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 08/06/2024

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

(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 000	INITIAL COMMENTS The survey team entered the facility on 7/31/24 to conduct a complaint survey and exited on 8/2/24. Additional information was obtained through 8/6/24 and therefore the exit date was changed to 8/6/24. (Event CDYV11) The following intakes were investigated: NC 219588; NC 219543; NC 219492; NC 219134; NC 218979; NC 218760; and NC 218472. Eight of the twenty-one complaint allegations resulted in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		8/27/24

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

Electronically Signed | 08/19/2024

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 08/06/2024

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

(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 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, and family interviews the facility failed to notify the responsible party of a transport to the hospital for one (Resident #2) of three residents reviewed for notification of a change in condition. Findings included: Resident #2 was admitted to the facility on 7/5/2024 with multiple diagnoses some of which were dementia, benign prostatic hyperplasia, chronic kidney disease, and atrial fibrillation.	F 580	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F580 Corrective actions accomplished for those	

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 08/06/2024

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

(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 580	Continued From page 2 Documentation under the profile tab in the electronic medical record of Resident #2 revealed a family member was listed as the responsible party. Documentation on a SNF/NF to Hospital Transfer form dated 7/11/2024 at 2:00 PM revealed Nurse #3 sent Resident #2 to the emergency room for bleeding from the urethra. Nurse #3 documented on the transfer form; the facility name was the resident representative who was notified of the transfer of Resident #2. An interview was conducted on 7/31/2024 at 1:20 PM with the family member who was listed as the responsible party for Resident #2. The responsible party stated she had visited the facility daily since the admission of Resident #2. The responsible party for Resident #2 stated on 7/11/2024 she received a phone call from the hospital notifying her Resident #2 was being admitted to the hospital. The responsible party stated she had not been notified by the facility Resident #2 was being sent to the emergency room and she was frustrated Resident #2 was in the emergency room for two hours before she was made aware. An interview was conducted on 8/1/2024 at 1:54 PM with Nurse #3. Nurse #3 confirmed she was an agency nurse who did not often work at the facility. Nurse #3 stated nobody was listed as a responsible party in the electronic medical record when she sent Resident #2 to the emergency room on 7/11/2024 at the request of the resident's physician. Nurse #3 stated she let Unit Manager #1 know she was unable to find the name and contact information for the responsible party prior	F 580	residents found to be affected by the deficient practice: Resident #2 is no longer in the facility. Identification of other residents having the potential to be affected by the same deficient practice: 100% of all discharges/Transfer to the hospital for the last 30 days were audited on 08/12/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other resident who was sent to the hospital and the resident□s responsible party was not notified. No other residents identified as missing notification when sent to the hospital. Findings of this audit is documented on the discharge/transfer audit tool located in the facility compliance binder. 100% audit of all incident reports created within the last 30 days was completed by the DON, ADON, and unit coordinator (#1 or #2) to ensure notification of changes was completed in a timely manner. The audit revealed no other occurrences of missing/delayed notification of changes to either physician or responsible party. The audit was complete on 08/19/2024 Findings of this audit is documented on the incident reports audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 8/19/2024, licensed nurse on duty will inform the resident; consult with the resident□s physician; and notify, the resident representative when there is; an	

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 08/06/2024

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

(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 580	Continued From page 3 to sending Resident #2 to the emergency room. Nurse #3 stated Unit Manger #1 also was unable to locate the name and contact information for the responsible party in the electronic medical record. Unit Manger #1 was interviewed on 8/1/2024 at 5:21 PM. Unit Manger #1 denied having any recollection of Nurse #3 asking for assistance to find contact information on 7/11/2024 for the responsible party for Resident #2 prior being sent to the emergency room. The Assistant Director of Nursing (ADON) was interviewed on 8/1/2024 at 3:01 PM. The ADON revealed the facility was very busy on 7/11/2024 because three residents had to be sent to the hospital. The ADON confirmed the responsible party for Resident #2 was very involved and visited daily and should have been notified of the transfer of Resident #2 to the emergency room on 7/11/2024.	F 580	accident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in the resident□s physical, mental, or psychosocial status, a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), and/or a decision to transfer or discharge the resident from the facility, to including when a resident is transferred to the hospital. This notification will be documented on each resident□s electronic medical records. Effective 8/19/2024, the facilities nursing administrative team, which includes the DON, ADON, Unit coordinators (#1, #2), and/or wound nurse, resumed the process for reviewing clinical documentation for the last 24 hours and physician orders written in the last 24 hours, or from the last clinical meeting to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any negative findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to	

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 08/06/2024

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

(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 580	Continued From page 4	F 580	include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of notifying physician and the responsible party in a timely manner for any incidents/accidents, change in condition, change of treatment/intervention, hospitalization, or death that occurred in the facility. This education will be completed by 8/27/2024, and any licensed nurses not educated by 8/27/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 8/27/2024, DON and/or ADON will monitor compliance with notification of changes to physician and or responsible party by reviewing the daily clinical meeting reports to ensure completion, timely notification to physician and responsible party for any item identified to meet notification requirements. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 08/27/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement	

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 08/06/2024

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

(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 580	Continued From page 5	F 580	Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 08/27/2024.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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, and interviews with resident, staff, and physician the facility failed to ensure clarification was obtained when a resident arrived for facility admission without orders for a medication the hospital discharge summary indicated he needed to treat a bone infection. This was for one (Resident # 1) of three residents reviewed for provision of medical care per professional standards of practice. The findings included: Record review revealed Resident # 1 was admitted to the facility on 7/3/24. Resident # 1's hospital discharge summary, dated 7/3/24, included the following information. The resident	F 684	F684 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 no longer in the facility, no other actions taken for resident #1 Identification of other residents having the potential to be affected by the same deficient practice: 100% of all new admission to the facility for the last 30 days were audited on 8/19/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other resident with the order for antibiotics that	8/27/24

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 08/06/2024

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

(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 684	Continued From page 6 had a history of stroke, paraplegia, prostate cancer, lumbar stenosis, chronic pain and lymphedema, and wounds. Vascular surgery was consulted during the hospitalization, and the vascular physician did not think the resident had peripheral vascular disease. One of Resident # 1's wounds was located on the right ankle and a MRI had shown right "lateral ankle with underlying osteomyelitis of the distal fibula." (Osteomyelitis is a bone infection and the fibula is the leg bone which extends into the ankle joint). Resident # 1's discharge summary also indicated that infectious disease physicians had been consulted and 6 weeks of Iv antibiotics Daptomycin and Rocephin were being considered at discharge The discharge summary also noted the resident was "going to SNF (skilled nursing facility) for extended antibiotics, wound care, and rehab." It further noted "need to f/u with ortho and ID (infectious disease) later on once abx (antibiotics) completed." It further noted, "CM (case manager) requested to arrange for SNF with IV abx at ANF (area nursing facility)." A review of Resident # 1's discharge summary revealed the antibiotic that was decided upon had not been included in the discharge medications. Review of facility records revealed Resident # 1 was admitted to the facility on 7/3/24. There were no orders for IV antibiotics until 7/7/24 at 6:09 PM on which date an order was entered for Ceftriaxone sodium intravenous 2 gm every 24 hours. The order was entered into the system for a diagnosis of sepsis and not osteomyelitis. The first time the MAR (medication administration record) showed the ceftriaxone was administered was on 7/8/24 (which corresponded to a Monday).	F 684	was not transcribed correctly in the facility medical records. Findings of this audit are documented on the new admission order audit tool located in the facility compliance binder. 100% audit of all new antibiotic orders-initiated within the last 30 days was completed by the DON, ADON, and unit coordinator (#1 or #2) to ensure ordered medication were transcribed correctly in resident□s medical records and administered per physician orders. The audit was completed on 08/19/2024. Findings of this audit is documented on the new antibiotic order audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 8/19/2024, an admitting licensed nurse on duty will review hospital discharge summary and transcribe all orders to resident□s medical records to include orders for antibiotic therapy. Any documented need for antibiotic therapy or other medication/treatment noted in the discharge summary without an order will be communicated to the discharging entity and/or facility attending physician immediately for clarification. Effective 8/19/2024, the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), Unit coordinators (#1, #2), and/or wound nurse, resumed the process for reviewing new admissions/readmission to ensure that the medication orders and other	

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 08/06/2024

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

(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 684	Continued From page 7 Unit Manager # 1 was interviewed on 8/1/24 at 2:00 PM and again on 8/2/24 at 2:15 PM and reported she was not the Unit Manager for Resident # 1. The resident had arrived around 3:00 to 4:00 PM on 7/3/24 and an orienting nurse was assigned to care for him. She (Unit Manager # 1) was asked to help show the orienting nurse how to do a skin assessment. The orienting nurse (Nurse # 9) left the room while she was doing the skin assessment. She (Unit Manager # 1) had not been responsible for putting orders in for Resident # 1. She had just helped with his skin assessment and given him general information about the facility. She reported that Unit Manager # 2 was the Unit Manager for Resident # 1, and the orders should have been put in on the day of admission. The Unit Manager further reported the nurse who was putting the orders in should have read the discharge summary, noted his diagnoses, and notified the provider of any clarification needed. Usually, the provider would have the staff call the hospital case manager to clarify if there was something that was missing in the discharge summary. According to Unit Manager # 1, this should have all happened on Resident # 1's day of admission. Unit Manager # 2 was interviewed on 8/1/24 at 4:05 PM and reported the following information. She did not become the Unit Manager for Resident # 1 until the date of 7/28/24. Nurse # 9 was the nurse who had admitted Resident # 1, and she was no longer at the facility. Unit Manager # 2 did not recall being responsible for Resident # 1's admission orders entry and clarification of what antibiotic he should be on. Nurse # 4 was interviewed on 8/1/24 at 3:20 PM and reported the following information. She	F 684	orders on the discharge summary, match the orders that are entered into the facility Electronic Health Records (EHR). Additionally, if there are recommendations on the discharge summary that are not reflected in the discharge orders, the clinical team will ensure the clarification is obtained from the discharging facility and/or resident□s attending physician. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. Effective 8/19/2024, the weekend supervisor will review new admissions/readmission to ensure that the medication orders and other orders on the discharge summary match the orders that are entered into the facility Electronic Health Records (EHR). Additionally, if there are recommendations on the discharge summary that are not reflected in the discharge orders, the clinical team will ensure the clarification is obtained from the discharging facility and/or resident□s attending physician. This systemic process will take place every Saturday and Sundays. Any identified issues will be addressed promptly. Any negative findings will be documented on the weekend supervisor report form and maintained in the clinical meeting binder. Effective 8/19/2024 the Clinical team,	

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 08/06/2024

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

(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 684	Continued From page 8 worked the first night Resident # 1 was admitted. She found the resident in the facility's electronic medical record system, but she had not been responsible for admitting him and making sure his orders were correct. She did not recall a need to clarify an antibiotic order for the resident. Resident # 1's admission Minimum Data Set) assessment, dated 7/8/24, coded the resident as cognitively intact. He also appeared on a 7/31/24 list of residents provided to the survey team as a resident the facility considered credible for interviews. During an interview with Resident # 1 on 7/31/24 at 2:40 PM, Resident # 1 reported the following information. Monday (7/8/24) was the first time that anyone gave him an IV antibiotic. He had arrived on 7/3/24 and over the weekend following the holiday of 7/4/24 there did not seem to be anyone to ask about why he was not getting it. The antibiotic was very important. It was the reason his foot was getting better. During an interview with Nurse # 12 on 8/1/24 at 3:04 PM, the nurse reported the following information. On 7/7/24 (Sunday) she had worked from 7 AM to 7 PM. That evening Resident # 1's family member had visited and spoken to one of the staff about the resident's PICC (peripheral inserted central catheter) not being flushed and him not getting antibiotics. She checked his orders and found things had not been entered correctly. She recalled she located an antibiotic order on the evening of 7/7/24 and placed it in the computer. Nurse # 12 reported the facility had several admissions per day during the first week of July 2024 (of which Resident # 1 was one) and there was a new electronic medical record	F 684	which consists of the DON, ADON, Minimum Data set (MDS), Unit coordinators (#1, #2), and/or wound nurse, resumed the process for reviewing physician orders written in the last 24 hours or from the last held clinical meeting to ensure such orders are transcribed correctly and administered per physician order. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. Effective 8/19/2024, the weekend supervisor will review the physician orders written in the last 24 hours orders that are entered into the facility Electronic Health Records (EHR). This systemic process will take place every Saturday and Sundays. Any identified issues will be addressed promptly. Any negative findings will be documented on the weekend supervisor report form and maintained in the clinical meeting binder. DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of ensuring medication and other orders in discharge summaries are transcribed and administered per physician order for each	

