wander/elopement alarm for 1 of 33 residents (Resident #71) whose comprehensive care plans were reviewed. During the recertification and complaint survey of 6/11/2021, the facility was cited for failure to develop a comprehensive care plan for a resident who was receiving daily doses of psychotropic and anticoagulant medications. In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Administrator stated it was an oversite that Resident #71's wanderguard was not added to her comprehensive care plan. She stated the MDS nurses were responsible for completing the comprehensive care plan and were to update the comprehensive care plan as needed based on information shared at the IDT meetings every morning. She stated the facility would start	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 867	Continued From page 156	F 867		

monitoring the development of comprehensive care plans.

F657: Based on record review and staff interviews the facility failed to ensure an interdisciplinary team reviewed and revised a resident's comprehensive care plan and failed to ensure the resident's representative was involved in care planning after a quarterly Minimum Data Set (MDS) assessment for 1 of 33 residents (Resident #71) whose care plans were reviewed.

During the recertification and complaint survey of 6/11/2021, the facility was cited for failure to conduct care plan meetings within the required timeframe.

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to review and revise the care plan in the areas of behavior, splints, code status, care plan revision and care plan development.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Administrator stated Resident #71's care plan was to be reviewed as needed due to changes in Resident #71 and quarterly when MDS assessments were completed.

677: Based on record review and staff and family interviews the facility failed to change a resident's soiled brief due to meal trays being passed on the halls for 1 of 8 resident reviewed for activities of daily living care (Resident #53).

During the recertification and complaint survey of 6/11/2021, the facility was cited for failure to provide complete daily bathing for a resident who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 867	Continued From page 157	F 867		

required total assistance for all daily care.

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to provide incontinence care and showers.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Regional Nure Consultant stated the QAA committee was monitoring nurse aides conducting incontinent care. She explained completing the task was not the issue, the issue was documentation that the task was provided to the resident. She stated nursing administration staff have been collecting data on incontinent care documentation and reminding nursing staff to document incontinent care provided.

F686: Based on observation, record review, resident, staff, and Physician interviews, the facility failed to follow physician orders for pressure ulcer dressing changes, compete wound care as ordered, and set an alternating pressure mattress according to the resident's weight. This occurred for 3 of 3 residents (Resident #1, Resident #81, and Resident #32) reviewed for wound care.

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to complete a full body skin assessment on admission to accurately identify any pressure related injury present and failed to implement treatment orders for a left heel deep tissue injury (DTI) identified by the facility as present on admission.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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F 867	Continued From page 158	F 867		

p.m., the Regional Nurse Consultant stated the wound nurse was educated on the process and documentation of treatments provided to residents with pressure ulcers. She explained data shared with the QAA committee reported the facility had not had any worsening of wounds. She further stated investigations into pressure wounds identified as acquired in the facility showed the resident had a pressure wound when admitted to the facility.

F689: Based on observations, record review, and staff, police dispatch, physician, and responsible party (RP) interviews the facility failed to prevent a severely cognitively impaired resident (Resident #71) with known wandering behaviors and poor safety awareness from becoming trapped alone in a locked administrative staff's office with the lights off without staff's knowledge. The facility also failed to provide evidence that a thorough investigation of the incident was conducted and to put corrective measures in place after the incident to prevent a potential recurrence. This deficient practice had a high likelihood of causing Resident #71 serious physical and psychosocial harm. Resident #71 did not have the cognitive capacity to express an adverse outcome. A reasonable person would have suffered feelings of fear, anxiety, and/or helplessness from the incident. This was for 1 of 11 residents reviewed for the provision of supervision to prevent accidents.

During the complaint survey of 9/20/2021 the facility was cited for failure to provide supervision needed to prevent falls during daily care of a dependent resident resulting in the resident falling from a raised bed onto the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 867	Continued From page 159	F 867		

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to provide 1:1 supervision of a resident as ordered by the physician.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Regional Nurse Consultant stated the missing resident was a single incident, and the QAA committee had identified an increase in falls and had developed a plan of correction. She further stated, in looking at the data for accidents, accidents were occurring in the time frame between 7:00 a.m.- 10:00 a.m. the most and the facility's plan was to hire an extra personal care aide during that time frame.

F727: Based on record review and staff interviews, the facility failed to have 8 consecutive hours of Registered Nurse (RN) coverage for 7 of 120 days reviewed.

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 23 of 26 days.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Administrator stated the facility had registered nurses working in the facility. The Regional Nurse Consultant stated there were three registered nurses (who were not hired in March 2023 and April 2023) that worked on the units, and they rotated coverage the weekends. She also said, the registered nurses (RN) on the administrative staff were on call to cover the weekends for RN coverage as needed and she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 867	Continued From page 160	F 867		

felt like the RN coverage on weekends had improved.

F758: Based on record review and Medical Director, and staff interviews, the facility failed to ensure an as needed (PRN) psychotropic medication was time limited in duration for 1 of 5 residents reviewed for unnecessary medications (Resident #17).

During the recertification and complaint survey of 6/11/2021, the facility was cited for failure to obtain documentation for the rationale and duration to extend the use of an as needed (PRN) order for a psychotropic medication beyond 14 days.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Regional Nurse Consultant stated Resident #17 was receiving the psychotic medication for seizure activity, not for a psychotic disorder, and physicians can stretch out the duration of psychotic medications after the initial 14 days. She explained based on that information when the prn order for the psychotic medication was reviewed by nursing administration, there was concerns identified with the order.

