		AND HUMAN SERVICES			FOR	D: 11/03/2014 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	ATE SURVEY
		345529	B. WING			C 9/25/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	20/2014
				5	201 CLARKS FORK DRIVE	
UNIVERS	SAL HEALTH CARE/N	IORTH RALEIGH		F	RALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY INDIVIDUALITY	AND RESPECT OF	F 2	241		10/20/14
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.				
	by: Based on record re interview, the facilit catheter bag covere & #208) of 3 sampl urinary catheter and dress in her own cle of day for 1 (Reside	NT is not met as evidenced eview, observation and staff y failed to keep the urinary ed for 3 (Residents #198, #212 ed residents with an indwelling d failed to assist a resident to othes appropriate to the time ent # 198) of 1 sampled wearing a hospital gown.			This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirement	of
	7/22/14 with multipl Dementia. The adr (MDS) assessment Resident #198 had	was admitted to the facility on e diagnoses including Senile mission Minimum Data Set dated 8/5/14 indicated that severe cognitive impairment ive assistance with dressing.	t F241		F241	
	The care plan date resident was deper living (ADLs) and th for the resident.	d 8/5/14 indicated that the ident with activities of daily ne staff was to provide all ADLs			Corrective action will be accomplished for the resident found to have been affected by the deficient practice:	r
	at 10:55 AM and 3: observed in bed we	5 AM and 4:30 PM and 9/24/14 30 PM, Resident #198 was earing a hospital gown. PM, NA # 1 was interviewed.			Residents #198, #212 and #208 have catheter bags covered. Resident #198 was provided personal	
	She stated that Res hospital gown ever outfits available. S	sident #198 was dressed in a yday because she had only 2-3 he added when Resident #198			clothing by facility laundry on September 24, 2014.	
		air, she had to wear her own s very rare. Most of the time			Corrective action will be accomplished fo those residents having potential to be	r
ABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	(X6) DATE

**Electronically Signed** 

10/29/2014

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	TIPL		<u>NO. 0938-0</u> DATE SURVE	
ND PLAN C	F CORRECTION	DENTIFICATION NUMBER:				COMPLETED	
						С	
		345529	B. WING			09/25/201 <sub>/</sub>	4
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVER	SAL HEALTH CARE/N	IORTH RALEIGH			201 CLARKS FORK DRIVE 2ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPLE DAT	OITE
F 241	Continued From pa	age 1	F 24	41			
	her outfits were in t	he laundry for washing and thing to wear but hospital			affected by the same deficient practice:		
		ated that she didn't know if the			On September 24, 2014 an audit was		
		aware that Resident #198			conducted for all residents with indwelling	•	
		ing but she had not informed			catheters to ensure that all residents wi		
	her about it. On $9/24/14$ at 3:35	PM, the closet of Resident			indwelling catheters have their catheter bags covered. Residents noted without		
		d. In the closet, one T-shirt,			indwelling catheter bags covered were		
		ir of pants and a house coat			provided with privacy bags and indwellin	ng	
	were observed.				catheter bags were covered.		
		PM, the administrative staff #3					
		The stated that she was not an arrest was not the stated that she was not the state of the state			On September 24, 2014 an audit was conducted by nursing staff for 100% of	all	
		she had checked the closet			residents to ensure that personal clothi		
		that the resident needed more			was available. Residents noted without		
		ated that she will call the			personal clothing were provided person	al	
	family to bring in m				clothing by responsible party and/or fac per laundry.	ility	
		was admitted to the facility on			Measures put into place or systemic	ont	
		le diagnoses including Senile mission Minimum Data Set			changes made to ensure that the defici- practice will not occur:	ent	
		t dated 8/5/14 indicated that			practice will not occur.		
		severe cognitive impairment,			Beginning September 26, 2014 education	on	
		rinary catheter and a stage IV			began by the Staff Development	_	
	pressure ulcer.				Coordinator and/or Director of Nursing		
		5 AM and 4:30 PM and 9/24/14 30 PM, Resident #198 was			all staff on dignity as it relates to covering of indwelling catheter bags. Staff will be		
		idwelling catheter attached to			required to receive in-service training p		
		urinary bag was observed			to returning to work.		
		urine and was not covered.					
		as in view of the room mate.			Beginning September 26, 2014 educati		
		5 AM, the room mate of observed to have a family			began by Staff Development Coordinate and/or Director of Nursing for all staff or		
		d the urinary bag was not			dignity as it relates to personal clothing	'	
	covered.				and ensuring that residents are properly	/	
		5 AM, Nurse #3 was			dressed in own clothes appropriate to the	ne	
		tated that urinary catheter bag			time of day per resident request. Staff		
						9	
	should be covered	at all times but didn't know 's bag was not covered.			be required to receive in-service training prior to returning to work.		

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If continuation sheet Page 2 of 32

	-	AND HUMAN SERVICES				APPROVE 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED	
		345529	B. WING			C 25/2014	
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVER	SAL HEALTH CARE/N	ORTH RALEIGH		5201 CLARKS FORK DRIVE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 241	that Resident #198' cover on it. She add that the privacy bag the wheelchair and one in the bed. 2. Resident # 208 y cumulative diagnos renal disease, urina hypothyroidism. Review of the care Resident # 208 had indwelling urinary c privacy cover over the Review of the Admi (MDS) dated 9/16/1 was cognitively inta urinary catheter. On 9/23/14 at 8:46 observed in bed. T bag did not have a # 208 was interview she would prefer it a privacy cover on it On 9/25/14 at 10:10 (NA # 2) was obser Resident # 208's in NA # 2 was interview that she did not know	PM, Nurse #2 was tated that she was not aware 's catheter bag had no privacy ded that she was just informed g for Resident #198 was left in therefore she did not have was admitted 9/9/14 with ses that included end stage ary retention, and plan dated 9/9/14 revealed d a plan of care for her atheter that included putting a the catheter bag. ission Minimum Data Set 14 revealed Resident # 208 ict and had an indwelling AM Resident # 208 was 'he indwelling urinary catheter privacy cover on it. Resident wed at this time and stated that if the urinary catheter bag had	F 24		pment irsing resident during dwelling erly te to the Rounds eekly x 2 ew sure eviewed or, pment irsing for thin 24 mance ustained. or ed and w results ting irsing to ering of		