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 08/06/2024

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

(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 684	Continued From page 9 system. Not everyone who was handling admissions had been trained in the new system. During an interview with the Administrator on 8/2/24 at 11:00 AM the Administrator reported the following information. The facility had undergone transition to new corporate ownership in June 2024. The facility also changed over to a new electronic medical record software provider around the dates of 7/3/24 and 7/4/24. Resident # 1 had been part of multiple admissions during the first week of July 2024, but she had not realized there had been a problem with establishing his orders for antibiotics. She had not been told. The facility's medical director, who was also Resident # 1's facility physician, was interviewed on 8/5/24 at 12:14 PM and reported the following information. When he first saw Resident # 1 the resident voiced to him about not receiving antibiotics. He recalled he talked to the Director of Nursing that day. He did not recall if it had been mentioned to him before and if he had told them to call the infectious disease physician to clarify. Part of the problem had been the discharge summary had not included the antibiotic order that the resident was to get. The resident was on the "tail end of the antibiotics" now and the antibiotic doses were being extended to account for doses not received. According to the physician, the resident had not been harmed. Interview with the facility's corporate Nurse Consultant on 8/2/24 at 10:00 AM revealed clarification of orders should be done at admission. He had just started as consultant of the facility on 7/30/24 and had planned for all new admission orders to be checked. This included a	F 684	admitted/readmitted resident. The education also emphasized on proper ways to enter medication in facility electronic medical records, and proper steps to be taken (including contacting the discharging entity and/or facility attending physician for clarification) when the need to continue a certain medication or treatment is documented in discharge summary without a physician order. This education will be completed by 8/27/2024. Any licensed nurses not educated by 8/27/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 8/27/2024, DON and/or ADON will monitor compliance with order transcription to include antibiotic therapy by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team cross referenced discharge summary orders with orders entered into the facility EHR for accuracy. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Results of the audit will be presented in QAPI for review and recommendation. Effective 08/27/2024, Director of Nursing	

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 08/06/2024

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

(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 684	Continued From page 10 pharmacist who would be onsite and checking orders.	F 684	will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 08/27/2024.	
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with a resident, family, staff, and physician the facility failed to ensure orders were obtained and carried out for flushes for a peripheral inserted central catheter. (A peripheral inserted central catheter is a type of intravenous access, which requires flushes with an ordered solution to maintain the patency in order that the line not clot off). This was for one (Resident # 1) of one sampled resident with an intravenous access site. The findings included: Record review revealed Resident # 1 was admitted to the facility on 7/3/24. Resident # 1's hospital discharge summary, dated 7/3/24, included the following information. Resident # 1's	F 694	F694 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 no longer in the facility, no other actions taken for resident #1 Identification of other residents having the potential to be affected by the same deficient practice: 100% of all current residents with an intravenous (IV), PICC, Central lines, or any other venous access line were audited on 08/19/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to	8/27/24

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 08/06/2024

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

(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 694	Continued From page 11 discharge summary indicated "going to SNF (skilled nursing facility) for extended antibiotics, wound care, and rehab." On 7/3/24 the resident was transferred to the facility for care. On the resident's admission nursing assessment, it was noted the resident had a PICC (peripheral inserted central catheter). From the dates of 7/3/24 through 7/6/24 there were no orders for the maintenance flushes and care of Resident # 1's PICC line. From 7/3/24 through 7/6/24 there was no documentation on the July MAR that the resident's PICC line was flushed. During this timeframe there were no antibiotics that were ordered to infuse through the PICC line. On 7/7/24 orders were entered into the resident's electronic medical record system for the first time to address the care of the PICC line. One of the orders, written on 7/7/24, was to flush the PICC line with 10 ml (milliliters) of normal saline, infuse medication, then 10 ml of saline followed by 5 ml of 10units/ml of heparin. Review of Resident # 1's orders revealed on 7/7/24 at 6:09 PM an order was entered for Ceftriaxone sodium intravenous 2 gm every 24 hours. The first time the Ceftriaxone was signed as administered was on 7/8/24 at 11:41 PM. Following 7/8/24, according to documentation on the July 2024 MAR, the antibiotic was signed as administered sometimes every day and sometimes twice per day. There was no documentation on the MAR to denote when the PICC line was flushed. Resident # 1's admission Minimum Data Set)	F 694	identify any other resident with no orders to flushes. Findings of this audit are documented on the venous access line audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 8/19/2024, an admitting licensed nurse on duty will add orders for flushes for all residents with venous lines and complete the venous line flushing per order. Effective 8/19/2024, the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), Unit coordinators (#1, #2), and/or wound nurse, resumed the process for reviewing new admissions/readmission, and physician orders written in the last 24 hours or from the last held clinical meeting to ensure that residents with venous access have orders for venous line flushes entered into the facility electronic medical record, and are flushed per order. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to	

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 08/06/2024

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

(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 694	Continued From page 12 assessment, dated 7/8/24, coded the resident as cognitively intact. He also appeared on a 7/31/24 list of residents provided to the survey team as a resident the facility considered credible for interviews. Resident # 1 was interviewed on 7/31/24 at 2:40 PM and again on 8/2/24 at 8:45 AM and reported the following information. Since being at the facility, it had varied when he got IV antibiotics for his osteomyelitis and when the PICC line was flushed. Some days there was a long time lapse in the hours after the antibiotic finished before anyone came to flush his PICC line. The PICC line had not been flushed for several days when he was first admitted on 7/3/24. Resident # 1's family member was interviewed on 8/1/24 at 11:15 AM and reported the following information. When she had visited Resident # 1 on 7/7/24 she learned no one had flushed his PICC line since he had been admitted. She went to a nurse and expressed concern. Another nurse from another hall heard her talking to Resident # 1's nurse and volunteered to flush the PICC line. July 7th was the first time the PICC line was flushed since he had been at the facility. During an interview with Nurse # 12 on 8/1/24 at 3:04 PM, the nurse reported the following information. On 7/7/24 (Sunday) she had worked from 7 AM to 7 PM. That evening Resident # 1's family member had visited and spoken to one of the staff about the resident's PICC (peripheral inserted central catheter) not being flushed. The nurse reported there should have been maintenance orders for flushing the PICC even if the resident was not getting antibiotics. She checked his orders and found things had not	F 694	include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of ensuring residents with venous access line to include an intravenous (IV), PICC, and/or Central lines has orders for flushes. This education will be completed by 8/27/2024. Any licensed nurses not educated by 8/27/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 8/27/2024, DON and/or ADON will monitor compliance with venous line flushes by reviewing daily clinical meeting reports to ensure completion and validate that residents with venous line have corresponding orders to flush the line entered in the facility EHR for accuracy. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 08/27/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure	

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 08/06/2024

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

(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 694	Continued From page 13 been entered correctly into the computer. The PICC was flushed on 7/7/24, and she could not find orders in the computer prior to that date which would have directed the nurses to do the flushes prior to 7/7/24. The facility's Nurse Consultant, who had started in the facility on 7/30/24, was interviewed on 8/1/24 at 1:20 PM and reported the following information. The facility had undergone a change over in their electronic medical record system provider in July 2024. When the resident was admitted there should have been orders obtained for flushes. During an interview with the facility's Medical Director on 8/5/24 at 12:14 PM, the medical director reported it varied with different individuals how quickly a PICC line could clot off if the access was not flushed to maintain the patency of the line. In some cases, the line could go one day without being flushed and in other cases it could go a week or a month.	F 694	the facility remains in substantial compliance. Compliance date: 08/27/2024.	
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, and interviews with resident, family, and staff the facility failed to ensure appropriate transportation was arranged in order that a resident attend a scheduled appointment with a specialist physician. This was for one (Resident # 1) of two residents reviewed	F 745	F745 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 no longer in the facility, no other actions taken for resident #1	8/27/24

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 08/06/2024

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

(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 745	Continued From page 14 for missed appointments. The findings included: Record review revealed Resident # 1 was admitted to the facility on 7/3/24. The resident's diagnoses in part included prostate cancer and chronic progressive lower extremity weakness with paraplegia. Resident # 1's admission Minimum Data Set) assessment, dated 7/8/24, coded the resident as cognitively intact. He was also assessed to be 79 inches tall (6 feet and 7 inches tall.) Interview with Resident # 1 on 7/31/24 at 2:40 PM revealed he had missed a urology appointment since his admission date to the facility on 7/3/24. He further reported the following information about the missed appointment. He was a very tall man and they had placed him in a wheelchair to be transported in a van to the urology appointment. They tried loading him in the wheelchair four times and could not get him in the van. They finally just took him back into the facility and he missed seeing his urologist that day. He had gone a later date, and he did not think his missed appointment had contributed to any problems. Resident # 1's family member was interviewed on 8/1/24 at 11:15 AM and reported the following. Resident # 1 had missed his urologist appointment on 7/10/24. They could not get him onto the van they said. The reason Resident # 1 saw the urologist was because he had prostate cancer. The urologist was waiting on his foot wound to get better to determine if he could then have radiation therapy for prostate cancer. She	F 745	Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of current resident clinical documentation, appointment calendrer, and grievance log for the last three months was completed by medical records coordinator, social worker #1, and/or social worker #2 on 08/19/2024, to identify any documented concerns related to missing appointments. Findings of this audit are documented on a Medical appointment audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 08/19/2024, the facility will provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident to include ensuring medical related appointments are scheduled and rescheduled in a timely manner. Effective 08/19/2024, the facility□s clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 and/or Unit coordinator #2 initiated a process for reviewing clinical documentation to include the review of medical appointments ordered and/or scheduled in the last 24 hours or from the last held clinical meeting to ensure the appointment is scheduled and take place as ordered. This systemic process will take place daily (Monday through Friday).	

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 08/06/2024

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

(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 745	Continued From page 15 did not understand why someone could not put him correctly onto the van and he had to miss his appointment. On 8/2/24 at 6:30 PM the transportation scheduler was interviewed and reported the following information. The transport person had tried to load Resident # 1 in a van, and the resident had his legs up in the wheelchair. The resident "refused" to put his legs down so that the transport person could secure his wheelchair. The scheduler was interviewed regarding whether the resident refused or if he had the capability to move his legs in a position within the wheelchair so it could be secured. The scheduler reported that for the next visit, the staff got him a different wheelchair, but the van was the same type of van. With a different wheelchair, his legs were in a position that he was able to be secured. The only thing that had changed in getting him to the appointment at a later time was the type of wheelchair. The Assistant Director of Nursing was interviewed on 8/1/24 at 1:40 PM and reported the following information. Resident # 1 had missed a urology appointment because the van driver could not figure out how to fit him in the van. The Rehabilitation Director was interviewed via phone on 8/5/24 at 1:53 PM and reported the following information. The therapy department had been working with Resident # 1 and he had contractures and limited range of motion in his lower extremities. He required mechanical lift transfers and could not do active range of motion in his legs. She had not been present on the date of the missed urology appointment, but if staff had needed a different type of wheelchair or help	F 745	Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/or Unit coordinator #1/#2. Findings of this systemic change will be documented on the daily clinical report form and maintained in the daily clinical meeting binder. 100% education of all current clinical leadership team members to include Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 and/or Unit coordinator #2 completed by the facility administrator. The emphasis of this education includes, but not limited to, the importance of ensuring each resident receive medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being including ensuring medical related appointments are scheduled, resident are transported on an appropriate mobility device, and alternative means of medical transportation is solicited when the resident cannot be transported on one form of mobility device/transportation. This education will be completed by 08/27/2024, any clinical team member not educated by 08/27/2024, will not be allowed to work until educated. This education is added to new hire orientation for all clinical team members effective 08/19/2024. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 08/19/2024, Director of nursing,	

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 08/06/2024

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

(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 745	Continued From page 16 in trying to get him correctly positioned in the one they had, then they could have asked the rehab department and they would have worked to help the staff so he could have attended his appointment.	F 745	Assistant Director of Nursing, and/or Unit coordinator #1 and/or Unit coordinator #2, will monitor compliance with resident□s medical appointments by reviewing the daily clinical meeting reports to ensure completion and proper follow through. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on appointment monitoring form located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing Assistant, Director of Nursing, and/or medical record coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. Compliance date 8/27/2024	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		8/27/24

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 08/06/2024

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

(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 755	Continued From page 17 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents, staff, pharmacists, and physician the facility failed to ensure 1) controlled drug receipt disposition records coincided with the order and administration of a resident's morphine which indicated the resident had not received the morphine as prescribed (Resident # 3) and 2) ensure non controlled medications were obtained from the pharmacy and administered per orders (Residents # 8 and # 13). This was for three of five sampled residents reviewed for medications. The findings included: 1. Resident # 3 was readmitted to the facility on	F 755	F755 Corrective actions accomplished for those residents found to be affected by the deficient practice: On 08/19/2024 Resident #3 was assessed by the attending physician for any signs and symptoms associated with missing morphine as prescribed. No negative signs or symptoms identified. On 08/19/2024 Resident #8 was assessed by the attending physician for any signs and symptoms associated with missing Escitalopram Oxalate (Lexapro) as prescribed. No negative signs or	