F761: Based on observations and staff interviews the facility failed to discard expired medications for 1 of 2 medication storage rooms observed (station 1 medication room), failed to keep unattended medications in a locked medication cart for 1 of 5 medication carts observed (700-hall medication cart), and failed to keep unattended medications in a locked treatment cart for 2 of 3 treatment carts observed (station 1 treatment cart and station 2 treatment cart).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 867	Continued From page 161	F 867		

During the recertification and complaint survey of 6/11/2021, the facility was cited for failure to label medications with the minimum identifying information required, to discard expired medications stored in medication carts and a medication storage room and to store medications in accordance with the manufacturer's storage instructions in medication carts.

During the revisit survey of 8/6/2021, the facility was cited for failure to: discard an expired insulin pen, keep unopened insulin in the refrigerator, label an insulin pen with a resident's name and directions, and date the opening of an inulin pen that had been used.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Regional Nurse Consultant stated pharmacy was in the facility recently and checked medication for expirations. She explained she thought the pharmacist review included checking the medication carts and the medication storage areas and stated she would need to clarify with the pharmacy who was responsible to monitor expirations in the medication rooms. She stated central supply ordered and checked expirations of over-the-counter medications, and the central supply person had been out of work since August 2023.

F812: Based on observations and staff interviews, the facility failed to 1) label/date opened food items stored in 1 of 1 one of one walk-in freezer and 2) label/date food items stored in 1 of 1 dry goods storage area. These practices had the potential to affect food served

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 162	F 867		

to all residents.

During the recertification and complaint survey of 6/11/2021, the facility was cited for failure to ensure that food items that had been opened were labeled and dated, and food items were stored off the floor.

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to discard expired food items stored ready for use in the reach-in and walk-in refrigerator and to ensure that food items in the walk-in freezer and dry storage area were not stored on the floor. The facility was also cited for failure also to allow dishware to air dry before being nested for storage.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Administrator stated she made observations of kitchen practices every three weeks and food items being labeled had not been identified as a concern. She explained the Dietary Manager had been at the facility less than thirty days, and the Assistant Dietary Manager was recently promoted to the position. She stated she wasn't sure that they were checking that the dietary staff were labeling food items.

F814: Based on observation and staff interviews, the facility failed to maintain the area surrounding the dumpsters free of debris for 2 of 2 dumpsters observed.

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to maintain the area surrounding the dumpster free from trash and debris.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 163	F 867		

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Administrator stated she was not aware of a policy that addressed the cleanliness of the dumpster or whose responsibility it was for the cleanliness around the dumpster. She stated it was her understanding now that the Maintenance and the Assistant Maintenance personnel were responsible and stated the Regional Nurse Consultant was still gathering information on cleanliness of the dumpster.

F842: Based on record reviews and staff interviews, the facility failed to maintain complete and accurate medical records in the areas of wound care (Residents #32, #58, #1 and #81) and splint management (Resident #53). This was for 5 of 32 resident records reviewed.

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to accurately document the placement of a left-hand splint used for positioning and mobility.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Regional Nurse Consultant stated documentation of tasks completed had been identified as a problem, and assessing completion of documentation of tasks competed was an ongoing assessment. She explained the nursing administrative team was collecting data to remind staff to document care provided to residents.

F880: Based on observations, record review and staff interviews, the facility failed to implement their infection control policy when a nurse aide did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 867	Continued From page 164	F 867		

not perform hand hygiene during meal delivery and set up which required the nurse aide (NA) to position resident's personal belongings for 1 of 2 NAs observed passing meal trays. This had the potential to result in cross-contamination of microorganisms between residents.

During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to follow posted Contact Precautions signage by not removing Personal Protective Equipment when exiting a resident's room, to sanitize hands when delivering lunch trays to a resident and to wear gloves when handling dirty linen.

In an interview with the Administrator and the Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., the Regional Nurse Consultant stated unit managers monitored infection control practices of the nursing staff and the nurse aide not performing hand sanitation between delivering trays to residents was an oversite. She further stated the nursing staff had been trained to perform hand sanitation between residents when delivering meal trays.

F947: Based on record review and staff interviews the facility failed to ensure Nurse Aides (NA) received at least 12 hours of in-service training in one year. This was for 5 of 5 NA in-service training records reviewed (NA #12, NA #10, NA #4, NA #5).
During the recertification and complaint survey of 6/17/2022, the facility was cited for failure to provide required dementia management training and abuse prevention training for current nursing staff.