Facility ID: 20040007

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE		ATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG_		MPLETED
		345529	B WING			С
	PROVIDER OR SUPPLIER	345529	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	9/25/2014
	- NOVIDER ON SOFFEIER				201 CLARKS FORK DRIVE	
UNIVER	SAL HEALTH CARE/N	IORTH RALEIGH			ALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
F 241	Continued From pa	age 3	F 24	41		
	cumulative diagnos artery disease, hyp retention. The interim care pl 9/12/14 was review # 212 was to receiv care. Review of the Adm (MDS) dated 9/19/1 was cognitively imp urinary catheter. On 9/24/14 at 8:52 observed in bed. So catheter that did no	was admitted 9/12/14 with ses that included coronary ertension and urinary an for Resident #212 dated ved and revealed that Resident ve indwelling urinary catheter ission Minimum Data Set 14 revealed Resident # 212 baired and had an indwelling AM Resident #212 was She had an indwelling urinary of have a privacy cover on it. vas attached to her bed in view			The Director of Nursing will report the findings of the daily rounds to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. The Administrator will review results of 72 hour meeting conducted by Social Worke to identify any issues related to personal clothing. The Administrator will present the findings of the 72 hour meeting review to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is obtained. Date of Completion October 20, 2014.	2 er W
F 279 SS=D	interviewed. She s bags should be cov On 9/25/14 at 7:30 observed up in her had a privacy cove 483.20(d), 483.20(I COMPREHENSIVE A facility must use	AM resident #208 was wheelchair. The catheter bag r on it. k)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's n of care.	F 21	79		10/20/14

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DAT	0938-039
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
		345529	B. WING				C 25/2014
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SAL HEALTH CARE/N	ORTH RALEIGH			01 CLARKS FORK DRIVE NLEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 4	F 2	279			
	objectives and time medical, nursing, a	ent that includes measurable tables to meet a resident's nd mental and psychosocial tified in the comprehensive					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident'	t describe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise \$483.25 but are not provided s exercise of rights under the right to refuse treatment ).					
	by: Based on record re interview, the facilit to address the use catheter and for the contracture for 1 of	NT is not met as evidenced eview, observation and staff y failed to develop a care plan of the indwelling urinary e care of the left hand 4 sampled residents with a and with contractures indings included:			F279 F279 Corrective action will be accompli the resident found to have been a by the deficient practice:		
	7/22/14 with multipl Dementia. The adr (MDS) assessment Resident #198 had and had an indwelli area assessments incontinence and in indicated to procee The comprehensive	dwelling urinary catheter			Resident #198 has care plans in p use of an indwelling catheter and management of left hand contract Corrective action will be accompli- those residents having potential to affected by the same deficient pra- On September 24, 2014 an audit conducted by the MDS coordinate residents with indwelling catheter	ture. shed for o be actice: was or for all	

Facility ID: 20040007

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
			A. BUILDING	3	C
		345529	B. WING		09/25/2014
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVER	SAL HEALTH CARE/N	IORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTIO
F 279	Continued From pa	age 5	F 279	9	
	<ul> <li>The physician's orders were reviewed. The attending physician had ordered to insert an indwelling catheter to Resident #198 on 7/24/14 to promote healing of the stage IV sacral pressure ulcer.</li> <li>On 9/23/14 at 11:45 AM and 4:30 PM and 9/24/14 at 10:55 AM and 3:30 PM, Resident #198 was observed with an indwelling catheter attached to a urinary bag.</li> <li>On 9/24/14 at 12:40 PM, MDS Nurse #2 was interviewed. She acknowledged that the care plan for the use of the indwelling catheter was missed. She added that she will check the care plans of all residents with an indwelling catheter to make sure that they had care plans in place.</li> </ul>			<ul> <li>appropriate care plans in place of an indwelling catheter and/or management of a contracture h plans put into place.</li> <li>Measures put into place or systechanges made to ensure that the practice will not occur:</li> <li>On September 24, 2014 educated done for MDS department by the of Nursing on expectation of care completion as it relates to indwer urinary catheters and management contracture.</li> </ul>	ad care emic le deficient ion was e Director re plan elling
	7/22/14 with multip Dementia and joint Minimum Data Set 8/5/14 indicated that cognitive impairme of motion on one si The occupational th 7/23/14 indicated th in left upper extrem cerebrovascular ac passive range of m Left hand contracted interphalangeal/dis poor hygiene noted hygiene to prevent Will assess need for 8/25/14, OT service Resident #198 had potential.	nerapy (OT) notes dated nat Resident #198 had "pain		<ul> <li>The Unit Manager / Unit Coordin Nursing Supervisor, Staff Devel Coordinator, MDS coordinator a Director of Nursing will review a admission charts within 24 hour physicians orders for the use of urinary catheters and/or contract ensure that appropriate care pla place.</li> <li>The MDS Coordinator will review physician telephone orders durin clinical meeting for physician order indwelling urinary catheters and management of a contracture. receipt of telephone order care be updated by the MDS Coordin that time.</li> <li>The MDS Coordinator will review resident care plans at least qual ensure that appropriate care plans</li> </ul>	opment ind / or II s for indwelling stures to in is in w all ng daily ders for /or Upon plan will nator at w all rterly to

Facility ID: 20040007

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		AND HUMAN SERVICES			FC	DRM	11/03/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		345529	B. WING				C 25/2014
NAME OF F	ROVIDER OR SUPPLIER		I	S	I REET ADDRESS, CITY, STATE, ZIP CODE	00/1	20/2014
UNIVERS	AL HEALTH CARE/N	ORTH RALEIGH			201 CLARKS FORK DRIVE ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE
F 279	Resident #198 was hand contracted. On 9/25/14 at 2:25 interviewed. She a plan for the left han	-	F 2	79	urinary catheters and/or management contractures. The Director of Nursing will review MD care plan review for accuracy weekly x months. Facility plans to monitor its performance to make sure that solutions are sustain The facility must develop a plan for ensuring that correction is achieved an sustained: The Director of Nursing will report the results of 24 hour admission chart aud and quarterly care plan reviews to the Quality Assurance and Performance Improvement Committee for monthly for six months or until a pattern of compliance is obtained.	S c six ce ned. nd	
F 282 SS=D	PERSONS/PER CA The services provic must be provided b	RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility y qualified persons in ich resident's written plan of	F 2	82	Date of completion: October 20, 2014		10/20/14
	by: Based on record re observations, the fa plan for the applica	NT is not met as evidenced eviews, staff interviews and acility failed to follow the care tion of a splint for one of four (Resident #37) reviewed for			F 282 Corrective action will be accomplished the resident found to have been affected		

