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	345529	A. BUILDING _____ B. WING _____	C 01/10/2024

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 1/9/24 through 1/10/24. Event ID# 8ZJ711. The following intakes were investigated NC00211763, NC00211394 and NC00211297. 3 of the 7 complaint allegations resulted in deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		2/8/24

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

Electronically Signed | 02/07/2024

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews, the facility failed to treat a resident with dignity and respect when Nursing Assistant (NA) #3 refused to assist Resident #2 with eating her meal at lunch time and then yelled at Resident #2 when her lunch tray fell on the floor. Nurse #2 observed the resident "shaking" and "crying" after the incident with NA #3. This occurred for 1 of 2 residents reviewed for dignity and respect. Findings included: Resident #2 was admitted to the facility on 12-13-23 with multiple diagnoses that included muscle weakness, arthritis in the right shoulder, and post left shoulder surgery. The 5-day Minimum Data Set (MDS) dated 12-19-23 revealed Resident #2 was moderately cognitively impaired and required substantial to maximal assistance with eating. There were no behaviors documented on the MDS. The facility's initial allegation report dated 1-2-24	F 550	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. This citation was from a facility self-reported initial investigation submitted by the facility administrator of January 2, 2024. The 5-day investigation was completed by the facility administrator on 1/8/24 and submitted on 1/8/24. The nursing assistant was suspended from work on 1/2/24 by the Administrator. How the facility will identify other residents potentially affected by the same deficient practice. All current residents have the potential to be affected by this deficient practice. All alert and oriented residents were interviewed by facility ambassadors this includes Administrator, Director of Nursing, Administrative Nursing, Social	

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F 550	Continued From page 2 for an incident occurring on 1-1-24 documented Resident #2 reported NA #3 had refused to feed her after Resident #2 had requested help with eating and that NA #3 spoke in a loud voice to Resident #2. The allegation report also documented Resident #2 had shoulder surgery and that Resident #2 had stated she had difficulty feeding herself. Resident #2 was interviewed on 1-10-24 at 11:45am. Resident #2 explained on 1-1-24 NA #3 had brought her lunch tray and sat the tray on her table. The resident stated she told NA #3 that she needed to have help eating and she said NA #3 had told her "No you can feed yourself." The resident stated NA #3 left the room and when she tried to feed herself, she accidentally knocked her tray on the floor before she was able to eat any of her lunch. Resident #2 stated when NA #3 answered her call light, NA #3 told her "You did it on purpose" and began "screaming" at her. The resident said she told NA #3 to leave her room because she did not want to be "screamed" at and NA #3 left the room. The resident explained Nurse #2 came in later and cleaned up the spilled lunch tray, brought her a new lunch tray, and assisted her in eating. Resident #2 stated a "couple of days" later NA #3 came to her room to help her eat her soup. She said NA #3 said to her "I don't want a hissy fit anymore." The resident discussed taking a couple of spoonful's of soup and then told NA #3 she was done because she was afraid the NA may do something. Resident #2 stated when the incident on 1-1-24 occurred, she was upset and crying. Nurse #2 was interviewed on 1-10-24 at 12:05pm. The nurse confirmed she had been assigned to Resident #2 on 1-1-24. Nurse #2	F 550	services, Admissions, Activity Director, Human Resources, Central Supply, Administrative Assistant, medical records, and Dietary Manager to determine if they were being treated with dignity and respect beginning on 2/1/24. The responsible party was called for all residents who are not cognitively sound. This was completed on 2/5/24. No further concerns were identified related to dignity and respect. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. An all staff in service was conducted on 2/2/24 regarding treating residents with dignity and respect and the consequences of non-compliance by the Staff Development Coordinator. Any employee who has not received this training by 2/7/24 will not be allowed to work until it is completed. All new hires, including agency, will receive training during orientation by the DON or Staff development nurse. During daily ambassador rounds, which includes the administrator, DON, SDC, medical records, activity director, central supply clerk, admissions, social worker, administrative nursing, receptionist, activity director, human resources director, business office manager and dietary manager will interview the resident and ask the resident if they are being treated with dignity and respect. All concerns will be forwarded to the	