In an interview with the Administrator and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 165 Regional Nurse Consultant on 10/18/2023 at 4:41 p.m., they explained the QAA committee did not meet in August 2023 and September 2023 because the facility was trying to collaborate with outside venders (pharmacy, psychological services, laboratory as examples) to provide information to the QAA committee meeting. They explained that during August 2023 and September 2023 clinical meetings were held every morning with department heads, and areas of concern were discussed with interventions implemented and follow up discussions. The Regional Nurse Consultant stated falls increased above the benchmark, and data collected was entered into a computer program that sorted the data into the day of the week, the shift and time of day accidents where occurring. She stated a performance improvement plan was started for falls. She further stated a 24-hour resident care report that was reviewed daily by the unit managers and brought to the morning clinical meetings for the interdisciplinary team to address any concerns identified.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 880	Continued From page 166 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

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F 880	Continued From page 167 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement their infection control policy when Nurse Aide (NA) #9 did not perform hand hygiene during meal delivery and set up which required NA #9 to reposition the resident's personal belongings for 1 of 2 NAs observed passing meal trays. This had the potential to result in cross-contamination of microorganisms between residents. Findings included: A review of the facility's policy titled; "Hand Hygiene" last revised 7/2021 revealed in part the following: "IV. Policy: The facility considers hand hygiene the primary means to prevent the spread of infections. Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately after gloves are removed; and when otherwise indicated to avoid the transfer of microorganisms to other residents, personnel, equipment, and the environment. V. Procedure: 7. Staff will perform hand hygiene	F 880	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: NA #9 was educated on proper hand hygiene while passing meal trays on 11/2/23 by the Regional Nurse Consultant and conducted a return demonstration with the Staff Development Coordinator on 11/2/23. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Observation rounds were conducted on 10/13/23 to ensure the clinical staff was performing hand hygiene while delivering the residents meal trays. On 11/7/23, the Staff Development Coor conducted hand hygiene return demonstration with the nurse aides on duty. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 168 according to CDC (Centers for Disease Control) guidelines and the '10 moments for hand hygiene' which consists of: b. Moment 2-Before and after touching the resident or the resident's surrounding". On 10/9/23 from 12:49 PM to 12:53 PM a continuous observation of the lunch tray meal delivery service was conducted in the facility on the 600 Hall. During this observation NA #9 was observed to remove a lunch meal tray from the meal cart and entered room 602. NA #9 placed the lunch meal tray on the overbed table belonging to the resident in room 602 bed A. She moved the overbed table, repositioned the resident's walker, took the cover from the meal plate, and handled the door when leaving the room. Without performing hand hygiene NA #9 removed another lunch meal tray from the meal cart and entered room 604. She placed the meal tray on the overbed table belonging to the resident in room 604 bed B, picked up the resident's bed control from the floor, repositioned the overbed table. NA #9 returned to the meal cart and was stopped when she attempted to remove another meal tray from the cart without performing hand hygiene. An interview with NA #9 on 10/9/23 at 12:53 PM indicated she had received education regarding performing hand hygiene between meal trays after contact with resident's environment. She stated there was hand sanitizer readily available on the 600 Hall. She went on to say she knew she should have performed hand hygiene between these meal trays, but she had just been moving too fast and had forgotten. On 10/12/23 at 9:12 AM an interview with the	F 880	A 100% education was initiated by the Staff Development Coordinator (SDC) on 11/9/23 with all clinical staff which included agency clinical personnel and the interdisciplinary team on completing proper hand hygiene when passing resident meal trays. Effective 11/13/23, any facility/agency clinical staff or member of the interdisciplinary team that has not been educated will not be allowed to work until education is received in- person or via telephone by Director of Nursing or designee. All newly hired nursing staff or clinical agency personnel will receive education during the orientation process by the Staff Development Coordinator (SDC) or designee on completing hand hygiene while passing meal trays. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing (DON) and/or Unit Manager(s) will conduct random observation rounds during all meals twice a week for 4 weeks, then once a week for 8 weeks and quarterly thereafter to ensure compliance. Findings will be presented at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance. Changes will be made to the plan as necessary to maintain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 169 Assistant Director of Nursing (ADON) indicated she was the facility's Infection Preventionist (IP). She stated NA #9 had been educated on when to perform hand hygiene and knew what she was supposed to do. She went on to say NA #9 should have performed hand hygiene after contact with resident's environment before taking another meal tray from the cart. The ADON stated this was to prevent cross contamination between residents. On 10/12/23 at 11:42 AM an interview with the Director of Nursing indicated NA #9 should have performed hand hygiene after contact with resident's environment before removing the next meal tray from the cart. She stated this was to prevent cross contamination between residents.	F 880		
F 925 SS=J	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, Physician, and pest control technician interviews the facility failed to control the presence of ants in the facility, maintain an effective pest control program, and to protect a vulnerable resident from having ants crawling on him while in bed. The resident sustained multiple ant bites/stings to his arms, torso, and upper back which resulted in the resident experiencing the discomfort of "stinging and itching". Furthermore, the resident stated having ants in his bed, on him, and having been stung/bitten made him feel upset and like "No one cared." The	F 925	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 was relocated from his room on 10/10/23 by his assigned nursing staff. Facility maintenance director completed a pest elimination treatment for Resident #1's original room with an approved pesticide for indoor insect elimination on 10/10/23. 2) Address how the facility will identify	11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 170 facility also failed to implement effective pest reduction measures when the ants were first observed on the resident by staff on 10-6-23. This occurred for 1 of 4 residents (Resident #1) observed for pest control. Immediate Jeopardy began on 10-6-23 when NA #1 first discovered red colored ants crawling on Resident #1's bed and person but had not reported the incident. Immediate Jeopardy was removed on 10-13-23 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. Findings included: Resident #1 was admitted to the facility on 3-30-23 with multiple diagnoses that included paraplegia (which included numbness below the waist), bilateral above the knee amputation, and diabetes. The quarterly Minimum Data Set (MDS) revealed Resident #1 was cognitively intact and required total assistance with two people for bed mobility, total assistance with one person for dressing, toileting, and personal hygiene. Resident #1 was interviewed in conjunction with an observation on 10-9-23 at 12:13pm. The resident stated, "I would be doing good if they would get these ants out of my room, so they quit crawling on me." Resident #1 discussed since last Monday (10-2-23) he had been reporting to	F 925	other residents having the potential to be affected by the same deficient practice: The Maintenance Director completed observation rounds and met with current facility staff to identify any other pest/ant sighting. Non were reported. Contracted outside pest company completed an inside and outside inspection on 10/11/23, no other pest sightings reported in resident rooms. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Maintenance Director implemented Pest sighting books for each facility nurses station. These books will be used to document any pest sightings, including ants. The maintenance director and/or assistant director will check the sight books, daily with rounds. Any identified sightings, maintenance director and/or assistant will provide immediate pre-treatment with an approved in-door pesticide and the facility contracted pest exterminator will be notified and an onsite visit for treatment will be scheduled. The Maintenance Director and Director of Nursing met with the current facility staff, including clinical agency and contract (HK/Laundry/Rehabilitation) staff on 10/10/23, to provide education on the usage of the pest sighting books. The Director of Nursing and Maintenance Director provided education on 10/10/2023, for all staff, including agency, regarding reporting ant sightings immediately to facility supervisors and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 171 staff ant activity in his room and told them the ants had been crawling on him and the bed. The resident stated no one had done anything except for one NA (NA #2) who, he stated, placed hot sauce in an area of the wall by the bathroom where the NA thought the ants maybe coming from and then placed a washcloth over the hot sauce to try and kill the ants. He explained he could not feel anything below his waist but had seen the ants crawling on his torso and arms. The resident also stated the ants had bit/stung him several times "you can see the one on my arm and I have felt the stinging when they bite my back." Resident #1 stated he had also told the nurses (could not remember any names) since Sunday (10-8-23) he was itchy but said he had not received any medication to relieve his itching. Resident #1 voiced being frustrated and feeling like "no one cares." During an observation of the resident, there was a small round reddened area on his upper left arm. There were no ants observed in the resident's room at the time of the observation and interview. A telephone interview was conducted with NA #1 on 10-10-23 at 3:15pm. NA #1 confirmed she had been assigned to Resident #1 on 10-6-23 during the 7:00pm to 7:00am shift. The NA discussed when she had gone into Resident #1's room to provide him care she had observed red ants crawling on the resident's bed and on the resident's torso and arms. She stated she "wiped' the ants off the resident onto the floor and changed his linens. The NA stated she had seen ants "a few weeks ago" in the living room area and said she had reported it to the nurse on duty (could not remember which nurse). NA #1 said she had not seen any ant bites/stings on Resident #1 and stated she had reported the ants to the	F 925	assessing residents for bites. If bites are found, the resident will be immediately relocated, and the identified room treated for pest sightings by the Maintenance Director or Assistant Maintenance Director. Employees will not be able to work after 10/10/23 until they receive this education from the director of nursing, administrative nurse and/or maintenance director. New staff, including agency will receive this education during the facility orientation. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility administrator will be completing a weekly review of maintenance work orders and pest control sighting logbook to confirm that all work orders and pest treatments have been completed within 48 hours. The facility nursing staff will contact the maintenance director and/or assistant maintenance person and document the pest /ant sighting in the pest control log located at each nurse’s station. This review will be completed daily for 5 days/4 weeks, then weekly for 3 months, then quarterly. The Maintenance Director and/or Administrator will complete a summary of the results of these reviews and present at the monthly facility QAPI meeting to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 172	F 925		