Facility ID: 20040007

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY PLETED	
		345529	B. WING _		09/2	C 25/2014	
NAME OF I	PROVIDER OR SUPPLIER		· [	STREET ADDRESS, CITY, STATE, ZIP COL			
UNIVER	SAL HEALTH CARE/N	ORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 282	Continued From pa	ge 7	F 28	32			
	range of motion.			by the deficient practice:			
	The findings include	ed:		Resident #37 has splint applie physician orders.	ed per		
	8/30/04 and readmidiagnoses including contracture of the h dysphagia. A review of the Mini 9/3/14 was conduct assessed as having The MDS indicated having functional lir	admitted to the facility on itted on 2/15/11 with multiple g multiple sclerosis, hand, abnormal posture and imum Data Set (MDS) dated ted. Resident #37 was g severe cognitive impairment. the resident was assessed as nitation in range of motion of tes on both sides of her body.		Corrective action will be acco those residents having potent affected by the same deficien On September 26, 2014 resid physician orders for splinting reviewed. Orders for splinting placed on the resident Medica Administration Record requiri licensed nurse to ensure splin and/or place the splint per physician	ial to be t practice: lents with were g were ation ng the nt in place		
	Care Plan for Resid plan of care dated A 2014 indicated the applied to her left h six hours a day. A review of the Phy	torative Nursing Program dent #37 was conducted. The August, 2014 and September, resident was to have a splint and and to wear the splint for sician's orders revealed an		orders. Measures put into place or sy changes made to ensure that practice will not occur: On September 26, 2014 educ by the Staff Development Coo / or Director of Nursing for nu	the deficient ation began ordinator and rsing staff in		
	left resting hand sp A review of the Res Care Plan and Flow August 2014 was co revealed the left ha 8/1/14, 8/2/14, 8/3/ 8/7/14, 8/10/14, 8/1 8/18/14, 8/19/14, 8/ 8/26/14, 8/28/14, 8/ was no documentat	Which read "Patient to wear lint for six hours a day." torative Nursing Program v Record for the month of onducted. The review nd splint was not applied on 14, 8/4/14, 8/5/14, 8/6/14, 1/14, 8/16/14, 8/17/14, 1/14, 8/16/14, 8/17/14, 1/23/14, 8/24/14, 8/25/14, 1/29/14, and 8/31/14. There tion indicating the refusal of r Resident #37 for the month of		reference to expectation for s application and documentatio application. The Unit Manager / Unit Coor Nursing Supervisor, Staff Dev Coordinator and / or Director will review Medication Admini- Records in coordination with r ensure that splinting is compl documented per physician or weeks, weekly x 4 weeks the months.	n of splint dinator, relopment of Nursing stration rounds to eted and ders daily x 2		

Facility ID: 20040007

If continuation sheet Page 8 of 32

TATEMENT	OF DEFICIENCIES OF CORRECTION	KANNERS      KANNERS			E CONSTRUCTION	(X3) DATE COM	0938-039 E SURVEY PLETED	
		345529	B. WING				C 25/2014	
	PROVIDER OR SUPPLIER	IORTH RALEIGH		52	TREET ADDRESS, CITY, STATE, ZIP CODE 201 CLARKS FORK DRIVE RALEIGH, NC 27616	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 282	A review of the Res of September 2014 revealed the left ha 9/3/14, 9/4/14, 9/6/ 9/21/14. There was the refusal of splint for the month of Se On 9/22/14 at 3:49 sitting in her wheel splint device on her On 9/24/14 at 3:22 lying in her bed with hand. On 9/24/14 at 5:30 sitting in her wheel splint device on her An interview was co Staff #2 on 9/25/14 restorative aide wa per week, not inclu times, the restorative from her duties in r instructed to work a resident hall. She so often the restorative as a NA because s when it occurred. A the nurses on the r place the left hand the restorative nursir was not notified wh removed from her of	storative Roster for the month was conducted. The review and splint was not applied on 14, 9/7/14, 9/14/14 and s no documentation indicating placement by Resident #37 eptember 2014. PM the resident was observed chair in her room without a r left hand. PM the resident was observed hout a splint device on her left PM the resident was observed chair in the dayroom without a	F 24	82	The Director of Nursing will review Medication Administration Record A daily for compliance. Review will b daily x 2 weeks, weekly x 4 weeks, monthly x 4 months. Facility plans to monitor its perform to make sure that solutions are sus The facility must develop a plan for ensuring that correction is achieved sustained: The Director of Nursing will present findings of the Medication Administ Record audits as it relates to splint the Quality Assurance and Perform Improvement Committee monthly for months or until a pattern of complia obtained. Date of Completion: October 20, 20	e done then ance stained. d and t the ration ing to ance or six ance is		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/03/2014 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED C
		345529	B. WING				25/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
UNIVER	SAL HEALTH CARE/N	ORTH RALEIGH			201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 309 SS=D	to document splint p Nursing Program F aide was expected refused to have a s Nursing Program F Staff #2 was unable splint was not place indicated on the car August 2014 and S An interview was co #1 on 9/25/14 at 10 stated she had bee nursing duties and i a resident hall appr She stated she did #2 when she was re restorative nursing. never refused to all splint. She stated if splint placement, th expected to docume record and to notify restorative aides wo Restorative Aide #1 the left hand splint w #37 daily as indicate months of August 2 483.25 PROVIDE C HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho	placement on the Restorative low Record. The restorative to document if the resident plint placed on the Restorative low Record. Administrative to explain why the left hand ed on Resident #37 daily as re plan for the months of eptember 2014. onducted with Restorative Aide :25 AM. Restorative Aide #1 n pulled from her restorative instructed to work as a NA on oximately two times a month. not notify Administrative Staff emoved from her duties in She stated Resident #37 has ow placement of her left hand a resident refused to allow the hall nurse. She stated the ork Monday through Saturday. was unable to explain why was not placed on Resident ed on the care plan for the 014 and September 2014. CARE/SERVICES FOR		282			10/20/14