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 08/06/2024

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

(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 755	Continued From page 18 7/3/24. The resident had a diagnosis of chronic pain. Per the resident's 7/3/24 hospital discharge summary, the resident and her guardian had chosen comfort care, and the facility was to follow up with a hospice referral once she was admitted to the facility. Discharge instructions on the 7/3/24 summary also included the resident should receive morphine sulfate 100mg/5 ml (20 mg/ml) concentrated solution. Give .25 ml (5 mg) into gastrostomy tube every six hours. There was also an order on the hospital discharge summary that the resident could have 5 mg morphine sulfate every four hours as needed. Review of physician orders revealed the morphine sulfate scheduled order was not initiated in the facility's electronic medical record until the date of 7/4/24 at 5:52 AM. The facility order read to give morphine sulfate oral solution 100 mg/5 ml give 0.25 mg via gastrostomy tube four times a day for pain or shortness of breath. This order was transcribed on the July MAR (medication administration record) to be scheduled at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. On 7/15/24 the morphine sulfate dosage was increased to .5 ml (10 mg) four times per day and placed on the July MAR for the same scheduled times. Review of Resident # 3's controlled drug receipt record and disposition form revealed the following information. On 7/4/24 30 ml (milliliters) of Morphine was filled by the pharmacy. The morphine had not been signed out on the control form four times every day in July 2024. (In order	F 755	symptoms identified. Resident #1 no longer in the facility, no other actions taken for resident #1 Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of current residents with orders for pain narcotic medication to include morphine, other medication including Lexapro and Gabapentin completed by Director of Nursing, Assistant Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2 on 09/19/2024 to identify any other resident who did not receive pain medication per physician orders in the last two weeks. Findings of this audit are documented on a pain medication audit tool located in the facility compliance binder. 100% audit of the controlled drug receipt/record/disposition form for current residents with orders for controlled medication completed by Director of Nursing, Assistant Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2 on 08/19/2024 to identify if medication were removed from the card per physician order. Findings of this audit are documented on Narcotic count audit tool located in the facility compliance binder. 100% inspection of all current resident medication ordered completed by comparing ordered medication in EHR and the available medication on each cart to assure all ordered medication including Lexapro are available to be used. The audit was completed on 08/19/2024 by	

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 08/06/2024

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

(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 755	Continued From page 19 to administer a controlled substance, a nurse must sign the date and time the controlled substance is removed from double locked storage in order to administer the controlled medication.) The number of times Resident # 3's morphine had been removed each day for administration were: On 7/4/24-none On 7/5/24-none On 7/6/24 none On 7/7/24 once On 7/8/24 twice On 7/9/24 three times On 7/10/24 two times On 7/11/24 two times On 7/12/24 two times On 7/13/24 two times On 7/14/24 two times On 7/15/24 two times On 7/16/24 two times On 7/17/24 two times On 7/18/24 no times On 7/19/24 one time On 7/21/24 two times On 7/22/24 one time On 7/23/24 two times On 7/24/24 two times On 7/25/24 two times On 7/26/24 one time On 7/27/24 two times On 7/28/24 two times On 7/29/24 one time On 7/30/24 three times On 7/31/24 three times Review of electronic medication administration narrative notes revealed no documentation the morphine was held on the above days because of sedation.	F 755	Unit Coordinator #1 and/or #2. all missing medication were re-ordered from the contracted pharmacy per physician order. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 08/19/2024, facility employees will administer medication based on physician orders to treat a specific condition as diagnosed, and document the administration of such medication in each resident□s clinical record. Effective 08/19/2024, the facility clinical team to include the Director of Nursing, assistant director of Nursing, Unit coordinator #1 or #2 revised the shift change process to provision for validating the accuracy of controlled drug to including morphine. This process will ensure medication is removed from the card based on the physician orders and, if otherwise, proper documentation will be included on the disposition of any medication removed/not removed from the card. Finding of this systemic change is documented on the narcotic count sheets located in the narcotic count binders on each medication cart. Effective 08/19/2024 all ordered medication for each resident will be maintained in the same medication cart. The overflow cart will no longer be used to split medication to ensure visibility of available medication as ordered by a physician. 100% education of all Licensed nurses and Medication aides to include full time, part time, and as needed nursing	

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 08/06/2024

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

(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 755	Continued From page 20 Review of Resident # 3's July MAR revealed blanks by some of the administration times for the morphine sulfate and at other times nurses initialed it was given although there was no corresponding date and time on the controlled receipt record and disposition sheet that it was pulled from the supply. Although not all inclusive, one of the nurse's initials which appeared on the July 2024 MAR were the ADON's (Assistant Director of Nursing's) initials. The ADON was interviewed on 8/2/24 at 9:25 AM and reported the following information. According to the ADON, If the morphine had been given correctly as ordered, then it would have been signed out from the controlled drug receipt record and disposition sheet because the nurses would have had to remove it and sign for the removal for administration to the resident. She viewed the MAR and reported during the dates and the times that her initials appeared on the July MAR, she did not know if she had actually been assigned to the resident. During the first week of July the facility had changed over to a new electronic medical record system and there were a lot of nurses who needed to get into the system so they could sign off on MARs and care. The IT (information technology) department could not keep up with all the staff needing sign ins to the system, so she had to sign in for them under her name and log in. Therefore, her initials appeared on the MAR and she was not sure at the time of the interview which nurses had been actually giving medications on all the dates that her signature appeared. According to the ADON, the facility had done their best with the transition, and she only logged in nurses under her log in because the nurses had to give medications.	F 755	employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to, the importance of administering medication to include pain medication, and other medications per physician order. Staff education also focused on the revised process for shift changes that include validating the count and ensuring medication was removed from cards per physician orders, and process to reorder medication from pharmacy in a timely manner. This education will be completed by 8/27/24. Any Licensed nurse and/or medication aide not educated by 8/27/24 will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new Licensed nurses and medication aides effective 08/27/2024 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication monitoring process. This monitoring process will be accomplished by reviewing medication administration records for all residents with orders for pain medication, and other medication to include Lexapro to ensure Licensed nurses and medication aides are administering such medication per physician orders. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two	

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 08/06/2024

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

(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 755	Continued From page 21 On 8/2/24 at 12:05 PM the Nurse Consultant reported he had checked to see if there was any other place the nurses had signed out for Resident # 3's morphine sulfate through an emergency supply and could find no record where they would have gotten the morphine any other place other than Resident # 3's supply from the pharmacy. Resident # 3's supply of morphine was checked on 8/2/24 at 12:45 PM with Nurse # 11 and Unit Manager # 1 to see if it was short and thereby possibly account for the missing doses not signed out. The supply was not short of morphine when compared to the controlled drug receipt record and disposition sheet on that date (8/2/24). It was observed that there was more in the morphine sulfate bottle than compared to the controlled drug receipt record and disposition sheet. The record indicated there was 10 cc left in the bottle, and it was observed that the bottle was showing 20 cc in the bottle. During an interview with Resident # 3's physician on 8/5/24 at 12:45 PM the physician reported he had not evidenced the resident in pain while she had been residing back at the facility. Resident # 3 was observed on 7/31/24 at 1:24 PM to not be exhibiting signs of pain. The resident was again observed on 8/2/24 at 8:40 AM and did not exhibit signs of pain. 2. Resident #8 was originally admitted to the facility on 6/12/2019 with cumulative diagnoses one of which was major depressive disorder. Documentation on the most recent Quarterly	F 755	more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a medication review monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the controlled medication monitoring process. This monitoring process will be accomplished by reviewing the controlled drug receipt/record/disposition form for all residents with orders for narcotic medication orders to ensure medication was removed from the card per physician order. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Narcotic count review monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete medication availability monitoring process. This monitoring process will be accomplished by reviewing five randomly selected residents orders and validating the availability of medication in the medication cart. This	

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 08/06/2024

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

(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 755	Continued From page 22 Minimum Data Set assessment dated 6/15/2024 revealed Resident #8 was independent with daily decision-making skills with no short- or long-term memory impairment. An interview was conducted with Resident #8 on an initial tour on 7/312024 at 11:42 AM. Resident #8 stated frequently the facility would run out of medications. Resident #8 indicated a facility nurse would tell her a medication was being reordered for her, a few days later she would be told the facility had run out of that medication for her, and then four or five days later the facility would obtain the medication for her. Resident #8 stated that currently she had not had the medication Lexapro for several days and she had been told it was on order. Documentation in the physician orders revealed Resident #8 had an order for 5 milligrams Escitalopram Oxalate (Lexapro) to be administered as one tablet one time a day by mouth for depression related to major depressive disorder. Documentation on the Medication Administration Record (MAR) for July revealed Resident #8 did not receive Escitalopram Oxalate as ordered on 7/26/2024, 7/29/2024, and 7/31/2024 because the medication was "on order." Documentation on the MAR for July revealed Resident #8 was administered Escitalopram Oxalate by Nurse #8 as ordered on 7/27/2024, 7/28/2024, and 7/30/2024. The Pharmacy Manager for the facility pharmacy was interviewed on 8/1/2024 at 10:32 AM. The Pharmacy Manager revealed Resident #8 should have had Escitalopram Oxalate doses available	F 755	monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Medication availability monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication administration monitoring process. This monitoring process will be accomplished by reviewing medication administration audit report ensure no resident is listed with missing medication administration. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Medication administration monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is archived.	

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 08/06/2024

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

(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 755	Continued From page 23	F 755	Compliance Date: 08/27//2024	

to her at the facility because a 30-day supply was sent to the facility on 7/18/2024. The Pharmacy Manager also revealed there were no doses of Escitalopram Oxalate removed from the electronic medication dispensing system for Resident #8 in July 20204.

Nurse #8 was interviewed on 8/3/2024 at 11:35 AM. Nurse #8 revealed she was an agency nurse who began working at the facility in the middle of July 2024. Nurse #8 recalled Resident #8 but did not recall where she obtained the Escitalopram Oxalate from to administer to Resident #8 on 7/27/2024, 7/28/2024, and 7/30/2024. Nurse #8 speculated she ordered the medication for Resident #8 and the medication came from the pharmacy. Nurse #8 stated she ordered a lot of medications that were not available for residents while on her various shifts at the facility but could not be certain that was what she had done for Resident #8. Nurse #8 confirmed if she documented she administered the medication to Resident #8 then she administered the medication to Resident # 8.

An observation and interview was conducted with the facility Nurse Consultant on 8/1/2024 at 9:21 AM. The Nurse Consultant explained, and it was observed the facility had an overflow cart on the hallway which Resident #8 resided. The Nurse Consultant further explained the overflow cart was kept at the nurses' desk and was used for storage of extra medications which did not fit on the medication cart used to dispense medications for the residents. A medication card for Escitalopram Oxalate for Resident #8 dated as delivered on 7/18/2024 was observed to be in the overflow cart and had not had any medication removed from it at the time of the observation.

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 08/06/2024

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

(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 755	Continued From page 24	F 755		

The Nurse Consultant confirmed Resident #8 did not have a medication card for Escitalopram Oxalate on the medication cart which the nurses used to dispense medication from at the time of the observation. The Nurse Consultant stated the medications for Resident #8 should all be kept on the same medication cart, so the nurses did not have to go to an overflow cart to look for a medication that was available.

An additional interview was conducted with the facility Nurse Consultant on 8/2/2024 at 12:05 PM. The facility Nurse Consultant stated the MAR documentation could not be trusted in the facility and was not a true reflection of the medication administered or who gave the medication to the resident. The Nurse Consultant further revealed the facility was not sure if medications were being obtained from other residents, removed from the supply in the electronic medication dispenser, or even administered at all.

3. Resident #13 was admitted to the facility on 7/4/2024 with cumulative diagnoses some of which included Type 2 Diabetes Mellitus and idiopathic peripheral autonomic neuropathy.

Documentation on an Admission Minimum Data Set assessment dated 7/8/2024 revealed Resident #13 was assessed as cognitively intact.

Resident #13 was interviewed on 8/1/2024 at 1:32 PM. Resident #13 stated he was admitted to the facility for rehabilitative services on the morning of 7/4/2024. Resident #13 stated when he was first admitted he did not receive his medication for several days and was initially ready to leave the facility due to a lack of medication availability. Resident #13 stated his

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 08/06/2024

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

(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 755	Continued From page 25	F 755		

biggest concern was the lack of availability of the medication Gabapentin, which he took for nerve pain three times a day. Resident #13 revealed throughout his stay at the facility the nurses would periodically not be able to locate his medication to give to him.

Documentation in a physician order initiated on 7/4/2024 at 6:16 AM revealed Resident #13 had an order for 300 milligrams Gabapentin to be administered as one oral capsule by mouth three times a day for nerve pain.

Documentation on the July Medication Administration Record (MAR) revealed Resident #13 did not receive the medication Gabapentin at 9:00 AM on 7/4/2024, 2:00 PM on 7/4/2024, 9:00 PM on 7/4/2024, 9:00 AM on 7/5/2024, and 2:00 PM on 7/5/2024. The July MAR indicated Resident #13 received the first dose of Gabapentin at 9:00 PM by the Assistant Director of Nursing on 7/5/2024.