nurse (Nurse #2).

NA #2 was interviewed by telephone on 10-10-23 at 3:19pm. NA #2 confirmed he had been assigned to Resident #1 on 10-7-23 and the evening of 10-9-23 from 7:00pm to 7:00am. The NA discussed Resident #1 informing him of having ants in his room and stated on 10-7-23 while in Resident #1's room providing care he saw red ants crawling on the resident's bed and body. NA #2 stated he cleaned the ants off Resident #1 by wiping them onto the floor with a washcloth and changed his linens. He also explained he thought the ants were coming from an area of the wall by the bathroom, so he stated he placed some hot sauce and a washcloth on the area of the wall in hopes to kill the ants. The NA stated it was after hours and he did not have access to any sprays to try and kill the ants. The NA stated on 10-9-23 he again saw ants on Resident #1's bed and body. NA #2 explained he washed Resident #1 and changed his linens. NA #2 said he did not observe any ant bites/stings on the resident and that he had reported the ant sighting on 10-7-23 to the nurse (Nurse #2).

During a telephone interview with Nurse #2 on 10-10-23 at 3:33pm, the nurse confirmed she had been working the 7:00pm to 7:00am shift on 10-6-23 and 10-7-23. Nurse #2 also confirmed she had been made aware and saw the red ants on Resident #1's bed, torso, and arms both days. The nurse discussed assisting NA #1 in "wiping" the ants off the resident's bed, torso, and arms onto the floor. She said she had not seen any ant bites/stings on the resident's arms or torso, so she did not inform the Physician or provide any medical care. Nurse #2 stated she had not completed a full skin assessment but had just

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 173	F 925		

assessed Resident #1's arms and torso. The nurse stated she also had not informed anyone in management or maintenance of the presence of ants in Resident #1's room because "I did not know who I was supposed to report to."