Facility ID: 20040007

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		AND HUMAN SERVICES			FORM	11/03/2014 APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		345529	B. WING			C 25/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
UNIVER	SAL HEALTH CARE/N	ORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 10	F3	309		
	by: Based on observat resident and staff ir use leg rests on the resident reviewed for resident's feet dang failed to assess and site/shunt daily eac policy for one of on (Resident #105). T 1. Resident #123 w 12/23/11. Cumulati (cerebrovascular ac non-dominant side An annual Minimum 8/25/14 indicated R and long term mem moderately impaire required extensive extensive assistant the unit. Ambulatio assessment period for moving on and of surface transfers (co assistance). Limita indicated on one sid and no limitation in extremities. Mobilit as wheelchair. On 9/23/14 at 10:00 observed sitting in I There were no leg in	NT is not met as evidenced tion, medical record review, nerviews, the facility failed to e wheelchair for one of one or positioning which resulted in gling (Resident #123) and d monitor the dialysis access h shift according to the facility e resident reviewed for dialysis 'he findings included: ras admitted to the facility ive diagnoses included: CVA ccident) with hemiplegia on the and dementia. In Data Set (MDS) dated tesident #123 had short term hory impairment and was d in decision-making. She assistance with transfers, and ce with locomotion on and off in did not occur during the . Her balance was impaired off the toilet and surface to only able to stabilize with staff tion in range of motion was de for the upper extremities range of motion for the lower ty device checked was noted D AM, Resident #123 was her wheelchair in her room. rests on the wheelchair at the tion. Both feet were noted not		F 309 F 309 Corrective action will I the resident found to I by the deficient practic Resident #123 has lead in place. Resident #105 has he site / shunt check dail according to facility por Corrective action will I those residents having affected by the same On September 26, 20 completed for all resid leg rests were in place indicated. Leg rests v residents as indicated On September 26, 20 completed for all resid indicated. Leg rests v residents as indicated On September 26, 20 completed for all resid dialysis to ensure that / shunt check daily ea facility policy. The as site / shunt check dail added to Medication A Records for licensed for assessment.	have been affected ce: g rests to wheelchair er dialysis access by each shift blicy. be accomplished for g potential to be deficient practice: 14 an audit was dents to ensure that e to wheelchairs as were provided to 1. 14 an audit was dents requiring t dialysis access site ich shift according to sessment of access ly each shift was Administration	

Facility ID: 20040007

If continuation sheet Page 11 of 32

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
		345529	B. WING	-		(	C 2 <b>5/2014</b>
	PROVIDER OR SUPPLIER	0.0020			TREET ADDRESS, CITY, STATE, ZIP CODE	09/2	25/2014
					201 CLARKS FORK DRIVE		
UNIVERS	SAL HEALTH CARE/N	IORTH RALEIGH			RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 309	Continued From pa	ae 11	F 3	09			
		nd there was no support			Measures put into place or system changes made to ensure that the d practice will not occur:		
	On 9/23/14 at 11:30 AM, Resident #123 was observed sitting in her wheelchair. No leg rests were on the wheelchair. There was no support provided for her feet and both feet were not touching the floor.			On September 26, 2014 education by the Staff Development Coordina / or Director of Nursing for nursing expectation of placement of leg res wheelchairs as indicated.	ordinator and rsing staff on		
	observed sitting in I Both feet were hang the floor. No leg re wheelchair and the her feet.	AM, Resident #123 was her wheelchair in her room. ging down and not touching sts were noted on the re was no support provided for			On September 26, 2014 education by the Staff Development Coordina and/ or Director of Nursing for licer nurses on expectation of assessment documentation of assessment of d access site / shunt check daily eac	ordinator or licensed sessment and nt of dialysis	
	observed in the din rests attached to th	PM, Resident #123 was ing room. There were no leg e wheelchair and both feet no support provided for her			The Unit Manager / Unit Coordinate Nursing Supervisor, Staff Developr Coordinator and / or Director of Nu will complete rounds daily on all res to ensure that leg rests are in place	nent rsing sidents	
	stated they did not #123 because she moved around in he	PM, the nurse manager #1 use leg rests for Resident had a restless right leg and er wheelchair by pulling on the way using her right arm and			resident wheelchairs as indicated. Rounds will be done daily x one mo weekly x 2 months then monthly x months.	onth,	
	Nurse manager #1	to manipulate the wheelchair. asked Resident #123 to move #123 moved her right leg but h the floor.			The Unit Manager / Unit Coordinate Nursing Supervisor, Staff Developr Coordinator and / or Director of Nu will audit Medication Administration Records to ensure documentation	velopment of Nursing tration	
	were part of the wh whenever Resident	AM, NA #3 stated the leg rests eelchair and should be put on #123 was in her wheelchair with proper positioning.			assessment of dialysis site / shunt each shift. Audits will be done daily weeks, weekly x 4 weeks, then mo 4 months.	yx2	
		AM, Administrative staff #1 d staff to put the leg rests on			The Director of Nursing will review	results	

Facility ID: 20040007

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CENTE		AND HUMAN SERVICES	1		OMB NO.	APPROVEI 0938-039	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED	
		345529	B. WING			C 25/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
UNIVER	SAL HEALTH CARE/N	IORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE	
F 309	<ul> <li>F 309 Continued From page 12 the wheelchair for Resident #123 for foot supp and to avoid foot drop (difficulty lifting the from part of your foot with inability to maintain your in the proper position).</li> <li>On 9/25/14 at 10:07 AM, the occupational therapist stated when Resident #123 was up i the wheelchair, the leg rests should be in place for proper support of her legs/ feet.</li> </ul>		F 3(	09 of rounds completed i application of leg rests weekly x 4 weeks, the months. The Director of Nursin Medication Administra daily for compliance. daily x 2 weeks, week monthly x 4 months.	s daily x 2 weeks, in monthly x 4 ng will review ition Record audits Review will be done		
	<ol> <li>Resident # 105 was admitted to the facility to the facility 4/10/13 with last readmission dated 9/28/13. Cumulative diagnoses included: end stage renal disease and dialysis.</li> <li>A facility policy titled "Hemodialysis", undated, stated, in part, "assessment of dialysis resident: 1. Assess each shift the feel for the thrill or use the stethoscope to listen for bruit."</li> <li>A care plan dated 6/16/14 and last reviewed and updated 9/11/14 indicated Resident #105 required hemodialysis for ESRD (end stage renal disease). Approaches included: hemodialysis three times a week. Assess shunt to arm for thrill/ bruit to ensure patency. Notify physician promptly if any changes were noted.</li> <li>A Quarterly Minimum Data Set (MDS) dated 9/16/14 indicated Resident #105 was cognitively intact. The assessment indicated she had received dialysis during the assessment period.</li> <li>Nursing notes from June 1, 2014 through September 24, 2014 were reviewed and revealed the following nursing documentation regarding</li> </ol>		<ul> <li>Facility plans to monities to make sure that solut.</li> <li>The facility must develow ensuring that correction sustained:</li> <li>The Director of Nursing findings of the rounds as it relates to the appropriate to resident wheelchair Medication Administration and the relates to assessme documentation of assessite / shunt to the Quate Performance Improve monthly for six months compliance is obtained.</li> <li>Date of Completion: Completi</li></ul>	ations are sustained. lop a plan for on is achieved and ag will present the completion review blication of leg rests is and the ation Record audit as int and essment of dialysis lity Assurance and ment Committee s or until a pattern of d.			

CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(22) MIII		E CONSTRUCTION	FORM OMB NO	: 11/03/2014 APPROVED . 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				CON	IPLETED
		345529	B. WING				25/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVER	SAL HEALTH CARE/N	ORTH RALEIGH			201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	6/2/14, 9/10/14, 9/1 9/19/14 and 9/24/14 noted regarding ass and bruit from 6/2/1 Dialysis resident co (completed by the f #105 to dialysis and facility) from June 1 2014 were reviewed following dates, the thrill and bruit were dialysis: 6/2/14, 6/4 7/14/14, 7/16/14, 7/ 8/13/14, 8/22/14 and On 9/23/14 at 10:00 she went to dialysis Wednesday and Fr staff would put a bay was located on her was completed. Re removed the banda no one at the facility the shunt site or list sure it was function stated everything w On 9/24/14 at 5:30 checked Resident 4 every day but did no results every day. S the results, it would On 9/25/14 at 11:28 checked Resident 4 bruit only on dialysis	<ul> <li>1/14, 9/16/14, 9/17/14,</li> <li>A. No documentation was sessment of the shunt for thrill 14 through 9/9/14.</li> <li>ammunication sheets acility and sent with Resident d returned by dialysis to the 1, 2014 through September 24, d and revealed, on the assessment of the shunt for not noted on return from 4/14, 6/18/14, 7/4/14, 7/7/14, 12/1/14, 7/28/14, 7/30/14, 10 8/27/14.</li> <li>D AM, Resident #105 stated around 6:00 AM on Monday, iday. She said the dialysis andage on her shunt site which left lower arm when dialysis esident #105 said she age the next day. She stated y checked her arm, touched tened to the shunt site to make ing properly. Resident #105 ras done at dialysis</li> <li>PM, Nurse #1 stated she #105's shunt for thrill and bruit of necessarily document the She stated, if she documented 1 be in her nursing notes.</li> <li>B AM, Nurse #2 stated she #105's shunt site for thrill and</li> </ul>	F	309			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	COMPLETED	
		345529	B. WING		C 09/25/2014	
NAME OF	PROVIDER OR SUPPLIER	0.0020		STREET ADDRESS, CITY, STATE, ZIP CODE	09/25/2014	
UNIVER	SAL HEALTH CARE/N	ORTH RALEIGH	5201 CLARKS FORK DRIVE RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLÉTIO	
F 309 F 312 SS=D	stated she expected facility policy and ch and bruit every shift that information to b nursing notes on no dialysis communica 483.25(a)(3) ADL C DEPENDENT RES A resident who is un daily living receives	d the nursing staff to follow the neck the shunt site for thrill t. She stated she expected be documented either in the on-dialysis days or on the tion sheet on dialysis days. CARE PROVIDED FOR	F 3(		10/20/14	
	by: Based on record re- interview, the facility incontinent care and 198 & #123) of 3 si- extensive assistance staff for activities of included: 1. Resident #198 w 7/22/14 with multipl Dementia. The adr (MDS) assessment Resident #198 had and needed extens and personal hygier indicated that the re- of bowels and had a The facility's policy dated 2/12/12 was	NT is not met as evidenced eview, observation and staff y failed to provide proper d nail care to 2 (Residents # ampled residents who needed ce or were dependent on the daily living (ADL). Findings was admitted to the facility on e diagnoses including Senile mission Minimum Data Set dated 8/5/14 indicated that severe cognitive impairment ive assistance with toilet use ne. The assessment also esident was always incontinent an indwelling urinary catheter. on perineal/incontinent care reviewed. The policy read in d to grasp edge of washcloth		F 312 F 312 Corrective action will be accomp the resident found to have been by the deficient practice: Resident #198 received approp incontinent care Resident #123 received nail car Corrective action will be accomp those residents having potential affected by the same deficient p On September 25, 2014 resider dependent on staff for incontine	affected riate re. plished for to be practice: nts	

Facility ID: 20040007

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		& MEDICAID SERVICES	(X2) MU	TIPLE CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
					С		
		345529	B. WING			25/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
UNIVERS	SAL HEALTH CARE/N	IORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 312	Continued From pa	ae 15	F3	12			
	and wash using dis wipe for each side a middle, always usin of the wipe and obt wash groin on the of front to the back sta then going to the in On 9/24/14 at 10:50 observed during the resident had a large disposable brief an hospital gown. Wh her left side, Nurse by cleaning the but disposable wipes. Nurse #3 proceede the stage IV sacral dressing change, N clean disposable brief asked if she would applying the clean I Nurse #3 was obse back and cleaned t wipes. The thighs Then, a clean dispo Nurse #3 was not of area/meatus of the On 9/24/14 at 3:20 perineal/incontinent #3. Nurse #3 had a	posable wipes, using clean and then another for the ng downward strokes. Dispose ain a new disposable wipe, butside of the labia from the arting outside the labia and side of the thighs. " O AM, Resident #198 was e incontinent care. The e bowel movement on the d a small amount on her ile the resident was turned to #3 provided incontinent care tocks/rectal areas using After the incontinent care, ed to change the dressing on decubitus ulcer. After the lurse #3 was about to apply a rief to the resident. When clean the perineal area before brief, she replied " oh yeah. " erved to turn the resident to her he thighs with disposable were observed to have feces. osable brief was applied. observed to clean the perineal		<ul> <li>Coordinators as it relates to c incontinent care. Appropriate care was provided to dependaresidents.</li> <li>On September 25, 2014 all renail status was checked by Ut / Unit Coordinators as it relate completion of nail care for depresidents. Nail care was providependant residents.</li> <li>Measures put into place or sy changes made to ensure that practice will not occur:</li> <li>On September 26, 2014 educe nursing staff began by Staff D Coordinator and / or Director on expectation of care for depresidents as it relates to incorrand nail care.</li> <li>The Unit Manager / Unit Coorr Nursing Supervisor, Staff Dev Coordinator and / or Director will complete incontinent care observations on 10% of reside per day. Observations will be 2 weeks, weekly x 4 weeks, th x 4 months. Observations will shifts and weekends.</li> </ul>	incontinent ant sidentNs nit Managers so to pendant ided to stemic the deficient stemic of all evelopment of Nursing pendant ntinent care dinator, relopment of Nursing ent census done daily x nen monthly		
	12/23/11. Cumulat (cerebrovascular ac	vas admitted to the facility on ive diagnoses included: CVA ccident) with hemiplegia n the non-dominant side and aviors.		The Unit Manager / Unit Coor Nursing Supervisor, Staff Dev Coordinator and / or Director will perform nail care audits o resident census per day. Aud done daily x 2 weeks, weekly	velopment of Nursing n 10% of lits will be		