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F 550	Continued From page 3 discussed not being aware of the incident with NA #3 until a short time later when she entered Resident #2's room and found her shaking and crying. She said Resident #2 had told her NA #3 had refused to help her eat and then "yelled" at her when she accidentally knocked her tray on the floor. The nurse stated Resident #2 told her she had not received another lunch tray and was hungry, so the nurse said she had obtained a lunch tray for Resident #2 and assisted her in eating. Nurse #2 stated Resident #3 had never showed any behaviors and had not had any incidences with any other NA. Nurse #2 stated she had reported the incident to the Director of Nursing (DON) as soon as she was finished assisting Resident #2 and was told by the DON to educate NA #3 on customer service. The nurse discussed not providing the education to NA #3 because "she kept walking away from me." She explained when Resident #2 was admitted, she needed assistance in eating due to her shoulder surgery and the NAs were aware through the staff's morning report that Resident #2 needed assistance. Nurse #2 also explained Resident #2 needed assistance with eating up until a week and a half ago when the resident had progressed in her treatment and could now feed herself. A telephone interview occurred with NA #3 on 1-10-24 at 1:40pm. NA #3 confirmed she had been assigned to Resident #2 on 1-1-24. The NA explained she had brought Resident #2 her lunch tray and the resident had asked her to help feed her. NA #3 said she told the resident "No" because Resident #2 could feed herself. The NA stated right after she walked out of Resident #2's room she heard a noise, so she went back into the room and saw Resident #2's lunch tray on the floor. NA #3 stated Resident #2 told her "See I	F 550	administrator for investigation. How the facility will monitor its performance to ensure the deficient practice does not recur. The Administrator and Social Worker will conduct interviews with 5 residents 3x/week x 2 weeks, 5 residents 2x/week x 4 weeks and 5 residents weekly x 6 weeks to determine if residents are being treated with dignity and respect. The facility administrator will complete a summary of these audit results and present them at the facility Quality Assurance Improvement Plan (QAPI (Quality Assessment and Performance Improvement)) to ensure continued compliance.	

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F 550	Continued From page 4 told you I can not feed myself." The NA explained she started cleaning up the lunch tray from the floor and Resident #2 began "yelling and cussing at me and then asked me to leave." NA #3 said she had reported the incident to Nuse #2. The NA stated she had been assigned to Resident #2 prior to the incident on 1-1-24 and did not have any issues. NA #2 was interviewed on 1-10-24 at 12:28pm. NA #2 stated she was familiar with Resident #2 and aware the resident required assistance in eating until 1.5 weeks ago when Resident #2 had progressed well enough to feed herself. She stated she was made aware of the requirement to assist Resident #2 in eating during the staff's morning report. The NA discussed not working on 1-1-24 but stated she had never heard of Resident #2 throwing her meal tray on the floor or yelling at any staff member. During an interview with the Administrator and DON on 1-10-24 at 1:29pm, the DON discussed speaking with NA #3 on 1-2-24 and the NA had told her Resident #2 had refused to allow NA #3 to assist her with her meal and then the resident threw her lunch tray on the floor. The DON also stated NA #3 told her she had not raised her voice at Resident #2. The Administrator discussed training being provided to all staff on dignity/respect and customer service prior to the incident and did not know why the incident occurred as NA #3 had not had any issues with customer service prior to the incident on 1-1-24.	F 550		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		2/8/24