Observation of wound care for Resident #1 occurred on 10-10-23 at 1:17pm with Nurse #4 and NA #3. Upon pulling back Resident #1's sheet, several red ants, too many ants to count, were seen crawling on the resident's bed and the resident's body. The red ants were crawling on Resident #1's arms, torso and into and out of his brief. Nurse #4 left the room to get the Maintenance Director and NA #3 left the room to get the Director of Nursing (DON). Upon return of the DON, Resident #1 was assessed for ant bites/stings and revealed a bite/sting to his left arm that was round, bright red approximately a centimeter in diameter and 4-5 ant bites/stings to the resident's upper back that were red and raised. Resident #1 stated he had felt the ants stinging/biting his back but that he was not currently itchy or in pain. Staff were observed to place the resident in his wheelchair and remove him from his room.

The Maintenance Director was interviewed on 10-10-23 at 1:26pm. The Maintenance Director explained there was a maintenance logbook at each nursing station to record any pest concerns and/or maintenance issues. He stated he checked the logbook two times a day and said there had not been any reports of ants in Resident #1's room. The Maintenance Director discussed there were ants found "over the summer" in a resident room on the other side of the building and in the living room area a "few" weeks ago. He stated he had called the pest

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 174	F 925		

control company both times and they came and treated the areas. The Maintenance Director discussed the pest control company coming every 2 weeks to treat pests (not just ants) however he explained he did not have any invoices to confirm the treatments.

Review of the maintenance logbook from August 2023 through October 2023 revealed no reports of ants in Resident #1's room however there had been reports of ants on 8-29-23 and 10-8-23 in other areas of the building.

A follow up interview was conducted with the Maintenance Director on 10-10-23 at 1:45pm. The Maintenance Director discussed calling the pest control company and said they were on their way to treat Resident #1's room.

Observation/interview of Resident #1 occurred on 10-10-23 at 5:23pm. Resident #1 was observed back in his room sitting in his wheelchair. Resident #1 stated he had not been back in his room long and that he had not seen any ants. He stated he had wheeled himself back into his room after activities and stated he was unaware he was supposed to go to another room until his room was treated. The resident also stated he was concerned about staying in the room because he did not know if the ants would return.

Observation of the facility's center courtyard occurred on 10-10-23 at 5:27pm. There were 5 active ant mounds observed. There were 2 located by the door to the courtyard and 3 along the walkways in the courtyard. The ant mounds were not located near Resident #1's room.

The Maintenance Director was interviewed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 175	F 925		

10-10-23 at 5:37pm. The Maintenance Director stated the pest control company was not coming to treat Resident #1's room until 10-11-23. He stated he was not aware Resident #1 was back in his room and confirmed other than cleaning the room there had not been any treatment provided.

During an interview with the DON, Assistant Director of Nursing (ADON) and the Corporate Nurse Consultant and Administrator on 10-10-23 at 5:43pm, the DON, ADON and the Corporate Nurse Consultant all stated they did not know who placed Resident #1 back into an un-treated room. The Administrator explained Resident #1 was supposed to be moved to another room.

Nurse #3 was interviewed on 10-10-23 at 5:51pm. Nurse #3 stated she saw Resident #1 wheel himself back into his room. She said she had been told by maintenance or housekeeping (could not remember who) that the room had been treated so she allowed the resident to stay in his room.

Review of Resident #1's medical record revealed a late entry note for 10-10-23 by Nurse #5. The nurse documented she had contacted the Physician regarding Resident #1's ant bites. She wrote there were no new orders, and the resident did not have any discomfort.

The Maintenance Director and the pest control Account Manager were interviewed on 10-11-23 at 12:00pm. Upon observing Resident #1's room, where the ants had been seen, there were no ants present. The Maintenance Director stated he had treated the room on 10-10-23 with an over-the-counter ant killer. He clarified he had treated the room after he had been informed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 176	F 925		

Resident #1 had returned to the room and stated he had not treated it beforehand because he knew the pest control company was coming to treat. The pest control Account Manager explained he could not know for certain what kind of ants were in Resident #1's room as there were no ants currently present. He did clarify that fire ants were the only ants that would bite without provocation. The pest control Account Manager discussed plans on treating the room on 10-11-23 and speaking with the facility on expanding their contract to cover the several active ant hills on the property. He stated he had observed the exterior of the building and had found 5 active ant hills in the courtyard and 7 active ant hills around the facility's perimeter.

A nursing note written by Nurse #5 dated 10-11-23 at 6:48pm documented Resident #1 was itching "a little" and she observed 2 circular scabbed areas to the resident's upper chest. Nurse #5 wrote that she called the Physician and obtained new orders.

Review of the Physician orders for Resident #1 revealed an order for Hydroxyzine (antihistamine medication) 25 milligrams by mouth every 8 hours as needed for itching.