An interview was conducted with the Pharmacy Manager of the facility pharmacy on 8/2/2024 at 10:40 AM. The Pharmacy Manager revealed on the evening of 7/5/2024 the pharmacy received the physician medication orders for Resident #13 and the medications, to include Gabapentin, were delivered to the facility in the early morning hours on 7/6/2024. The Pharmacy Manager stated 90 capsules of Gabapentin, or a 30-day supply was signed for at the facility for Resident #13 on 7/6/2024. The Pharmacy Manager also confirmed doses of Gabapentin were not removed from the facility electronic medication dispensing system since his admission.

The Assistant Director of Nursing (ADON) was

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 08/06/2024

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

(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 755	Continued From page 26	F 755		

interviewed on 8/2/2024 at 9:20 AM. The ADON revealed she was not in the building to give Gabapentin to Resident #13 on 7/6/2023 at 9:00 PM and she would not have any way of knowing which nurse it was she gave her login information to, so the administration of the Gabapentin on 7/6/2024 could not be confirmed.

An observation and interview were conducted on 8/2/2024 at 10:50 AM with Nurse #7 at the medication cart for the hall which Resident #13 resided. Nurse #7 removed the medication card for Gabapentin for Resident #13, and it was observed to be dated as dispensed on 7/5/2024 with two doses remaining from the original 90 capsules dispensed. Nurse #7 stated the medication card with the remaining two doses was the last of the Gabapentin dispensed on 7/5/2024 for Resident #13.

Additional documentation on the July and August MARs revealed of the 88 doses of Gabapentin removed from the medication cards for Resident #13, only 74 doses of Gabapentin were documented as administered to Resident #13. The documentation in the July MAR revealed on two occasions Resident #13 was not available for administration of Gabapentin as ordered on 7/11/2024 at 2:00 PM and 7/27/2024 at 2:00 PM. On five occasions the July MAR had blank spaces indicating Gabapentin was not administered to Resident #13 on 7/7/2024 at 9:00 AM, 7/7/2024 at 2:00 PM, 7/12/2024 at 9:00 AM, 7/12/2024 at 2:00 PM, and 7/28/2024 at 2:00 PM. The documentation on the July and August MARs revealed, at the time of the observation of the two doses of Gabapentin left on the medication card, the last dose of Gabapentin administered to Resident #13 was at 9:00 PM on 8/1/2024.

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 08/06/2024

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

(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 755	Continued From page 27 Fourteen doses of Gabapentin for Resident #13 were not accounted for when or by whom they were administered in the 27 days. An interview was conducted with the facility Nurse Consultant on 8/2/2024 at 12:05 PM. The facility Nurse Consultant stated the MAR documentation could not be trusted in the facility and was not a true reflection of the medication administered or who gave the medication to the resident. The Nurse Consultant further revealed the facility had no way of knowing if medications were being obtained from other residents, removed from the supply in the electronic medication dispenser, or even administered at all.	F 755		
F 759 SS=D	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 and staff interview the facility failed to ensure their medication rate was below five percent. Two nurses and two Medication Aides were observed to administer medications. Three errors were detected out of 26 opportunities for error resulting in a 11.53 % medication error rate. One error was an omission, one error was because of the wrong medication administered, and one error was the wrong administration time for sliding scale insulin. The findings included: 1a. On 8/1/24 at 8:05 AM Medication Aide #1 (MA	F 759	F759 Corrective actions accomplished for those residents found to be affected by the deficient practice: On 08/19/2024 Resident #14 was assessed by the attending physician for any signs and symptoms associated with missing Ferrous gluconate, and incorrect administered insulin as prescribed. No negative signs or symptoms identified. On 8/19/2024, the Regional clinical Director provided one on one education to the Director of Nursing on five rights of	8/27/24

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 08/06/2024

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

(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 759	Continued From page 28 # 1) was observed as she administered medications to Resident # 14. MA # 1 viewed the electronic medication administration record and reported Resident # 14 was due to receive Ferrous Gluconate. MA # 1 looked through the cart and could not find any. She then went to look in a different area of the facility and returned to say that there was none. She was not observed to give any Ferrous Gluconate to Resident # 14. Following the medication pass observation, a review of orders revealed Resident # 14's orders included he receive Ferrous Gluconate 324 milligrams (37.5 elemental iron) twice per day for a diagnosis of anemia. This order originated on 7/10/23. The information that the medication was not available had been entered by MA # 1 into Resident # 14's record for his morning dose that was due on 8/1/24. 1b. On 8/1/24 at 8:23 AM the DON (Director of Nursing) walked up to MA # 1's medication cart. MA # 1 asked the DON if she could give Resident # 14 his morning insulin. The DON looked at the electronic MAR, removed a blood sugar monitoring machine and an insulin pen from the medication drawer. She then entered Resident # 14's room. It was noted the resident had already eaten part of his breakfast when she entered. The DON checked Resident # 14's blood sugar and showed the surveyor that the reading was 194. The DON stated per the instructions he was to get a routine insulin dose of 5 units and 1 unit extra for his blood sugar reading of 194. The DON was observed to give 6 units from a Humulin NPH KwikPen by subcutaneous route into Resident # 14's arm. The DON reported that one of the 6 units was for the sliding scale. Following the mediation pass, the surveyor reviewed Resident # 14's record in order to	F 759	medication administration (right resident, right medication, right dose, right time, and right route). Identification of other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. 100% inspection of all current resident medication ordered completed by comparing ordered medication in EHR and the available medication on each cart to assure all ordered medication including Ferrous Gluconate are available to be used. The audit was completed on 08/19/2024 by Unit coordinator #1 or #2 all missing medication were re-ordered from the contracted pharmacy per physician order. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 08/19/2024, facility employees will administer medication based on physician orders to treat a specific condition as diagnosed, and document the administration of such medication in each resident□s clinical record. Effective 08/19/2024 all ordered medication for each resident will be maintained in the same medication cart. The overflow cart will no longer be used to split medication to ensure visibility of available medication as ordered by a physician. 100% education of all Licensed nurses and Medication aides to include full time, part time, and as needed nursing	

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 08/06/2024

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

(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 759	Continued From page 29 reconcile the observed medications given with the orders in the electronic record. Resident # 14's orders during the reconciliation review revealed Resident # 14 had orders which read the sliding scale regular insulin was to be given before meals. The order read: Humulin R injection inject subcutaneous before meals for diabetes; blood glucose -140/40 (Take blood sugar value subtract 140, divide by 40 to determine units to administer). According to the observation the sliding scale insulin had been given at the wrong time and should have been before breakfast. Additionally, it was the wrong type of insulin. 1c. On 8/1/24 at 8:23 AM the DON (Director of Nursing) was observed to give 6 units from a Humulin NPH KwikPen by subcutaneous route into Resident # 14's arm. The DON reported that one of the 6 units was for the sliding scale and the other five units was for his morning routine insulin coverage. Following the mediation pass, the surveyor reviewed Resident # 14's record in order to reconcile the observed medications given with the orders in the electronic record. Resident # 14's orders during the reconciliation review revealed the resident did not have orders for morning NPH insulin. Resident # 14 had orders for 5 units of regular insulin twice per day. On 8/1/24 at 10:42 AM the DON reviewed Resident # 14's orders with the surveyor and saw the insulin orders were for regular insulin and not NPH. The DON accompanied the surveyor back to the medication cart and viewed the insulin KwikPen she had used for Resident # 14. She validated that she had given NPH insulin instead of the regular. She looked through the top drawer of the medication cart and could not find Resident # 14's regular insulin.	F 759	employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to, the importance of administering medication to include pain medication, insulin, ferrous gluconate, and other medications per physician order. The education also focused on the five rights of medication administration (right resident, right medication, right dose, right time, and right route). This education will be completed by 8/27/24. Any Licensed nurse and/or medication aide not educated by 8/27/24 will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new Licensed nurses and medication aides effective 08/27/2024 Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication monitoring process. This monitoring process will be accomplished by completing medication observation for three randomly selected residents with different Licensed nurses or medication aid to ensure medications are available and administered per physician order. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or	

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 08/06/2024

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

(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 759	Continued From page 30 On 8/1/24 at 12:30 PM the DON reported to the surveyor that Resident # 14's regular insulin had been located in one of the medication cart's bottom drawers. The physician had been notified of the insulin error and stated to monitor the resident. The resident was doing okay and had not experienced any serious side effects at the time of the 12:30 PM interview. During a follow-up interview with the DON on 8/6/24 at 2:45 PM the DON was interviewed about what she felt contributed to the error and reported she was nervous, but she also felt like she had given the right insulin based on what she had seen populated on the MAR (Medication Administration Record) prior to pulling the insulin pen from the cart. She had not recognized the insulin should have been regular until the surveyor asked her to review the electronic orders.	F 759	until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a medication observation monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete medication availability monitoring process. This monitoring process will be accomplished by reviewing five randomly selected residents orders and validating the availability of medication in the medication cart. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Medication availability monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is archived. Compliance Date: 08/27//2024	
F 760 SS=E	Residents are Free of Significant Med Errors	F 760		8/27/24

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 08/06/2024

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

(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 760	Continued From page 31 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, staff interview, and physician interview the facility failed to ensure residents received antibiotics or insulin correctly. This was for one (Resident # 1) of six sampled residents whose medications were reviewed and for one (Resident # 14) out of four residents observed during a medication pass observation. The findings included: 1. Record review revealed Resident # 1 was admitted to the facility on 7/3/24. Resident # 1's hospital discharge summary, dated 7/3/24, included the following information. The resident had wounds. One of Resident # 1's wounds was located on the right ankle and a MRI had shown right "lateral ankle with underlying osteomyelitis of the distal fibula." (Osteomyelitis is a bone infection and the fibula is the leg bone which extends into the ankle joint). Resident # 1's discharge summary indicated "going to SNF (skilled nursing facility) for extended antibiotics, wound care, and rehab." The discharge summary did not note which antibiotic Resident # 1 was to receive at the facility after hospital discharge. Review of physician orders revealed no antibiotics were ordered when the resident was admitted on 7/3/24 to the facility. The facility's medical director, who was also	F 760	F760 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 no longer in the facility, no other actions taken for resident #1. On 08/19/2024 Resident #14 was assessed by the attending physician for any signs and symptoms associated with an incorrect administered insulin as prescribed. No negative signs or symptoms identified. On 8/19/2024, the Regional clinical Director provided one on one education to the Director of Nursing on five rights of medication administration (right resident, right medication, right dose, right time, and right route). Identification of other residents having the potential to be affected by the same deficient practice: 100% of all new admission to the facility for the last 30 days were audited on 08/19/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other resident with the order for antibiotics that was not transcribed correctly in the facility medical records. Findings of this audit are documented on the new admission order audit tool located in the facility compliance binder.	

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 08/06/2024

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

(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 760	Continued From page 32 Resident # 1's facility physician, was interviewed on 8/5/24 at 12:14 PM and reported the discharge summary had not included the antibiotic order that the resident needed when he was first admitted. It was ordered days later. Review of Resident # 1's orders revealed on 7/7/24 at 6:09 PM an order was entered for Ceftriaxone sodium intravenous 2 gm every 24 hours. A review of Resident # 1's July 2024 MAR (Medication Administration Record) revealed the order had been put into the electronic record so that it populated twice on the MAR. There was no specific time for the resident to receive the antibiotic. Under the MAR's first Ceftriaxone order there was a column for the administration time, and which was entitled "hours." Within this column there was an entry which read "24 h" rather than a specific time to administer the antibiotic. Below the first Ceftriaxone order on the MAR, the same information appeared as an exact duplicate of the first. There was no scheduled time for the second entry. The first time the Ceftriaxone was signed as administered was on 7/8/24 at 11:41 PM under the first Ceftriaxone order. From the dates of 7/8/24 through the date of 7/31/24 the antibiotic was checked as administered 30 times on the July MAR. At times it was checked off as administered only once a day. At times it was checked off on both entries making it appear as if it was given twice. An example of this was on 7/9/24 when it was checked as given on 7/9/24 at 3:50 PM and again on 7/9/24 at 9:14 PM. Resident # 1's admission Minimum Data Set) assessment, dated 7/8/24, coded the resident as	F 760	100% audit of all new medication orders including antibiotics-initiated within the last 30 days was completed by the DON, ADON, and unit coordinator (#1 or #2) to ensure ordered medication were transcribed correctly in resident□s medical records, populated, and administered per physician orders. The audit was completed on 08/19/2024. Findings of this audit are documented on the new order audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 08/19/2024, facility employees will administer medication based on physician orders to treat a specific condition as diagnosed, and document the administration of such medication in each resident□s clinical record. Effective 8/19/2024, an admitting licensed nurse on duty will review hospital discharge summary and transcribe all orders to resident□s medical records to include orders for antibiotic therapy. Any documented need for antibiotic therapy or other medication/treatment noted in the discharge summary without an order will be communicated to the discharging entity and/or facility attending physician immediately for clarification. Effective 8/19/2024, the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), Unit coordinators (#1, #2), and/or wound nurse, resumed the process for reviewing	