Facility ID: 20040007

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345529		-		C 09/25/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	03/23/2014
UNIVER	SAL HEALTH CARE/N	IORTH RALEIGH			201 CLARKS FORK DRIVE ALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIO
F 312		-	F 3	12		
	8/25/14 indicated R	n Data Set (MDS) dated Resident #123 had short term hory impairment and was			then monthly x 4 months. Observative will include off shifts and weekends	
	and long term memory impairment and was moderately impaired in decision-making. Physical behavior symptoms directed towards others was noted as to have occurred 13 days and rejection of care occurred 1-3 days during the assessment period. Resident #123 required extensive assistance with personal hygiene and				The Director of Nursing will review incontinent care observations daily compliance. Review will be done of weeks, weekly x 4 weeks, then mo 4 months.	laily x 2
	bathing. A care plan dated 8 #123 required staff (activities of daily liv				The Director of Nursing will review care audits daily for compliance. F will be done daily x 2 weeks, weekl weeks, then monthly x 4 months.	Review
	verbal cues to help smaller steps. Allo One person to assi walking, bathing, et	prompt. Break tasks up into w rest breaks between tasks. st with bed mobility, transfers, tc.			Facility plans to monitor its perform to make sure that solutions are sus The facility must develop a plan for ensuring that correction is achieved sustained:	stained.
	#123 was resistant Approaches include calmly. Strike up a	3/29/14 indicated Resident to daily care most days. ed: Approach slowly and conversation before starting tive and resistive to care, leave h later.	tring , leave I he Director of Nursing findings of the incontine observations and nail ca the Quality Assurance a Improvement Committe		The Director of Nursing will presen findings of the incontinent care observations and nail care audit re the Quality Assurance and Perform Improvement Committee monthly f months or until a pattern of complia	view to lance or six
	Resident #123 reversion right hand and the reverse elongated extrabove the fingertipe	On 9/22/14 at 3:46 PM, an observation of Resident #123 revealed the fingernails on her right hand and the thumb nail on her left hand were elongated extending approximately ½ inch above the fingertips. Black material was noted under all the fingernails.			obtained. Date of Completion: October 20, 2	
	observed sitting in The fingernails on I nail on her left hand	1 AM, Resident #123 was her room in her wheelchair. her right hand and the thumb d were elongated ch above the fingertips and				

		AND HUMAN SERVICES				FORM	: 11/03/2014 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATI COM	E SURVEY IPLETED
		345529	B. WING				C <b>25/2014</b>
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
UNIVER	SAL HEALTH CARE/N	ORTH RALEIGH			201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 312	black material was Resident #123 kept clenched into her po- fingers could not be On 9/24/14 at 9:37 observed sitting in H Her left hand was co- visible. The fingern thumb nail on her le approximately ½ ind black material was On 9/24/14 at 4:00 conducted and rever remained elongated the fingertips. Brow under her nails. On 9/25/14 at 7:28 care) was observed bathed resident, pe Resident #123's ha resist care. NA #3 transported Reside NA #3 stated AM (A oral care, combing dressing the reside acknowledged she Resident #123 and long. NA #3 stated nails was due to Re- head and she got th nails. NA#3 also sa did not want her mo- them filed down and assisted with nail ca	<ul> <li>noted under all the nails.</li> <li>the fingers on her left hand alm so observation of those e obtained.</li> <li>AM, Resident #123 was her room in her wheelchair.</li> <li>clenched with the fingers not hails on her right hand and the eft hand were elongated ch above the fingertips. Brown/ noted under her nails.</li> <li>PM, an observation was ealed Resident #123's nails d approximately ½ inch above m/ black material was noted</li> <li>AM, ADL (activities of daily d. NA (nursing assistant) #3 rformed oral care and combed ir. Resident #123 did not completed her care and nt #123 to the dining room. ADL) care included bathing, the hair, applying lotion, nt and fingernail care. She did not perform nail care for that the fingernails were too the black material under her esident #123 scratching her ne black hair dye under her aid Resident #123's daughter other's nails cut but wanted d the daughter usually</li> </ul>	F	312			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C 09/25/2014	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVER	SAL HEALTH CARE/N	ORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			
F 312	stated she expected the fingernails daily of morning care. A Resident #123's da cut the nails but to t nails to be clean.	d nursing staff to clean under with an orange stick as part dministrative staff #1 stated ughter did not want them to file them down and wanted the	F 3			
F 315 SS=D	RESTORE BLADD Based on the reside assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder	F 3	15	10/20/14	
	by: Based on record re interview, the facilit catheter care and fa urinary catheter tub #198)of 3 sampled urinary catheter. Fi 1 a. Resident #198 7/22/14 with multipl Dementia. The adr (MDS) assessment Resident #198 had and had an indwelli The comprehensive	was admitted to the facility on e diagnoses including Senile nission Minimum Data Set dated 8/5/14 indicated that severe cognitive impairment ng urinary catheter. e care plan was reviewed. plan to address the use of the		F 315 Corrective action will be accom the resident found to have been by the deficient practice: Resident # 198 received appro- catheter care. Resident # 198 has catheter tu secured. Corrective action will be accom those residents having potential affected by the same deficient	n affected priate bing plished for Il to be	

Facility ID: 20040007

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	OMB NO. (X3) DATI	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED	
						С	
		345529	B. WING			25/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE		
UNIVER	SAL HEALTH CARE/N	IORTH RALEIGH		5201 CLARKS FORK DRIVE 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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 315	Continued From pa	ae 19	F 3	15			
	The facility's policy on catheter care (undated) was reviewed. The policy read in part " be certain that tubing is secured, without kinks and the drainage bag is below the level of the bladder but not resting on or dragging on the floor. " On 9/23/14 at 4:40 PM and 9/24/14 at 10:55 AM, Resident #198 was observed in bed with an indwelling catheter in place. The catheter tubing was observed not secured with a leg strap. On 9/24/14 at 11:05 AM, Nurse #3 was interviewed. She stated that catheter tubing should have been secured with a leg strap. She didn't know why Resident #198's catheter tubing was not secured. On 9/24/14 at 4:25 PM, Nurse #2 was interviewed. She stated that NAs were supposed to be checking the leg strap during care and inform the nurse if needed. She added that she was just informed about it.			<ul> <li>On September 24, 2014 t</li> <li>/ Unit Coordinator reviewed with foley catheters to inco of catheter care and secu- tubing. Residents were p appropriate catheter care tubing was secured.</li> <li>Measures put into place of changes made to ensure practice will not occur:</li> <li>On September 26, 2014 ed by Staff Development Co- Director of Nursing on ex- care to include securing of tubing.</li> <li>The Unit Manager / Unit Of Nursing Supervisor, Staff Coordinator and / or Director</li> </ul>	ed all residents lude completion iring of catheter provided and catheter or systemic that the deficient education began ordinator and / or pectation of foley of catheter Coordinator, Development		
	7/22/14 with multipl Dementia. The add (MDS) assessment Resident #198 had and had an indwelli The comprehensive There was no care indwelling catheter. The facility's policy was reviewed. The catheter care daily defecation or bowe around urethral me	e care plan was reviewed. plan to address the use of the		<ul> <li>will complete foley care o include securing of cather residents with foley cather Observations will be done weekly x 4 weeks, then m months.</li> <li>The Director of Nursing w care observations daily to securing of catheter tubin compliance. Review will weeks, weekly x 4 weeks 4 months</li> <li>Facility plans to monitor it to make sure that solution</li> </ul>	bservations to ter tubing on ters daily. e daily x 2 weeks, nonthly x 4 vill review foley o include g for be done daily x 2 , then monthly x		