During a telephone interview with the Medical Director on 10-12-23 at 7:50am, the Medical Director discussed being informed by the facility on 10-10-23 of the ants and the ant bites on Resident #1. He explained when he spoke with staff on 10-10-23 Resident #1 was not having any itching or reaction to the ant bites, so he had not ordered any medication at that time. The Medical Director said on 10-11-23, staff had contacted him regarding Resident #1 complaining of itching

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 177	F 925		

and discomfort which was unrelated to the ant bites/stings, so he stated he ordered medication. The Medical Director said he would have expected staff to report the ant issue as soon they were aware and that there was a possibility of harm if Resident #1 had been allergic to the ant bites.

The DON was interviewed on 10-13-23 at 10:03am. The DON discussed feeling there was a lack of education with staff on knowing who to report issues to and where the maintenance communication book was located. She stated if staff saw an infestation of ants in Resident #1's room on 10-6-23 and 10-7-23, staff should have contacted her and moved Resident #1 to another room. The DON said she expected staff to ensure residents safety and notify her of any situation involving the safety of residents if they do not know who to report to.

On 10-10-23 at 7:15pm the Administrator was informed of the Immediate Jeopardy. The facility provided a credible allegation of Immediate Jeopardy removal on 10-13-23. The allegation of Immediate Jeopardy removal indicated:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the non- compliance:
On October 10, 2023, at approximately 2:30pm, it was reported by the survey team that an observation was made that resident #1 had ants in his bed.
Resident #1 stated he reported the ants on 10/6/2023 and 10/7/2023 to a nursing assistant. CNA #1 (10/6) said last Friday she observed ants in his bed and on the floor. She said she changed the sheets, provided Activities of Daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 178	F 925		

Living (ADL) care, cleaned the floor, and did not notice any reddened areas on the resident. She indicated that she reported it to Nurse #1.
CNA #2 stated on 10/7/23, she alerted Nurse #2 of the sighting of ants. Nurse #2 assisted CNA #2 in providing care and changing the sheets.
Nurse #2 stated she was alerted to the ants by CNA #2 on 10/7/23.
On exam, neither Nurse #1 nor Nurse #2 found reddened areas on Resident #1 that could be interpreted as a bite and the resident had no complaints of itching or discomfort on his upper extremities or lower torso. Nurse #1 nor Nurse #2 reported the sighting of ants to the Maintenance Director or facility Administrator after the incidents.
Complete skin assessments were completed on all current residents on 10/10/2023 by the Director of Nursing and administrative nurses.
No other abnormalities were found.
Interviews were conducted by the facility Social Worker on 10/11/2023 with the alert and oriented residents and no further pest sightings were reported.
Resident #1 was relocated from his room to another room on 10/10/23 by his assigned nursing staff. The Maintenance Director completed a treatment for Resident #1's original room with an approved pesticide for indoor insect elimination on 10/10/23 in late afternoon.

Any resident had the potential to be affected by this alleged deficient practice.

Specify action the facility will take to alter the process or system failure to prevent a serious outcome from occurring or recurring and when the action will be completed:
A facility notification was mailed to each resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 179	F 925		

representative on 10/11/2023 to alert them to make sure all food brought in the facility to residents will need to be placed in a sealed container to prevent further sightings.

Corporate Contractor completed a reeducation with the facility maintenance director on timely follow up of work orders, including pest control sighting logbook, on 10/12/23. The facility administrator will be completing a weekly review of maintenance work orders & pest control sighting logbook to confirm that all work orders and pest treatments have been completed in a timely manner. This will include at the time of a pest sighting the facility nursing staff will contact the maintenance director and/or assistant maintenance director; they will also add the pest/ant sighting in the pest control log located at each nursing station.

The Director of Nursing (DON) and Maintenance Director met with the current facility staff, including clinical agency and contract (HK/Laundry/Rehabilitation) staff on 10/10/2023 to discuss reporting pest sightings and no other sightings were reported by staff. Current facility staff, including clinical agency and contract (HK/Laundry/Rehabilitation) staff will receive this training prior to being able to work on their next assignment. The Director of Nursing and Administrative Nurses ensures this education is being completed prior to employees being able to work at the facility.

The Maintenance Director and the contracted pest control provider inspected the perimeter of the building on 10/11/23 for signs of active ant mounds, and any areas identified were treated with approved pesticides.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 180	F 925		

On 10/11/23, the contract pest control company provided an inspection of the facility and was not able to identify the type of ant. This was evident in their report on 10/11/23.

The Corporate Contractor and Maintenance Director completed an observation inspection of the interior and exterior of the facility on 10/12/23 and identified 5 active ant mounds in the courtyard and 7 on the exterior of the facility. The Corporate Contractor and Maintenance Director completed treatment of these areas. Also, the contracted pest control company provided additional treatment.

The Maintenance Director developed Pest Sighting Logbooks on 10/10/2023 for each nurse's station so the staff can document any sighting. If there were any sightings noted on residents or in rooms, the Director of Nursing and Administrator will be notified immediately by the staff member upon discovery and the resident will be removed from the identified area. The Pest Sighting Logbook will be reviewed by the Maintenance Supervisor to assure the area where the sighting occurred has been treated. The DON and Maintenance Supervisor educated all staff beginning 10/10/23 on the pest sighting logbooks. All staff can document in the logbooks as they are available at each nurse's station. Current facility staff, including clinical agency and contract (HK/Laundry/Rehabilitation) staff will receive this training prior to being able to work on their next assignment. The Director of Nursing and Administrative Nurses are monitoring that this education is being completed prior to employees being about to work at the facility.