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 08/06/2024

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

(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 760	Continued From page 33 cognitively intact. He also appeared on a 7/31/24 list of residents provided to the survey team as a resident the facility considered credible for interviews. Resident # 1 was interviewed on 7/31/24 at 2:40 PM and again on 8/2/24 at 8:45 AM and reported the following information. Since being at the facility, it had varied when he got IV antibiotics for his osteomyelitis. Some days he received it twice per day and it might be eight or nine hours apart. Other days he got it once a day or not at all. He did verify that the first time he received it was on 7/8/24 as the MAR indicated. The facility's Nurse Consultant, who had started in the facility on 7/30/24, was interviewed on 8/2/24 at 12:05 PM and reported the following information. The facility had undergone a change over in their electronic medical record system provider in July 2024 and the MAR could not necessarily be considered as correct. The pharmacy director was interviewed on 8/2/24 at 10:40 AM and reported the following information. The pharmacy first sent Resident # 1's Ceftriaxone on 7/7/24. Since that time, they had sent a total of 30 doses as of 8/2/24. On 8/2/24 at 10:50 AM the Nurse Consultant, DON (Director of Nursing), and ADON (Assistant Director of Nursing) were accompanied to the medication room where Resident # 1's Ceftriaxone was stored in the medication refrigerator. The number of Resident # 1's Ceftriaxone doses still left in the refrigerator was pulled from storage and counted. There were 10 doses of the Ceftriaxone remaining from the 30 doses which had been supplied from the pharmacy on 7/7/24. This indicated the facility had given 20 doses thus far as of 8/2/24. It was	F 760	new admissions/readmission to ensure that the medication orders and other orders on the discharge summary, match the orders that are entered into the facility Electronic Health Records (EHR). Additionally, if there are recommendations on the discharge summary that are not reflected in the discharge orders, the clinical team will ensure the clarification is obtained from the discharging facility and/or resident□s attending physician. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. Effective 8/19/2024 the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), Unit coordinators (#1, #2), and/or wound nurse, resumed the process for reviewing physician orders written in the last 24 hours or from the last held clinical meeting to ensure such orders are transcribed correctly and administered per physician order. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. 100% education of all Licensed nurses	

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 08/06/2024

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

(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 760	Continued From page 34	F 760		

agreed upon that if the facility had started the antibiotic on 7/7/24 when supplied by the pharmacy and given it daily since, then there should have been 26 doses used out of the 30 sent. This would then indicate there should be four doses remaining out of the 30 supplied on 7/7/24 when it was ordered and sent from the pharmacy. This indicated that Resident # 1 had six additional Ceftriaxone doses in the medication room that had not been administered since it had been sent by the pharmacy. The Nurse Consultant, DON, and ADON acknowledged there had been missed doses. The Nurse Consultant reported they did not have the IV Ceftriaxone in back up supply and that it came specifically from the pharmacy. The Nurse Consultant informed the DON and ADON to contact the Infectious Disease physician and determine if the antibiotic needed to be extended.

During the interview with the facility's Medical Director on 8/5/24 at 12:14 PM, the Medical Director reported Resident # 1 was on the "tail end" of his antibiotics. The antibiotics had been extended and he did not feel the resident had been harmed from the missed doses.

2. During a medication observation on 8/1/24 at 8:23 AM the DON (Director of Nursing) walked up to MA # 1's (Medication Aide's) medication cart. MA # 1 asked the DON if she could give Resident # 14 his morning insulin. The DON looked at the electronic MAR, removed a blood sugar monitoring machine and an insulin pen from the medication drawer. She then entered Resident # 14's room. The DON checked Resident # 14's blood sugar and showed the surveyor that the reading was 194. The DON stated per the instructions he was to get a routine insulin dose

and Medication aides to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to:
1. The importance of administering medication to include insulin, antibiotics, and other medications per physician order.
2. The five rights of medication administration (right resident, right medication, right dose, right time, and right route).
3. Ensuring medication and other orders in discharge summaries are transcribed and administered per physician order for each admitted/readmitted resident.
4. Proper ways to enter medication in facility electronic medical records, and proper steps to be taken (including contacting the discharging entity and/or facility attending physician for clarification) when the need to continue a certain medication or treatment is documented in discharge summary without a physician order.
This education will be completed by 8/27/2024. Any licensed nurses not educated by 8/27/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses.

Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

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 08/06/2024

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

(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 760	Continued From page 35 of 5 units and 1 unit extra for his blood sugar reading of 194. The DON was observed to give 6 units from a Humulin NPH KwikPen by subcutaneous route into Resident # 14's arm. Following the medication pass, the surveyor reviewed Resident # 14's record in order to reconcile the observed medications given with the orders in the electronic record. Resident # 14's orders during the reconciliation review revealed Resident # 14 had orders for 5 units of regular insulin twice per day and he was to receive sliding scale regular insulin before meals for his diabetes. The orders read: Humulin R (Regular) injection solution 100 units/ml (milliliter) give five units subcutaneous two times per day. Humulin R injection, inject subcutaneous before meals for diabetes; blood glucose -140/40 (Take blood sugar value subtract 140, divide by 40 to determine units to administer). Review of Resident # 14's orders revealed he did not have orders for morning NPH insulin. On 8/1/24 at 10:42 AM the DON reviewed Resident # 14's orders with the surveyor and saw the insulin orders were for regular insulin and not NPH. The DON accompanied the surveyor back to the medication cart and viewed the insulin KwikPen she had used for Resident # 14. She validated that she had given NPH insulin instead of the regular. She looked through the top drawer of the medication cart and could not find Resident # 14's regular insulin. On 8/1/24 at 12:30 PM the DON reported to the surveyor that Resident # 14's regular insulin had been located in one of the medication cart's bottom drawers. The physician had been notified of the insulin error and stated to monitor the resident. The resident was doing okay and had not experienced any serious side effects at the time of the 12:30 PM interview.	F 760	Effective 8/27/2024, DON and/or ADON will monitor compliance with order transcription to include antibiotic therapy by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team cross referenced discharge summary orders with orders entered into the facility EHR for accuracy. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Results of the audit will be presented in QAPI for review and recommendation. Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication monitoring process. This monitoring process will be accomplished by completing medication observation for three randomly selected residents with different Licensed nurses or medication aid to ensure medications are available and administered per physician order. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a medication observation monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will	

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 08/06/2024

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

(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 760	Continued From page 36 During a follow-up interview with the DON on 8/6/24 at 2:45 PM the DON was interviewed about what she felt contributed to the error and reported she was nervous, but she also felt like she had given the right insulin based on what she had seen populated on the MAR (Medication Administration Record) prior to pulling the insulin pen from the cart. She had not recognized the insulin should have been regular until the surveyor asked her to review the electronic orders.	F 760	complete medication availability monitoring process. This monitoring process will be accomplished by reviewing five randomly selected residents orders and validating the availability of medication in the medication cart. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Medication availability monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is archived. Compliance Date: 08/27//2024	
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 resident interviews, record reviews,	F 835	F835	8/27/24

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 08/06/2024

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

(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 835	Continued From page 37 staff interviews, pharmacist interviews, and physician interviews administration failed to ensure adequate training and systems were in place as the facility changed over from one medical record system to another during a week when the facility had 14 hospital admissions which required orders to be initiated for care, medications, and treatments. This was for four (Residents #1, Resident # 2, Resident # 3, and Resident # 13) sampled residents of the 13 residents who were admitted during the week of the facility's change over to their new medical record system. (One of the thirteen residents was admitted twice during the first week of transition). The findings included: 1a. Resident # 1 was admitted on 7/3/24. Resident # 1's hospital discharge summary, dated 7/3/24, included the information that Resident # 1 had wounds and osteomyelitis (a bone infection). According to the discharge summary the resident was to be transferred to a skilled nursing facility for extended antibiotics and for wound care. The discharge summary did not note the specific antibiotic the resident was to receive once he arrived at the facility following discharge. The discharge summary did note wound care orders. Resident # 1's admission Minimum Data Set) assessment, dated 7/8/24, coded the resident as cognitively intact. He also appeared on a 7/31/24 list of residents provided to the survey team as a resident the facility considered credible for interviews. Resident # 1 was interviewed on 7/31/24 at 2:40 PM and again on 8/2/24 at 8:45 AM and reported the following information. Monday (7/8/24) was the first time that anyone	F 835	Corrective actions accomplished for those residents found to be affected by the deficient practice: The administrator of record who was responsible for overseeing the transition is no longer working with the facility. The new Administrator started on 08/04/2024. Identification of other residents having the potential to be affected by the same deficient practice: 100% inspection of the facility resources reviewed by the new facility administrator to verify the facility has adequate resources to effectively and efficiently maintain the highest practicable physical, mental, and psychological well-being of each resident. Findings of this audit are documented on the facility resource audit tool located in the facility compliance binder. 100% review of all cited deficiencies and the plan of correction completed on 8/19/2024 to validate the identified noncompliance is addressed for the affected residents, audits are completed for resident who has potential to be affected and systemic changes have been implemented to assure attaining and maintaining compliance. Findings of this audit are documented on a pain medication audit tool located in the facility compliance binder. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 8/19/2024, the new administrator initiated the process of conducting daily stand-up meeting that will be comprised of	

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 08/06/2024

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

(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 835	Continued From page 38 gave him an IV antibiotic. He had arrived on 7/3/24 and over the weekend following the holiday of 7/4/24 there did not seem to be anyone to ask about why he was not getting it. The antibiotic was very important. It was the reason his foot was getting better. Once the facility staff started giving him an antibiotic it varied when he received it. Some days he received it twice per day and it might be eight or nine hours apart. Other days he got it once a day or not at all. He did verify that the first time he received it was on 7/8/24. Also, he had experienced trouble with the nurses not flushing his PICC (peripheral inserted central catheter) line consistently. (A peripheral inserted central catheter is a type of intravenous access, which requires flushes with an ordered solution to maintain the patency in order that the line not clot off). Unit Manager # 1 was interviewed on 8/1/24 at 2:00 PM and again on 8/2/24 at 2:15 PM and reported she was not the nurse who had entered orders for Resident # 1 upon admission. The nurse who was putting the orders in should have read the discharge summary, noted his diagnoses, and notified the provider of any clarification needed. According to Unit Manager # 1, this should have all happened on Resident # 1's day of admission. During an interview with Nurse # 12 on 8/1/24 at 3:04 PM, the nurse reported the following information. On 7/7/24 (Sunday) she had worked from 7 AM to 7 PM. That evening Resident # 1's family member had visited and spoken to one of the staff about the resident's PICC (peripheral inserted central catheter) not being flushed and him not getting antibiotics. She checked his orders and found things had not been entered	F 835	all department leaders to discuss different clinical, operational, and resource management items. This meeting will be conducted to ensure the facility resources are used effectively and efficiently to maintain the highest practicable physical, mental, and psychological well-being of each resident. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. Any findings will be addressed promptly. Effective 8/19/2024 The facility administrator will ensure any transition taking place in the facility will be managed in a manner that will not affect residents□ care and/or outcome. Effective 8/19/2024 the facility administrator will oversee the completion of the systemic changes for each cited deficiency and ensure employees are trained adequately on the new electronic health record to ensure medication and other orders are entered/populated correctly per physician order. 100% education of all department leaders by the facility administrator. The emphasis of this education includes but not limited to, the importance of conducting daily stand-up meeting and discuss resource allocation to assure they are used effectively and efficiently to maintain the highest practicable physical, mental, and psychological well-being of each resident. This education will be completed by 8/27/24. Any department leader not educated by 8/27/24 will not be allowed to	

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 08/06/2024

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

(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 835	Continued From page 39 correctly. She recalled she located an antibiotic order on the evening of 7/7/24 and placed it in the computer. Nurse # 12 reported the facility had several admissions per day during the first week of July 2024 (of which Resident # 1 was one) and there was a new electronic medical record system. Not everyone who was handling admissions had been trained in the new system. A review of Resident # 1's orders revealed following admission, Resident # 1's first antibiotic order was on 7/7/24 when he was ordered to receive 2 grams of IV (intravenous) ceftriaxone daily. During an interview with the ADON (Assistant Director of Nursing) on 8/2/24 at 9:25 AM Resident # 1's MAR was reviewed and she validated that the Ceftriaxone order had not been placed in the computer in order that it populate correctly for the entire month of July 2024 so that the nurses would know when to administer it. Nurses had signed they initialed they gave the Ceftriaxone 30 times between 7/8/24 and 7/31/24. There was no scheduled time on the MAR for the nurses to give it at a specific time each day. According to the ADON, the nurse who had entered the Ceftriaxone may not have known how to enter the order so that it would populate correctly on the MAR. It appeared to the ADON as whomever had entered the antibiotic order was trying to get the order to populate for both a morning and evening dose because the order appeared twice in two different places on the MAR. The ADON reported there were a lot of admissions during the first week of July 2024 when Resident # 1 was admitted, and the facility was transitioning from one medical record system to another. There had been a lot of information to	F 835	work until educated. This education will be provided annually and will be added to the new hire orientation for all new department leaders effective 08/27/2024. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 8/27/2024, The facility administrator will monitor compliance with resource allocation by ensuring the daily stand-up meeting take place to discuss the proper use of facility resources to maintain the highest practicable physical, mental, and psychological well-being of each resident. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the administrator promptly. This monitoring process will be documented on a stand up meeting tool located in the facility compliance binder. Effective 08/27/2024Facility administrator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance Date: 08/27//2024	

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 08/06/2024

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

(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 835	Continued From page 40	F 835		

deal with and the staff had done their best.