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F 684	Continued From page 5 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Nurse Practitioner interview, the facility failed to follow a physician order for laboratory services for 1 of 1 resident reviewed for providing care according to professional standards (Resident #1). Findings: Resident #1 was admitted to the facility on 2/23/18 with the following diagnose cerebral infarction due to embolism and osteomyelitis. The 11/27/23 Annual Minimum Data Set (MDS) revealed Resident #1 was moderately cognitively impaired. There were no other MDS completed. A review of the Nurse Practitioner's progress note dated 12/10/23 for 12/8/23 visit revealed documentation of her assessment of Resident #1. The progress notes documented Resident #1 stating he did not feel well and was nauseated. The Practitioner documented that she would obtain lab work due to Resident #1's weakness, complaints of not feeling well and nausea. Review of the paper physician's orders dated 12/8/23 revealed Resident #1 was to have a complete blood count (CBC) and a	F 684	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The labs ordered for Resident #1 were drawn by the hospital on 12/9/2024. The resident was admitted to the hospital on 12/9/2024 and did not return to the facility until 12/18/24. Resident #1 is currently receiving lab orders as ordered by an attending physician. How the facility will identify other residents having the potential to be affected by the same deficient practice. All current physician orders have been reviewed for the previous 30 days to ensure that all physician orders, including lab orders, have been implemented each day. This was completed by the Director of Nursing (DON) and/or administrative nurses on 2/6/24. What measures will be put in place or	

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F 684	Continued From page 6 comprehensive metabolic profile (CMP) completed. Review of the facility's lab book revealed no entry for 12/8/23 or 12/9/23 for Resident #1 to have his labs completed. Review of Resident #1's electronic and paper medical record revealed no lab results from 12/8/23. An interview with Medication Aid (MA)#1 on 1/10/24 at 9:00 am revealed she was working on 12/8/23 when the Nurse Practitioner assessed Resident #1. She stated she did not transcribe physician orders and she would provide the flagged order to the Unit Coordinator; however, she was not sure if she provided Resident #1's the order for lab work to the Unit Coordinator on 12/8/23. The Nurse Practitioner was interviewed on 1/10/24 at 10:15 am. The Nurse Practitioner stated she assessed Resident #1 on 12/8/23 and wrote an order for a CBC and CMP and she placed the flagged order in the chart at the nurses' station. She said when she wrote an order, she flagged the order in the chart and either placed the chart at the nurses' station or in the chart bin for nurse to transcribe. An interview with the Unit Coordinator (Nurse #1) on 1/10/24 at10:50 am revealed she would sometimes initial the physician orders but could not remember the physician order dated 12/8/23 regarding the labs for Resident #1. She stated if the order was not signed off, indicating the order was processed, then more than likely the order was missed.	F 684	systemic changes made to ensure that the deficient practice will not recur. When the physician writes an order, the administrative nurse will transcribe it to the electronic medical record. A review of physician orders, including lab orders, will be completed daily Monday through Friday by the licensed nurse to ensure they are implemented daily using the 24-hour chart audit tool. The Director of Nursing educated all licensed nurses, including the agency, on the process of transcribing orders and checking each resident□s chart for orders daily beginning on 2/2/24. This will be completed by 2/7/24. Any licensed nurse, including agency not educated by 2/7/24 will not be allowed to work until education is completed by DON and/or SDC (Staff Development Coordinator). The SDC will be monitoring to ensure that all licensed nurses, including agency receive this training. How the facility will monitor its performance to ensure the deficient practice does not recur. The current resident physician and/or nurse practitioner (NP) orders will be reviewed by the DON, administrative nurses, and administrator during the morning clinical meeting 5 days a week for 4 weeks, then bi-weekly for 3 months, then quarterly, to ensure timely implementation of each physician order,	

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F 684	Continued From page 7 During an interview with the Director of Nursing on 1/10/24 at 11:00 am revealed the process for a physician order was that the nurse (hall nurse or the Unit Coordinator) was supposed to initial the order and then place the resident's name in lab book at the nurses' station on the appropriate date the labs were to be drawn. She stated since Resident #1's lab order was not signed/initialed by the nurse, and the resident's name was not placed in the lab book and then the physician order for Resident #1's labs dated 12/8/23 did not get transcribed. The Administrator was interviewed on 1/10/24 at 11:30 am. The Administrator stated she was not sure of the process for the physician orders, and she did not do the clinical part; however, Resident #1's physician order dated 12/8/23 for lab work should have been completed by the nurses on the day the order was written.	F 684	including lab orders. The Director of Nursing and/or facility administrator will complete a summary of their audit results and present them at the facility monthly QAPI meeting to ensure continued compliance. The administrator along with administrative nursing will review all resident physician and or NP orders during clinical meetings daily to ensure all orders are implemented timely.	
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	F 867		2/8/24

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F 867	Continued From page 8	F 867		

are high risk, high volume, or problem-prone, and opportunities for improvement.