The Maintenance Director and/or the Assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 181	F 925		

Maintenance Supervisor initiated weekly pest control rounds on 10/10/2023 to include room, bed, bath and building perimeter. There were no other sights inside the building on 10/10/23.

The facility has a contract with a pest control company. The pest control company will be providing weekly observations to ensure there are no further ant or pest issues. The pest control company was onsite 10/11/2023 to complete interior and exterior treatments. The pest control company found no further live ant activity in the facility in their report that was provided by the Maintenance Director on 10/11/23. They treated the facility for pests to include acrobat ants, American cockroaches, ants, Argentine ants, Black widow spiders, brown banded cockroaches, cockroaches, German cockroaches, odorous house ants, oriental cockroaches, pavement ants, Pharoah ants and smoky brown cockroaches.

The Director of Nursing and Maintenance Director provided education on 10/10/2023, for all staff, including agency, regarding reporting ant sightings immediately to facility supervisors and assessing residents for bites. If bites are found, the resident will be immediately relocated, and the identified room treated for infestation by the Maintenance Director or Assistant Maintenance Director. Employees will not be able to work until they receive this education from the director of nursing, administrative nurse and/or maintenance director. Any employee who does not receive this education will not be able to work until education is completed by DON, Administrative Nurse and/or Maintenance Director. The DON and/or administrative nurses will be responsible for ensuring that the employees receive this required education prior to working.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 182 Allegation of Immediate Jeopardy removal date: 10/13/23 On 10-13-23 the facility's plan for Immediate Jeopardy removal was validated by the following. Multiple residents had been interviewed and confirmed they had not seen ant activity in their rooms. Observation of resident rooms revealed no current ant activity. There were pest sighting logbooks located at each nursing station. Upon interviewing staff, staff stated they had received education on the pest sighting logbooks and reporting any pest sightings immediately. Verification of completed skin assessments on all residents were completed. The pest control company was observed on 10-11-23 and 10-12-23 as explained by the exterminator, to be treating ants in the building and on the facility grounds outside. The facility's Immediate Jeopardy removal date of 10-13-23 was validated.	F 925		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews	F 947		11/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 183 and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure Nurse Aides (NA) received at least 12 hours of in-service training in one year. This was for 5 of 5 NA in-service training records reviewed (NA #12, NA #10, NA #4, NA #5). Findings included: Education records from 6/1/2022 to 10/16/2023 provided by the facility's Regional Nurse Consultant reported the following training completed by each nurse aide. The number of hours of in-service training were not provided: * NA #12: Understanding Bloodborne Pathogens on 5/4/2023 and Let's Talk About COIVID Vaccination on 7/20/2023. * NA #10: Let's Talk About COVID Vaccination on 7/20/2023 * NA #13: Basics of Hand Hygiene, Effective Communication and Fire Safety: The Basics on 4/25/2023 and Let's Talk About COVID Vaccination on 7/20/2023. * NA #4: Weights, Weight: Measuring with a Wheelchair and Height Measurements on 7/9/2023 and Let's Talk About COVID Vaccination on 7/20/2023 * NA #5: Let's Talk About COVID Vaccination on 7/20/2023,	F 947	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: There was no resident named in this alleged deficient practice. CNA #12, #10,#13,#4, and #5 have scheduled training sessions to complete their annual requirement. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected by this alleged deficient practice. The Staff Development Coordinator will audit CNA training records to determine the hours of yearly training completed for each CNAs. This audit will be completed by 11/13/23. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: CNAs who have not completed training within a quarter will be removed from schedule until training is completed. 4) Indicate how the facility plans to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 184 On 10/16/2023 at 8:21 a.m. in a phone interview with NA #12, she stated she started employment at the facility on 6/17/2023 and thought abuse, dementia and emergency preparedness training was covered in the online training that the facility provided during orientation. On 10/16/2023 at 10:14 a.m. in a phone interview with NA #5, she stated she had worked at the facility since 2011. She explained in-facility in-services were held at the facility for training sometimes, and there were online computer training modules to complete yearly. She stated she had not been able to work on her education modules for the last four to five months while at work due to providing resident care. She stated the facility verbally and electronically sent reminders for the staff to complete on-line training online, and she did not have the electronic notifications set up on her electronic devices. She was unable to recall when she last received abuse, dementia, and elopement training. On 10/16/2023 at 10:16 a.m. in a phone interview with NA #4, she stated she started at the facility in 2017. She explained the facility was conducting in-facility in-services all the time and there were online training modules she was supposed to complete yearly. She stated she had not been able to complete the online training because her email was not working properly and did not always have access on her computer at home. She stated she had abuse training a few months ago and she had not completed dementia and emergency preparedness training in the last year. Attempts to interview NA #10 and NA #13 about	F 947	monitor its performance to make sure that solutions are sustained: Training records will be monitored monthly for 4 months, then quarterly by the Director of Nursing to ensure CNAs complete monthly in-services to ensure that they receive at least 12 hours of in-service training annually. The Director of Nursing will complete a summary of the audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 185	F 947		

their educational training were unsuccessful.