On 8/2/24 at 10:50 AM it was validated with the Nurse Consultant, ADON, and DON that Resident # 1 had missed Ceftriaxone doses after it had been ordered on 7/7/24. This was determined by reconciling the number of doses still on hand in the facility versus what had been supplied from the pharmacy and what had been due to be given.

Review of Resident # 1's July 2024 MAR from 7/3/24 through 7/31/24 revealed no order populated on the MAR for PICC lines flushes. According to orders, an order first originated in the computer system on 7/7/24 to flush the PICC line with saline prior to antibiotic administration and saline and heparin following antibiotic administration. According to the facility Nurse Consultant on 8/1/24 at 1:20 PM the facility's new electronic medical record system had order sets which could be pulled up for the care and flushes of a PICC line when a resident was admitted. According to the Nurse Consultant flush orders should have been initiated on 7/3/24 in the facility's new electronic medical record system.

During another interview with Resident # 1 and his family member on 8/1/24 at 4:45 PM Resident # 1 reported he had not had dressing changes on 7/3/24 through 7/7/24 and had continued to have problems with consistent dressing changes.

During a review of Resident # 1's record with the Nurse Consultant and Unit Manager # 1 on 8/2/24 at 2:15 PM it was confirmed that initial wound treatment orders had not been entered into the facility's new electronic medical record system on 7/3/24 when he was admitted. When the orders

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 08/06/2024

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

(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 835	Continued From page 41	F 835		

were entered, not all the orders were complete (the resident's right ankle dressing order had never been entered in July 2024). Also, it was validated at this time with the Nurse Consultant and Unit Manager # 1 by reviewing Wound Physician notes for July 2024 that the Wound Physician had made multiple treatment change plans for Resident # 1's wounds which were never placed in the electronic medical record system and initiated. According to Unit Manager # 1 she had been aware of the new treatment orders and as of 8/2/24 she thought they had been entered correctly into the electronic record so they would populate on the treatment administration record, but the orders had not been entered correctly so that they would populate on the TAR.

1b. Resident # 3 was readmitted to the facility on 7/3/24 with directions on the hospital discharge summary, dated 7/3/24, to follow up with a hospice provider, provide comfort foods, and discontinue tube feedings.

According to an interview with the Vice President of the hospice provider on 8/5/24 at 11:26 AM they did not receive a referral for hospice until 7/5/24.

According to a record review the resident had orders entered on 7/4/24 and initiated for an enteral feeding of Nutren 1.5 at 55 cc (cubic centimeters)/hour.

According to orders this enteral feeding order was in effect until 7/10/24, on which date it was discontinued. The first order that the resident could receive a diet and eat was on 7/10/24.

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 08/06/2024

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

(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 835	Continued From page 42	F 835		

According to an interview with Resident # 3's guardian on 7/31/24 at 12:57 PM the 7/10/24 order changes to discontinue the enteral feeding and provide comfort were made after she brought to the attention of facility staff on 7/10/24 that the facility was not following the hospital discharge instructions.

Interview with Resident # 3's physician on 8/5/24 at 12:45 PM revealed he did not recall seeing a full discharge summary noting instructions to follow up with the hospice provider, discontinue to the resident's tube feeding, and to provide comfort foods when he first saw the resident following admission.

Unit Manager # 1 was interviewed on 8/2/24 1:10 PM and reported she found Resident # 3's discharge summary imbedded in a paper chart on 7/10/24 when the guardian brought to her attention that the orders were not correct from the hospital. During an interview with Unit Manager # 1 on 8/1/24 at 2:00 PM the Unit Manager reported nurses were to read the hospital discharge summary when a resident was admitted.

During an interview with the ADON (Assistant Director of Nursing) on 8/2/24 at 9:25 AM the ADON reported there were a lot of admissions during the first week of July 2024 when Resident # 3 was admitted, and the facility was transitioning from one medical record system to another. (During this time the DON had been on a leave of absence, and she was the acting DON). There had been a lot of information to deal with and the staff had done their best. As they were transitioning to the new system, more admissions kept coming from the hospital.

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 08/06/2024

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

(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 835	Continued From page 43	F 835		

Resident # 3's MAR was also reviewed with the ADON on 8/2/24 at 9:25 AM and the ADON confirmed her initials appeared on multiple dates and times signifying that she had administered Morphine Sulfate per an order to Resident # 3 during the month of July 2024. According to the ADON during the change over to the facility's new electronic medical system, she had allowed other nurses to log into the electronic medical system under her name. Therefore, her initials appeared as completing administration of medications which she had not actually given. According to the ADON the nurses needed to sign in and the IT (information technology) department could not provide sign- in access quickly enough. Therefore, that was why she had to allow nurses to sign in under her access. A review of Resident # 3's controlled drug receipt disposition records for Resident # 3's Morphine Sulfate did not coincide with the July 2024 MAR administration times. At times, the Morphine Sulfate was signed as given on the MAR although there was no indication it had been removed from double locked storage in order to actually be administered. According to the ADON on 8/2/24 at 9:25 AM some of the nurses who had been logging in under her sign in to the new electronic medical system had been agency nurses and at the time of the interview she had no way of knowing which nurse had been responsible for administering the Morphine to Resident # 3 when her (the ADON's initials) appeared on the MAR and it had not been signed out from storage.

1c. Resident #2 was admitted to the facility on 7/5/2024 from the hospital. Documentation on the hospital discharge summary dated 7/5/2024 revealed Resident #2 was treated in the hospital

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 08/06/2024

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

(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 835	Continued From page 44	F 835		

for sepsis from a catheter associated urinary tract infection.

Resident #2 had cumulative diagnoses some of which included atrial fibrillation, seizure disorder, hypertension, protein calorie malnutrition, chronic obstructive pulmonary disease, gastrointestinal reflux and chronic kidney disease.

Documentation on an Admission Minimum Data Set assessment dated 7/5/2024 revealed Resident #2 was severely cognitively impaired, always incontinent of bowel and bladder, and required substantial assistance with showering/bathing.

An interview was conducted with the responsible party (RP) for Resident #2 on 7/31/2024 at 1:20 PM and the following information was revealed. The RP confirmed Resident #2 was admitted to the facility on 7/5/2024 at approximately 4:30 PM or 5:30 PM. RP visited Resident #2 daily since his admission to the facility. The RP was very alarmed when Resident #2 was first admitted because the facility was unable to obtain medications for Resident #2 for several days over the weekend to include his antiseizure medications, an inhaler, and nebulizer treatments. The RP did not understand how the nursing staff were giving Resident #2 nebulizer treatments when there was never a nebulizer in his room for the staff to use. Resident #2 was never given a bed bath until 7/16/2024 and was left dirty. Resident #2's arm was bleeding from a skin tear he sustained after he arrived and received no treatment for it. Resident #2 was sent to the emergency room on 7/11/2024 and the RP was never notified by the facility. The RP was notified by the hospital Resident #2 was being

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 08/06/2024

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

(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 835	Continued From page 45	F 835		

admitted to the hospital after being in the emergency room for several hours. The transfer paperwork given to the hospital from the facility nursing staff indicated Resident #2 was sent to a hospital in the state of Maryland instead of the local hospital. The RP indicated there was a lot of confusion with the medications and services in general and the only response given from the acting Director of Nursing was that agency nursing staff didn't know what they were doing.

There was no documentation in the medical record to indicate an initial assessment, room assignment, orientation to facility, or ordering of medications was initiated on 7/5/2024 for Resident #2. There was no documentation in the medical record to indicate who the nursing staff member was who admitted Resident #2.

There was no documentation in the medical record of Resident #2 having any physician orders initiated or administered in the facility on the evening of 7/5/2024 or the morning of 7/6/2024.

Resident #2 had the following scheduled physician orders initiated on 7/6/2024.

Resident #2 was ordered to receive 100 micrograms/Actuation Breath Activated Amuity Ellipta Inhalation Aerosol Powder Breath to be administered as one puff inhaled orally one time a day for wheezing at 9:00 AM.

Resident #2 was ordered to receive 40 milligrams (mg) Atorvastatin Calcium tablet to be administered as one tablet by mouth at bedtime for hypertension at 9:00 PM.

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 08/06/2024

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

(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 835	Continued From page 46	F 835		

Resident #2 was ordered to receive 20 mg Esomeprazole Magnesium capsule delayed release to be administered as one capsule by mouth one time a day for Gastroesophageal reflux disease at 6:00 AM.

Resident #2 was ordered to receive 0.4 mg Flomax to be administered as one capsule by mouth one time a day for benign prostatic hyperplasia at bedtime.

Resident #2 was ordered to receive 10 mg Fluoxetine HCL to be administered as one capsule by mouth one time a day for depression at bedtime.

Resident #2 was ordered to receive 250 mg Levetiracetam to be administered as one tablet by mouth at bedtime related to seizures.

Resident #2 was ordered to receive 10 mg of Lisinopril to be administered as one tablet by mouth related to Hypertension at 9:00 AM.

Resident #2 was ordered to receive 0.5mg/2 milliliters Budesonide Suspension to be administered as 1 vial inhaled orally via nebulizer two times a day for chronic obstructive pulmonary disease at 9:00 AM and 9:00 PM.

Resident #2 was ordered to receive 100 mg Flecainide Acetate to be administered as one tablet by mouth every twelve hours for irregular heartbeat at 9:00 AM and 9:00 PM.

Documentation on the July Medication Administration Record revealed Nurse #1 administered the scheduled doses of the three medications Atorvastatin Calcium, Levetiracetam,

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 08/06/2024

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

(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 835	Continued From page 47	F 835		

and Flecainide Acetate to Resident #1 on 7/6/2024 at 9:00 PM. There was no documentation Resident #2 was administered the Amuity Ellipta Inhaler, Flomax, Fluoxetine HCL, or Budesonide Suspension nebulizer treatment on the evening of 7/6/2024.

Documentation on an admission skin observation tool dated 7/6/2024 at 10:22 PM completed by Nurse #1 stated Resident #1 had a skin tear on the left antecubital or the crook of the elbow.

There was no documentation on the Treatment Administration Record of any treatment or services for the skin tear identified on 7/6/2024.

Nurse #1 was interviewed on 7/31/2024 at 8:06 PM and revealed the following information. Nurse #1 confirmed she was a full-time nurse at the facility who worked on the 7:00 PM to 7:00 AM shift. Nurse #1 revealed 7/5/2024 was the period during which the facility was switching from one electronic medical record system to another electronic medical record system. Nurse #1 indicated in the previous electronic medical record system; the floor nurses did not have access to initiate the admissions process. Nurse #1 revealed she did not recall completing the admission process for Resident #2. Nurse #1 stated she would have had to get help to complete the admission process in the new electronic medical record system because she didn't know how to do it at that point. Nurse #1 did not recall who helped her or if anybody did help her with the admission process for Resident #2. Nurse #1 did not recall where she obtained the medications from, she documented as administering to Resident #2 on 7/6/2024 at 9:00 PM. Nurse #1 did not recall if or when

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 08/06/2024

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

(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 835	Continued From page 48	F 835		

medications came to the facility for Resident #2. Nurse #1 did not recall sending medication orders to the pharmacy for Resident #2 as a part of the admission process. Nurse #1 stated she would have required help to obtain medications from the automated medication dispensing machine because her password had expired, and she had not gotten a new one from the Assistant Director of Nursing. Nurse #1 did not recall getting assistance from another nurse on 7/6/2023 at 9:00 PM to obtain medications from the automated medication dispensing machine for Resident #2. Nurse #1 did not recall Resident #1 having a skin tear upon admission and did not recall how the skin tear occurred if it did occur in the facility. Nurse #1 did not recall completing the admission skin observation tool for Resident #2.

An interview was conducted with the facility Nurse Consultant on 8/01/2024 at 9:38 AM and it was confirmed Nurse #1 was the nurse who admitted Resident #2 to the facility on 7/5/2024 but it could not be determined at that time what room he was admitted to.

Documentation in an Administration note dated 7/7/2024 at 8:40 AM by Medication Aide #1 (Med Aide #1) stated, "awaiting arrival of medications from the pharmacy."

Documentation on the July MAR revealed Resident #2 was administered the medication Lisinopril by Med Aide #1 on 7/7/2024 at 9:00 AM but, was not administered the Amuity Ellipta inhaler, Budesonide Suspension nebulizer treatment, or the Flecainide Acetate documented as not available from the pharmacy.

Med Aide #1 was interviewed on 8/1/2024 at

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 08/06/2024

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

(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 835	Continued From page 49	F 835		

10:03 AM. Med Aide #1 confirmed Resident #2 did not have any medications available from the pharmacy on the morning of 7/7/2024. Med Aide #1 did not recall giving the medication Lisinopril to Resident #1 or where she obtained the medication from. Med Aide #1 stated the medication could have been obtained from the automated medication dispensing machine, but she would have required assistance from a nurse to do so. Med Aide #1 did not recall if she obtained assistance from a nurse to obtain the medication Lisinopril from the electronic medication dispensing machine.