§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;

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F 867	Continued From page 9 (ii) How they will develop corrective actions that will be designed to effect change at the systems 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.	F 867		

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F 867	Continued From page 10 §483.75(g) Quality assessment and assurance. §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, resident, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint surveys of 4/1/21, 8/11/22 and 11/30/23 and the complaint survey of 1/18/23. This was for a deficiency in the area of Residents Rights/Exercise of Rights (F550). The continued failure during five federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings: This tag is cross-referenced to: F550: Based on record review, staff, and resident interviews, the facility failed to treat a	F 867	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The administrator and QAPI team during our monthly QAPI meeting on January 30, 2024, reviewed F550 citation from 4/1/21, 8/1/22, 11/30/23 and 1/18/23. The root cause analysis was identified during the QAPI meeting. Resident number 2 was discharged to home on 1/11/24. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents can be affected by this practice. The administrator and SW interviewed all alert and oriented residents	

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F 867	Continued From page 11 resident with dignity and respect when Nursing Assistant (NA) #3 refused to assist Resident #2 with eating her meal at lunch time and then yelled at Resident #2 when her lunch tray fell on the floor. Nurse #2 observed the resident "shaking" and "crying" after the incident with NA #3. This occurred for 1 of 2 residents reviewed for dignity and respect. During recertification and complaint survey of 4/1/21 the facility was cited for failing to provide a resident with pants resulting in the resident being embarrassed and feeling bad. During the recertification and complaint survey of 8/11/22 the facility was cited for failing to treat residents in a dignified manner when staff entered a resident's room without knocking or asking permission to enter. During the complaint survey of 1/18/23 the facility was cited for failing to treat a resident with dignity by not providing incontinence care when needed. During the recertification and complaint survey of 11/30/23 the facility was cited for staff using racial slurs and vulgar hand gestures when interacting with a resident. During an interview with the Administrator on 1/10/24 at 10:54 am, the Administrator discussed continued monitoring of residents for dignity and respect from their previous survey. She also discussed the facility conducting education with all staff on dignity/respect and using their Quality Assurance Committee to ensure compliance with the issue of dignity and respect.	F 867	to ensure they were being treated with dignity and respect. For those residents who are not interviewable family members were called. On 1/30/24, the facility department managers led by the Administrator reviewed the repeat citations to determine the root cause of the repeat deficiencies cited at the survey's completion. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. An all-staff Inservice conducted by the Staff Development Coordinator was started on 2/2/24 regarding treating residents with dignity and respect, the consequences of non-compliance will be disciplinary action up to termination. Any employee who has not received this training by 2/7/24 will not be allowed to work until it is completed. The Director of Operations retrained the Administrator and Director of nursing on the QAPI process on 2/6/24. Monthly QAPI minutes will be reviewed by the Regional Director of Operations and/or the Regional Clinical Consultant to ensure that all plans are effective, attainable, and addressing all self-identified and cited deficiencies. How the facility will monitor its performance to ensure the deficient practice does not recur. During daily ambassador rounds the ambassador which includes the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 12	F 867	administrator, DON, SDC, medical records, activity director, central supply clerk, admissions, social worker, administrative nursing, receptionist, activity director, human resources director, business office manager and dietary manager will interview the resident and ask the resident if they are being treated with dignity and respect. The Regional Director of Operations (RDO) and/or the Clinical Nurse Consultant will review QAPI notes monthly for 3 months, then quarterly 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.	