Facility ID: 20040007

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ND PLAN (	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C 09/25/201	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVER	SAL HEALTH CARE/N	IORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE	
F 315	debris. " The facility's policy on a female resider 2/12/12 was review grasp the catheter eliminate pulling on disposable wipe wa urinary opening to a body. " On 7/24/14, there w an indwelling cathe promote wound hea decubitus ulcer. On 9/24/14 at 10:50 observed during the resident had a large disposable brief an hospital gown. Wh her left side, Nurse by cleaning the but disposable wipes. Nurse #3 proceede the stage IV sacral dressing change, N clean disposable bi asked if she norma stated " oh yeah. " turn the resident to thighs with disposa observed to have fe brief was applied.	on perineal/incontinent care int with a urinary catheter dated red. The policy read in part " at the insertion site to the catheter and with a ash the catheter starting at the about 4 inches away from the vas physician's order to insert ter to Resident #198 to aling to stage IV sacral 0 AM, Resident #198 was e incontinent care. The e bowel movement on the d a small amount on her ile the resident was turned to #3 provided incontinent care tocks/rectal areas using After the incontinent care, ed to change the dressing on decubitus ulcer. After the lurse #3 was about to apply a rief to the resident. When illy clean the perineal area she Nurse #3 was observed to her back and cleaned the ble wipes. The thighs were exes. Then a clean disposable Nurse #3 was not observed to area/meatus or to clean the	F 315	<ul> <li>ensuring that correction is achieved sustained:</li> <li>The Director of Nursing will preservations of the incontinent care observations and nail care audit of the Quality Assurance and Perfor Improvement Committee monthly months or until a pattern of compostained.</li> <li>Date of completion: October 20, 1000</li> </ul>	ent the review to mance / for six liance is	

If continuation sheet Page 21 of 32

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED		
		345529	B. WING		09/25/2014		
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVER	SAL HEALTH CARE/N	ORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTIO		
F 315	· · · · · · · · · ·	-	F 31	5			
	resident.	and catheter care to the					
F 318 SS=D	483.25(e)(2) INCRE IN RANGE OF MO	EASE/PREVENT DECREASE TION	F 31	8	10/20/14		
	resident, the facility with a limited range appropriate treatme	ent and services to increase d/or to prevent further					
	by:	NT is not met as evidenced					
		eview, observation and staff y failed to provide the		F 318			
	(Residents # 198, #	ement as ordered for 3 4 37 & # 123) of 4 sampled ation in range of motion.		Corrective action will be accompl the resident found to have been a by the deficient practice:			
	1. Resident #198 w 7/22/14 with multipl Dementia and joint	as admitted to the facility on e diagnoses including Senile contracture. The admission (MDS) assessment dated		Resident # 198, #37 and #123 ha splints in place in place per physi order.			
	8/5/14 indicated that cognitive impairment of motion on one si	at Resident #198 had severe nt and had limitation in range		Corrective action will be accompl those residents having potential t affected by the same deficient pra	o be		
	7/23/14 indicated th in left upper extrem cerebrovascular ac passive range of m	hat Resident #198 had " pain ity from previous cident (CVA) which limits otion to left upper extremity.		On September 26, 2014 resident physician orders for splinting wer reviewed. Orders for splinting we placed on the resident Medication	e ere า		
	interphalangeal/dist poor hygiene noted	d at wrist and proximal tal interphalangeal joints with . Therapist performed hand skin breakdown to left hand.		Administration Record requiring t licensed nurse to ensure splint in and/or place the splint per physic orders.	place		

Facility ID: 20040007

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							0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		345529	B. WING			C 09/25/2014	
NAME OF I	PROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVER	SAL HEALTH CARE/N	ORTH RALEIGH			201 CLARKS FORK DRIVE ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	Continued From pa	qe 22	F 3	18			
	Will assess need for left hand splint. " Or 8/25/14, OT services were discontinued a Resident #198 had reached her maximum potential and had recommended to apply cushion to the resident's left finger contract				Measures put into place or systemic changes made to ensure that the d practice will not occur: On September 26, 2014 education	leficient began	
pai (tin doi 0 n Re con ma On Sh fac Re leff On inte for see hai an Me nui On inte for set hai an for for for for for for for for for for	The physician's ord patient to wear left (times) 6 hours exc donned/doffed by n On 9/23/14 at 10:50			by the Staff Development Coordina / or Director of Nursing for nursing reference to expectation for splint application and documentation of s application.	staff in		
	Resident #198 was contracted and ther management devic On 9/24/14 at 3:30 She stated that she facility for seven ye	observed. Her left hand was e was no contracture			The Unit Manager / Unit Coordinate Nursing Supervisor, Staff Developr Coordinator and / or Director of Nu will review Medication Administratic Records in coordination with round ensure that splinting is completed a documented per physician orders of weeks, weekly x 4 weeks then mor months.	nent rsing on s to and daily x 2	
	for Resident #198 c seen her wearing a hand. She added th any device, it shoul Medication Adminis	PM, Nurse # 2 was tated that she was the nurse on 7-3 shift and she had not splint or cushion on her left nat if she was on a splint or d have been written on the stration Record (MAR) for the it was not on the MAR.			The Director of Nursing will review Medication Administration Record A daily for compliance. Review will b daily x 2 weeks, weekly x 4 weeks, monthly x 4 months.	e done	
	On 9/24/14 at 4:49 interviewed. She si of Resident #198 of	PM, Nurse #1 was tated that she was the nurse n 3-11 shift. She indicated en the resident wearing a			Facility plans to monitor its perform to make sure that solutions are sus The facility must develop a plan for ensuring that correction is achieved sustained:	tained. d and	
	interviewed. She st	PM, Nurse Manager #1 was tated that Resident #198 had hand contracture cushion on			The Director of Nursing will presen findings of the Medication Administ Record audits as it relates to splint the Quality Assurance and Perform	ration ing to	