On 10/13/2023 at 3:27 p.m. in an interview with the Staff Development Coordinator (SDC) and the Regional Nurse Consultant, the SDC stated educational training was provided through in-facility in-services and online training for the nurse aides yearly for the nurse aides to receive the twenty-four hours of continued education. She explained the yearly report for nurse aide training consisted of the training completed from January to December yearly. She explained online training modules were to be completed upon being hired and corporate emailed staff on different training modules to be completed monthly and she didn't know the process for communicating training received on nurse aide education records. She stated abuse and dementia were to be completed annually. In a follow up interview with the SDC on 10/18/2023, she stated she started as the SCD in September 2023 and was developing a new system to track educational training received through in-facility in-services. She further stated abuse training was last held in June 2023 by an in-facility in-service, and there had been no dementia or emergency preparedness training documented for the year.

On 10/18/2023 at 10:18 a.m. in an interview with the Regional Nurse Consultant, she stated the facility had identified a breakdown in the system for monitoring and documenting staff training.

On 10/18/2023 at 4:41 p.m. in an interview with the Administrator, she stated nurse aides were to have twelve hours a year of educational training. She explained the facility should be documenting nurse aide educational training and monitoring the number of hours each nurse aide had

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	345561	A. BUILDING _____ B. WING _____	C 10/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 186 completed monthly. She stated the facility needed to develop a better system of monitoring and documenting educational training for the nurse aides.	F 947		
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide required dementia management training for 7 of 8 nursing staff (Nursing Assistant (NA) #12, NA #10, NA #13, NA #4, NA #5, Nurse #4 and Nurse #5) reviewed for education requirements. Findings included: Education records from 6/1/2022 to 10/16/2023 provided by the facility's Regional Nurse Consultant were reviewed for the following nursing staff: * NA #12: There was no dementia management training recorded on the education records. * NA #10: There was no dementia management training recorded on the education records. * NA #13: There was no dementia management training recorded on the education records. * NA #4: There was no dementia management training recorded on the education	F 949	1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: CNA #12, #10, #13, #4, #5, and Nurse #4 and #5 will receive dementia training by 11/13/23. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected by this alleged deficient practice. The Staff Development Coordinator will audit training records to determine CNAs and nurses who have not completed Dementia training by 11/13/23. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: CNAs and nurses who have not completed dementia training 60 days after	11/13/23

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F 949	Continued From page 187 records. * NA #5: There was no dementia management training recorded on the education records. * Nurse #4: There was no dementia management training recorded on the education records. * Nurse #5: There was no dementia management training recorded on the education records. On 10/16/2023 at 8:21 a.m. in a phone interview with NA #12, she stated she started employment at the facility on 6/17/2023. She stated she thought dementia training was covered in the online training that the facility provided during orientation. On 10/16/2023 at 10:14 a.m. in a phone interview with NA #5, she stated she had worked at the facility since 2011. She explained in-facility in-services were held at the facility for training sometimes, and there were online computer training modules to complete yearly. She stated she had not been able to work on her education modules for the last four to five months while at work due to providing resident care. She stated the facility verbally and electronically sent reminders for the staff to complete on-line training online, and she did not have the electronic notifications set up on her electronic devices. She was unable to recall when she last received dementia training. On 10/16/2023 at 10:16 a.m. in a phone interview with NA #4, she stated she started at the facility in 2017. She explained the facility was conducting in-facility in-services all the time and there were online training modules she was supposed to	F 949	scheduled course will not be allowed to work until training is completed. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Training records will be audited by Human Resources to ensure dementia training is completed for licensed nurses and nursing assistants annually. The audit is to be reviewed weekly x 2 months then biweekly x 4 months. Human Resources will present a summary of the course completion audit for dementia training at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	

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F 949	Continued From page 188	F 949		

complete yearly. She stated she had not been able to complete the online training because her email was not working properly and did not always have access on her computer at home. She stated she had not completed dementia training in the last year.

Attempts to interview NA #10 and NA #13 about their educational training were unsuccessful.

Nurse #4 was hired at the facility in May 2023. In an interview with Nurse #4 on 10/13/2023 at 2:44 p.m., she stated she had not received dementia and Alzheimer's training. She explained dementia and Alzheimer's training was provided through online training, and she had not had the time to complete the training online.

In an interview with Nurse #5 on 10/13/2023 at 2:47 p.m., she stated she could not recall having training on dementia or Alzheimer's. She stated there were online modules for dementia training that she had not completed.

In an interview with the Staff Development Coordinator (SDC) and Regional Nurse Consultant on 10/13/2023 at 3:27 p.m., the SDC (who started at the facility in September 2023 as SDC) stated nursing staff were to receive dementia training annually, and nursing staff had not received dementia training within the last year. They explained dementia training was provided to the staff through online modules, and modules where to be completed within one week for new hired employees.

In an interview with Regional Nurse Consultant on 10/18/2023 at 10:18 p.m., she stated the facility had identified a breakdown in monitoring and

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F 949	Continued From page 189 documenting educational training of the nursing staff. In an interview with the Administrator on 10/18/2023 at 4:41p.m., she stated the nursing staff should be completing the dementia training and the facility needed to develop a system to monitor and document nursing staff had completed dementia training.	F 949		