Documentation on the July MAR revealed Resident #2 was administered the evening scheduled medications on 7/7/2024 Atorvastatin Calcium, Esomeprazole Magnesium, Flomax, Fluoxetine HCL, Levetiracetam, and Flecainide Acetate by Nurse #1 except for the Budesonide Suspension nebulizer treatment, which was documented as refused by Resident #2.

An interview was conducted with the Pharmacy Manager for the facility pharmacy on 8/1/2024 at 10:32 AM and provided the following information. The pharmacy received the physician orders for Resident #2 after the close of business on 7/6/2024. The pharmacy delivered the medication to the facility on 7/8/2024 at 12:54 AM. All medications ordered for Resident #2 were available in the facility automated medication dispensing machine. There was no medication removed from the facility automated medication dispensing machine for Resident #2 while he was a resident of the facility.

An interview was conducted with the facility Nurse Consultant on 8/1/2024 at 3:45 PM. The Nurse

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 08/06/2024

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

(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 835	Continued From page 50	F 835		

Consultant explained that the record the pharmacy had of the medication that was removed from the electronic medication dispensing machine was not an accurate record in the facility. The Nurse Consultant explained the nursing staff could open the drawers of the medication dispensing machine and remove several medications for several residents if they were not controlled substances.

There was no documentation in the electronic medical record that Resident #2 received any baths or showers the first week of his admission from 7/5/2024 to 7/11/2024.

An interview was conducted with the ADON on 8/2/2024 at 12:15 PM. The ADON stated there was absolutely no way to determine which nurse aides were assigned to Resident #2 during his first week of admission to the facility and additionally it would be very difficult to find contact information for the agency nursing staff who cared for Resident #2 from 7/5/2024 to 7/11/2024.

Documentation on a Skilled Nursing Facility Hospital Transfer Form signed and dated 7/11/2024 at 2:00 PM by Nurse #3 revealed Resident #2 was sent to the emergency room for bleeding related to the urinary tract. The documentation further revealed Resident #2 was sent to a military hospital in Maryland and the long-term care facility was named as the resident representative.

An interview was conducted on 8/1/2024 at 1:54 PM with Nurse #3. Nurse #3 confirmed she was an agency nurse who did not often work at the facility. Nurse #3 stated nobody was listed as a responsible party in the electronic medical record

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 08/06/2024

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

(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 835	Continued From page 51	F 835		

when she sent Resident #2 to the emergency room on 7/11/2024 at the request of the resident's physician. Nurse #3 stated she let Unit Manager #1 know she was unable to find the name and contact information for the responsible party prior to sending Resident #2 to the emergency room. Nurse #3 stated Unit Manger #1 also was unable to locate the name and contact information for the responsible party in the electronic medical record.

Unit Manger #1 was interviewed on 8/1/2024 at 5:21 PM. Unit Manger #1 denied having any recollection of Nurse #3 asking for assistance to find contact information on 7/11/2024 for the responsible party for Resident #2 prior being sent to the emergency room.

Resident #2 was discharged from the facility to another long-term care facility on 7/22/2024. On 7/22/2024 a care plan was initiated for Resident #2.

An interview was conducted on 8/1/2024 at 10:10 AM with the Minimum Data Set assessment coordinator (MDS Coordinator #1). MDS Coordinator #1 stated in the new electronic medical record system, the admissions assessment generated the initial care plan. MDS Coordinator #1 stated if a resident was admitted correctly then the initial baseline care plan would automatically be created.

1d. Resident #13 was admitted to the facility on 7/4/2024 with cumulative diagnoses some of which included Type 2 Diabetes Mellitus and idiopathic peripheral autonomic neuropathy.

Documentation on an Admission Minimum Data Set assessment dated 7/8/2024 revealed

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 08/06/2024

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

(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 835	Continued From page 52	F 835		

Resident #13 was assessed as cognitively intact.

Resident #13 was interviewed on 8/1/2024 at 1:32 PM. Resident #13 stated he was admitted to the facility for rehabilitative services on the morning of 7/4/2024. Resident #13 stated when he was first admitted he did not receive his medication for several days and was initially ready to leave the facility due to a lack of medication availability. Resident #13 stated his biggest concern was the lack of availability of the medication Gabapentin, which he took for nerve pain three times a day.

Documentation in a physician order initiated on 7/4/2024 at 6:16 AM revealed Resident #13 had an order for 300 milligrams Gabapentin to be administered as one oral capsule by mouth three times a day for nerve pain.

Documentation on the July Medication Administration Record (MAR) revealed Resident #13 did not receive the medication Gabapentin at 9:00 AM on 7/4/2024, 2:00 PM on 7/4/2024, 9:00 PM on 7/4/2024, 9:00 AM on 7/5/2024, and 2:00 PM on 7/5/2024. The July MAR indicated Resident #13 received the first dose of Gabapentin at 9:00 PM by the Assistant Director of Nursing on 7/5/2024.

An interview was conducted with the Pharmacy Manager of the facility pharmacy on 8/2/2024 at 10:40 AM. The Pharmacy Manager revealed on the evening of 7/5/2024 the pharmacy received the physician medication orders for Resident #13 and the medications, to include Gabapentin, were delivered to the facility in the early morning hours on 7/6/2024. The Pharmacy Manager also confirmed doses of Gabapentin were not

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 08/06/2024

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

(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 835	Continued From page 53	F 835		

removed from the facility electronic medication dispensing system since his admission.

The Assistant Director of Nursing (ADON) was interviewed on 8/2/2024 at 9:20 AM. The ADON stated on 7/4/2024 and 7/5/2024 some of the nurses did not have access to the electronic medical record. The ADON explained she had to text information technology services to obtain access for the nurses, but this took a while because all the buildings were going through a transition from one electronic medical record system to another. The ADON explained she gave her login information to the nurses who did not have access to the electronic medical record system so they could document medication administration. The ADON revealed she was not in the building to give Gabapentin to Resident #13 on 7/5/2024 at 9:00 PM and she would not have any way of knowing which nurse it was she gave her login information to, so the administration of the Gabapentin on 7/5/2024 could not be confirmed.

A review of a report entitled "Admissions 7/1/24 to 7/7/24" revealed during this timeframe there were 13 residents admitted from the hospital. One of these 13 was sent to the hospital and readmitted a second time during this time period, which therefore indicated the facility had 14 different times they were responsible for transitioning residents from the hospital to their facility for care. Residents # 1, # 2, # 3, and 13 were admitted during this first week.

The ADON was interviewed on 8/2/2024 at 9:38 AM. The ADON explained the nursing staff were putting the orders into the new electronic medical record system for the new admissions the first

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 08/06/2024

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

(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 835	Continued From page 54	F 835		

week in July and the orders did not need to be confirmed. The ADON further explained the physician was called and verbally approved the orders for the new admissions. The ADON stated when the new electronic record system was initiated in the facility there was a "glitch" in the system and the pharmacy was not getting the medication orders so, the orders had to be faxed to the pharmacy to be initiated for a new admission. The ADON indicated this caused a delay in getting orders initiated for the new admissions when the facility changed from one electronic medical record system to another. The ADON revealed the facility took a lot of admissions during the transition period for electronic medical record systems. The ADON stated she was not in the building over the 7/4/2024 holiday weekend but she could have been contacted by phone if the nurses had any problems.

The Administrator was interviewed on 8/2/24 at 11:00 AM regarding a transition to new corporate ownership and the facility's change over to a new electronic medical record software provider. The Administrator reported the following information. In June 2024 the facility became part of another corporate entity. There was a decision to change over to a different software provider for their electronic medical record system. In June the facility sent part of their staff to an offsite training. These employees were to then train their direct care staff in smaller group settings in the facility. The staff, who were responsible for training, still had care responsibilities to perform while also providing the training. There was also online training that their staff could access. Around 7/3/24 and 7/4/24 the change over to the new electronic medical record system occurred, and

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 08/06/2024

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

(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 835	Continued From page 55	F 835		

everything did not change over correctly. There is a budget set for the facility and the facility needed to meet the budget. Typically, the facility admitted around 14 residents per month prior to being owned by the new corporation. After the new corporation purchased the facility, admissions increased. "They" were not going to stop admissions. During the beginning of July 2024 while continuing to admit residents, she (the Administrator) did not realize there was a problem with transitioning between two providers for their electronic medical records. Things slowed down after the first week of July 2024 and during the second week of July 2024 she realized no one was "checking the checkers" when things were being placed into the new electronic system. She then received a call from Resident # 2's family member about him missing medications. During recent times the facility had also lost their wound care nurse and one of their unit managers. There had been a lot of changes, and she felt someone should have said there were problems when they first encountered problems.

An interview was conducted with the facility Nurse Consultant on 8/1/2024 at 11:11 AM and again on 8/2/2024 at 9:53 AM. The Nurse Consultant provided the following information. The Nurse Consultant stated the facility pharmacy was going to go through all the medications in the building, to include the new admissions, to determine the correct medications were available for each resident. The Nurse Consultant stated there was no way of knowing if nurses were borrowing from other residents, if the medications were being administered, or if medications were being administered from what was sent from the hospital. The Nurse Consultant explained the new company that took over the facility had provided a

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 08/06/2024

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

(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 835	Continued From page 56	F 835		

lot of training in the new electronic medical record system in the month prior to the transition on 7/1/2024. The facility was even given a grace period to start with the new medical record system and was allowed to start on 7/4/2024. The facility had the ADON, DON, and unit supervisors attend the training in the new system first and then come back to the facility and train the other nurses. In addition, the company offered online training for the facility staff. It was the responsibility of the Administrator to make sure there was a smooth transition by assuring the staff were trained in the new electronic medical record system.

An interview was conducted with the Vice President (VP) of Operations for the facility on 8/2/2024 at 6:25 PM and the following information was provided. The training for the transition from one elecronic medical record system to another occurred in ten of the buildings owned by the company. The company that owned the facility did not know there was a log in issue during the transition to the new electronic medical record system. Two clinicians or Regional Director of Clinical Services were in the facility during the transition to the new electronic medial record system. Any log in issues could have been fixed in seconds. Admissions absolutely could have been held off if the facility was not ready to take on admissions during the transition. It was not known there were any issues until the facility Nurse Consultant brought it to her (VP of Operations) attention. There was training available in June on how to use the new electronic medical record system. The Administrator and Medical Records personnel received minimal training. The clinical leadership in the facility should have been doing 24 to 48

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 08/06/2024

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

(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 835	Continued From page 57	F 835		

hour audits for new admissions. There were no calls to the corporate hotlline of any concerns in the building with the admission process.

One of the Regional Directors of Clinical Services, who was in the facility during the electronic medical record transition period, was interviewed at 9:46 AM on 8/5/2024. The Regional Director of Clinical Services provided the following information. The Regional Director was in the building from 7/1/24 to 7/3/24. Other Regional Directorof Clinical Services were working remotely. She was training one of the unit managers on the new electronic medical record system and confirming orders. She was answering questions from the interim DON (who was the ADON) and Admissions on how to put admission information into PCC. All of the orders for the residents in the building were confirmed by noon on 7/3/2024. The DON was actively giving nurses login access information as the nurses arrived for work. If the access information was not working the interim DON was calling the help desk number for information. If the nurses couldn't get into electronic medical record system all of the MARs were printed so they could document on the paper MAR. A lot of the agency staff already knew how to use the new electronic medical record system. There was not a "push" to admit residents the first week of July but if the facility could take on more residents to build up the census then they were encouraged to do so. All of the medication orders were confirmed to be in the new electronic medical record system for the residents on 7/3/2024. The Regional Director was not aware of any issues with the receipt of medications from the pharmacy for new admissions. No concerns were voiced in a

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 08/06/2024

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

(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 835	Continued From page 58 corporate debriefing held after the July 4th weekend. The admission of 14 residents was very reasonable. That was two admissons a day and should have easily been accomplished by the facility. To her knowledge the electronic medical record system help desk was never overwhelmed with calls or questions during the transition process and was always available. The facility's Medical Director was interviewed on 8/5/24 12:14 PM and reported the following information. He was aware the facility was changing over medical record systems in July 2024, and it had been hard for them. The new electronic system was intended to be newer and better. Regarding Resident # 1 not receiving PICC line flushes and antibiotics as intended, the Medical Director reported the following. At times residents could go up to a month without the PICC line being flushed and still remaining patent. Resident # 1 also was on the "tail end" of his antibiotics and he did not feel the resident had suffered harm from any missed doses. The antibiotics were being extended to cover for missed doses. He had been in the facility and although it had been a hard changeover for the staff, he was not aware of any "disasters" which had occurred. The Medical Director reported they had to do the right thing and continue to take care of people as they were transitioning.	F 835		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services	F 849		8/27/24

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 08/06/2024

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

(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 849	Continued From page 59	F 849		

through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical,

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 08/06/2024

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

(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 849	Continued From page 60	F 849		

mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must

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 08/06/2024

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

(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 849	Continued From page 61	F 849		

report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners

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 08/06/2024

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

(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 849	Continued From page 62 participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with a resident's guardian, staff, hospice provider, and physician the facility failed to initiate a hospice referral when the resident	F 849	F849 Corrective actions accomplished for those residents found to be affected by the deficient practice:	

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 08/06/2024

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

(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 849	Continued From page 63 was readmitted with clear instructions that her wishes were for comfort measures which included comfort foods and no tube feedings. After the hospice referral was made, Resident # 3's wishes were still not made known by the hospice provider and facility staff to the physician so that tube feedings could be stopped and comfort foods initiated until the guardian questioned the plan of care. This was for one (Resident # 3) of one sampled resident reviewed for hospice services provided at the facility. The findings included: Record review revealed Resident # 3 was readmitted to the facility on 7/3/24 after being hospitalized from 6/19/24 to 7/3/24. Resident # 3's hospital discharge summary, dated 7/3/24, included the following information. The resident had a history of multiple strokes, history of tracheostomy with decannulation, spasticity, chronic pain, history of pulmonary embolism, peripheral vascular disease, history of gastrostomy placement, colostomy placement, and failure to thrive. During the resident's hospitalization she was treated for bacteremia and septic shock. Her prognosis was determined to be "guarded" and she had limited treatment options. Discussion was held with Resident # 3 and the resident's guardian and the goal of comfort care was set. Both the resident and her guardian chose comfort care. The plan was to discontinue tube feedings and allow the resident to eat for pleasure and comfort. Under "discharge instructions" the resident's diet instructions were "for comfort-stop tube feeds." Under follow up discharge instructions there was a notation for follow up to a specific area hospice provider.	F 849	On 08/19/2024, resident #3 was assessed and admitted to contracted hospice services. Identification of other residents having the potential to be affected by the same deficient practice: 100% of all new admission to the facility for the last 30 days were audited on 08/19/2024 by the Director of Nursing, Assistant Director of Nursing, and/or social worker (#1 or #2) to identify any other resident with the referral for hospice care that was not transcribed correctly in the facility medical records and followed appropriately. No other residents identified as missing hospice care referral. Findings of this audit are documented on the new admission-hospice audit tool located in the facility compliance binder. 100% audit of all new orders initiated within the last 30 days was completed by the DON, ADON, and/or social worker (#1 or #2) to ensure any referral for hospice care were followed through correctly. The audit was completed on 08/19/2024. Findings of this audit are documented on the new order audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 08/19/2024, the facility will arrange for the provision of hospice services through contracted Medicare-Certified hospice prover(s) in a timely manner. Effective 08/19/2024, license nurse on duty at the time hospice care is initiated	

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 08/06/2024

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

(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 849	Continued From page 64 A review of Resident # 3's facility orders revealed no order for a referral for hospice care on 7/3/24 or for a diet of comfort food to be given when she was admitted. On 7/4/24 an order was initiated for an enteral feeding of Nutren 1.5 at 55 cc (cubic centimeters)/hour. According to orders this enteral feeding order was in effect until 7/10/24, on which date it was discontinued. The first order that the resident could receive a diet and eat was on 7/10/24. On 7/7/24 an order was entered for the resident to have a hospice referral. On 7/9/24 a significant MDS (Minimum Data Set) assessment was completed which noted the resident was cognitively intact and dependent on staff for bathing and hygiene needs. Eating was checked as not applicable to the resident, and the resident was also checked as having a feeding tube for her nutrition. The resident's care plan was updated on 7/19/24 to reflect the resident received hospice services and was not expected to improve in condition. One of the approaches was to refer to the hospice provider as needed. Resident # 3 was observed on 7/31/24 at 1:24 PM to not be able to converse at that time. Resident # 3's guardian was interviewed on 7/31/24 at 12:57 PM and reported the following information. When Resident # 3 was readmitted to the facility, the facility restarted the resident's tube feeding although it had been decided that the resident no longer would receive enteral feedings. It had also been decided that the	F 849	will inform the attending physician on any resident wishes related to care and services in the facility, to include but not limited to, the decision to stop tube feedings and/or initiate comfort foods. A licensed nurse on duty will document and implement resident choices per physician orders in resident□s medical records. Effective 08/19/2024, the facility□s clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1. Social workers (#1, or #2), and/or Unit coordinator #2 initiated a process for reviewing clinical documentation to include the review of hospice care referral ordered in the last 24 hours or from the last held clinical meeting to ensure the referrals are arranged with the certified hospice provider as ordered. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/or Unit coordinator #1/#2. Findings of this systemic change will be documented on the daily clinical report form and maintained in the daily clinical meeting binder. 100% education of all current clinical leadership team members to include Director of Nursing, Assistant Director of Nursing, Medical records coordinator, social worker (#1, or #2) Unit coordinator #1 and/or Unit coordinator #2 completed by the facility administrator. The emphasis of this education includes, but is not limited to, the importance of ensuring	

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 08/06/2024

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

(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 849	Continued From page 65 resident could have comfort foods at the hospital, and she had been able to eat ice cream while hospitalized. When she returned to the facility on 7/3/24 the facility did not give the resident any food to eat. When she (the guardian) learned of the issue she talked to Unit Manager # 1 a week later on 7/10/24, and the Unit Manager was able to find orders for the tube feeding to be discontinued and a diet order in a paper chart that had not been entered into the facility's electronic system when she was admitted. The resident's tube feeding was discontinued on 7/10/24 and they started letting her have food for the first time after the guardian spoke to Unit Manager # 1. A hospice worker (the chaplain) had visited prior to 7/10/24 and the logistics of the resident getting food and the tube feeding discontinued had not been worked out even when hospice had been involved prior to 7/10/24. The hospice chaplain had let the staff know the resident wanted some juice on a date prior to 7/10/24 and the chaplain had been told that the resident could not have anything to drink. The associate Vice President of Resident # 3's hospice provider was interviewed on 8/5/24 at 11:26 AM and reported the hospice nurse who had initially admitted Resident # 3 and cared for her was no longer with the agency and not available for interview. The Vice President looked through records and reported that their hospice service received orders for the first time for a facility referral on 7/5/24. After getting in touch with the guardian on 7/8/24 they initiated services. In general, when they received referrals, they tried to immediately work on getting a guardian's approval for hospice services and initiating services as soon as possible.	F 849	facility arrange for the provision of hospice services through contracted Medicare-Certified hospice prover(s) in a timely manner. This education will be completed by 08/27/2024, any clinical leadership team member not educated by 08/27/2024, will not be allowed to work until educated. This education is added to new hire orientation for all clinical team members effective 08/19/2024. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 08/19/2024, Director of nursing, Assistant Director of Nursing, and/or social worker #1 and/or social worker #2, will monitor compliance with resident□s hospice referral by reviewing the daily clinical meeting reports to ensure completion and proper follow through. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on appointment monitoring form located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing Assistant, Director of Nursing, and/or social worker #1, or #2) will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is	

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 08/06/2024

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

(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 849	Continued From page 66 Unit Manager # 1 was interviewed on 8/2/24 1:10 PM and reported the following. She had not been responsible for reading Resident # 3's discharge summary and doing admission orders for the resident. She was not aware of what problems had occurred prior to 7/10/24 which resulted in the resident's and guardian's wishes for no tube feeding to be provided and to allow her to have comfort foods. When the guardian talked to her on 7/10/24, she found "imbedded in a paper chart" the 7/3/24 hospital discharge summary which noted the referral for hospice, no tube feedings, and that the resident could eat comfort foods. The guardian was the one who had explained everything to her, and this had not been explained by the hospice workers so that it could be worked out prior to 7/10/24. On 8/2/24 the facility provided Resident # 3's hospice notes they had from hospice staff up until the date of 8/2/24. There were only two notes. The first was dated 7/15/24, which was after the guardian intervened about wishes that had been decided upon in the hospital and relayed in the 7/3/24 discharge summary. Resident # 3's physician was interviewed on 8/5/24 at 12:45 PM and reported the following information. When the resident was admitted, he did not recall seeing a full discharge summary that had accompanied the resident. If there was a 7/3/24 discharge summary with clear discharge instructions noting to follow up with hospice and discontinue the resident's tube feeding, then this should have been done at time of admission to the facility.	F 849	achieved. Compliance date 8/27/2024	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/27/24

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 08/06/2024

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

(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 67 §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 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:	F 880		

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 08/06/2024

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

(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 68 (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. §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 observation, record review, and staff interview the facility failed to 1) perform hand hygiene while performing dressing changes and prior to obtaining supplies from the facility's treatment cart and 2) keep scissors in a clean field before using them to cut dressing items used directly in a resident's wound bed and 3) ensure caring of different wounds was a separate task with different gloves and hand hygiene to avoid potential cross contamination between wound beds. This was for one (Resident # 1) of one	F 880	F880 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 no longer in the facility, no other actions taken for resident #1 Identification of other residents having the potential to be affected by the same deficient practice: All residents have a potential to be affected by this alleged noncompliance	

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 08/06/2024

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

(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 69 sampled resident who was observed during wound care. The findings included: Review of the facility's infection prevention control policy, dated 2/6/20, revealed staff were to perform hand hygiene when removing gloves and gloves were to be removed when moving from a contaminated body site to a clean body site. On 8/1/24 at 6:15 PM Nurse # 11 prepared to care for Resident # 1's wounds. At the time, the resident reported his left foot had already been dressed for the day. Unit Manager # 1 also joined Nurse # 11 while she was in the room and also helped with the direct care of the wounds. During the observation, the Unit Manager was the one who cared for the resident's sacrum wound and his right ischium. The wound beds were observed to be distinctly two separate areas. Unit Manager # 1 was observed to care for the two wounds as one. She therefore removed the sacrum and ischium dressings with the same gloves. Although she used separate cleaning gauze for both the sacrum and right ischium she used the same gloves and did not perform hand hygiene between the two distinct wound beds of the sacrum and the ischium while cleaning the wound beds. After cleaning the wound beds of the sacrum and the ischium she changed gloves but did not perform hand hygiene before applying dressings to the wound beds. She then used the same gloves to apply new dressings to the sacrum and the ischium. While performing care for the sacrum and the ischium she needed to cut the Aquacel Ag dressing which was to go directly	F 880	Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 08/19/2024, facility employees will follow the facility infection prevention and control policy to include hand washing while providing wound care and maintaining clean field for items used during wound care as well. 100% education of all employees to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, infection preventionist, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to, the importance of hand washing before, during, and after providing care; after using bathroom and when removing gloves. This education will be completed by 8/27/24. Any employee not educated by 8/27/24 will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new employee effective 08/27/2024 100% education of all licensed nurses to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, infection preventionist, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to, the importance of maintaining clean fields when conducting wound care, and ensure clean items, to include scissors, are kept in clean field. This education will be completed by 8/27/24. Any Licensed	

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 08/06/2024

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

(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 70 into the wound beds. The Unit Manger used scissors that had been laid on the air conditioning (AC) unit and which had not been kept on the clean surface prepared for the supplies nor which were cleaned before cutting the Aquacel Ag. After cutting the Aquacel Ag with the scissors laying on the resident's AC unit, she placed the Aquacel directly in the wound beds. The Unit Manger was observed to then prepare to care for the resident's right heel wound and right ankle wound. During the cleansing part of the care, she did not wash the right ankle and the right heel as two separate areas. She did not use different gloves and with hand hygiene between the two. Prior to the application part of the dressing change, the Unit Manager recognized that she needed supplies which had not been brought into the room. The Unit Manager then took off her gloves and without performing hand hygiene, she was observed to go to the treatment cart outside to look through several drawers. After looking through the treatment cart she returned to the room. When she returned to the room with the surveyor, Nurse 11 had gloved and stated she would do the dressings to the right foot. Nurse # 11 was observed to apply the dressings to the right outer ankle and to the heel with the same gloves and without hand hygiene between the two distinct wound beds. During the observation of wound care on 8/1/24 at 6:15 PM, Resident # 1's was not observed to have any foul odor or purulent drainage. The DON was interviewed directly following the dressing changes and reported the staff should be treating the wounds as distinct separate wounds which would entail glove changes and	F 880	nurse not educated by 8/27/24 will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new Licensed nurses effective 08/27/2024 Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 08/19/2024, the Facility administrator, Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will monitor compliance with infection prevention and control policy by randomly observing three staff members for proper hand hygiene, and three licensed nurses for wound care. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a medication observation monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until 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 08/06/2024

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

(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 71 hand hygiene between wounds. The Wound Physician, who routinely visited the facility, was interviewed on 8/5/24 at 5:14 PM and reported the following information. Care should be provided in a clean technique which includes keeping scissors on a clean field and/or cleaning them prior to use if they have not been maintained in a clean field. She knew the facility had been without a consistent wound care nurse and felt that could contribute to staff not consistently following clean techniques while providing care. She had last seen all of Resident # 1's wounds on 7/25/24 and none of them had any purulent drainage within them or looked infected.	F 880	pattern of compliance is archived. Compliance Date: 08/27//2024	