Facility ID: 20040007

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		345529			C 09/25/2014	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CC		
UNIVER	SAL HEALTH CARE/N	NORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 318	MARs for August a nursing to apply an to the resident. 2. Resident #123 y 12/23/11. Cumulat cerebrovascular ac on the non-dominal A rehabilitation dep 6/4/14 stated chan UE (upper extremit nursing reported R noncompliant and made to apply her Restorative nursing apply splint as resid Nursing notes were was noted that Res hand splint on 8/21 An annual Minimur 8/25/14 indicated F and long term men moderately impairer required extensive transfers, locomoti dressing, toilet use bathing. The asse range of motion on extremities. Physician orders for reviewed and revea Resident #123 to w when up in w/c (wh	ler was not transcribed to the ind September, 2014 for ad therefore it was not provided was admitted to the facility on tive diagnoses included: ccident (CVA) with hemiplegia int side. bartment referral/ screen dated ges in ROM (range of motion) ty) (splints). Restorative esident #123 was combative when attempts were splint (right hand splint). g instructed to continue to dent tolerated. e reviewed and documentation sident #123 refused the left	F 318	<ul> <li>Improvement Committee momonths or until a pattern of cobtained.</li> <li>Date of Completion: October</li> </ul>	ompliance is	

Facility ID: 20040007

If continuation sheet Page 24 of 32

		& MEDICAID SERVICES				<u>. 0938-039</u>
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
					С	
		345529	B. WING		09/25/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
UNIVER	SAL HEALTH CARE/N	IORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 318	therapy clarification to apply splint as R wearing. An observation was 10:00 AM. Residen wheelchair in her ro- clenched. She was An observation was AM. Resident #123 in her room. Her left was not wearing a On 9/24/14 at 3:51 observed sitting in room. Her left hand The restorative nur September 2014 w documentation for 9/21-22, and 9/24. On 9/25/14 at 9:24 stated sometimes to pulled off their resto- floor to work as a n unsure how often the restorative aides di they were pulled fro- Administrative staff nursing staff to do fa and apply splints w pulled to the floor.	a: due to non-compliance, staff esident #123 tolerated s conducted on 9/23/14 at nt #123 was sitting in her bom. Her left hand was s not wearing a left hand splint. s conducted on 9/24/14 at 9:39 3 was sitting in her wheelchair eft hand was clenched. She left hand splint. PM, Resident #123 was her wheelchair in the dining d was clenched. She was not	F 31	8		

If continuation sheet Page 25 of 32

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE SURVEY COMPLETED		
			A. BUILDING			С		
		345529	B. WING				25/2014	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
				Ę	5201 CLARKS FORK DRIVE			
UNIVERS	SAL HEALTH CARE/N			F	RALEIGH, NC 27616			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	DN .	(X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	Х	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE	
TAG	REGULATORTOR	SCIDENTIFTING INFORMATION)	TAG		DEFICIENCY)	RIALE		
			l I					
F 318	Continued From pa	ae 25	F 3	10	2			
1 010		ige 20	ГЈ	10	)			
	On 9/25/14 at 10:07	7 AM, the occupational						
		last referral/ screen for						
		arding the left hand splint						
		4. The recommendation at						
		storative to continue to try to						
	apply if the patient t	tolerated.						
	0= 0/05/44 =+ 40:00							
		5 AM, restorative nursing aide was pulled off her restorative						
		ly two times a month. She						
		et Administrative staff #2 know						
		bulled to work as a nursing						
		or. She stated the unit						
	manager was awar	e and believed that the unit						
	manager told Admir	nistrative staff #2.						
		s admitted to the facility on						
	diagnoses including	itted on 2/15/11 with multiple						
		and, abnormal posture and						
	dysphagia.							
	-)							
	A review of the Mini	imum Data Set (MDS) dated						
		ed. Resident #37 was						
	-	g severe cognitive impairment.						
		the resident was assessed as						
		nitation in range of motion of						
		es on both sides of her body.						
	A review of the Res	torative Nursing Program						
		lent #37 was conducted. The						
		August 2014 and September						
	2014 indicated the	resident was to have a splint						
		and and to wear the splint for						
	six hours a day.							
	A rouious of the com	plana for Decident #27						
		e plans for Resident #37 was n of care dated 9/8/14						

Facility ID: 20040007

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PRINTED: 11/03/2014

A: BUILDING     C       345529     B. WING     09/25/20'       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       UNIVERSAL HEALTH CARE/NORTH RALEIGH     STREET ADDRESS, CITY, STATE, ZIP CODE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX	TATEMENT	OF DEFICIENCIES	KONT SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	• •		ONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED
345529         B. WING         09/26/201           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, OTV, STATE, ZIP CODE         STREET ADDRESS, OTV, STATE, ZIP CODE           UNIVERSAL HEALTH CARE/NORTH RALEIGH         STREET ADDRESS, OTV, STATE, ZIP CODE         STREET ADDRESS FLAW OF CORRECTION           MARE OF PROVIDER STATEMENT OF DEFICIENCIES         FRACH DEFICIENCY WILS THE PRECEDED BY PULL         PREFIX         PREFIX         PREFIX         PREFIX         CONSIGNER STRAM OF CORRECTION         OWN           TAG         VEXATORY OR LSC IDENTIFYING INFORMATION)         TAG         PREFIX         PREFIX         PREFIX         CONSIGNER STRAM OF CORRECTION         OWN         PREFIX         PREFIX         PREFIX         TAG         PREFIX         PREFIX         PREFIX         TAG         PREFIX         PREFIX         PREFIX         TAG         TAG         TAG         TAG         PREFIX         TAG         PREFIX         TAG         <		F CORRECTION	IDENTIFICATION NOWBER.	A. BUILD	ING			
UNIVERSAL HEALTH CARE/NORTH RALEIGH         S201 CLARKS FORK DRIVE RALEIGH, NC 27618           (#A) D PHEEW TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         CROVERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)         O PREFIX           F 318         Continued From page 26 indicated the resident required assistance with the resident the correct application of the spint and to assist her with the application according to the scheduled wearing time.         F 318           A review of the Physician's orders revealed an order dated 2/24/14 which read " Patient to wear left resting hand spint for six hours a day."         F 318           A review of the Restorative Nursing Program Care Plan and Flow Record for the month of August 2014 was conducted. The review revealed the left hand spint was not applied on 8/1/14, 8/2/14, 8/2/3/14, 8/2/14, 8/2/14, 8/2/14, 8/2/14, 8/26/14, 8/28/14, 8/29/14, 8/2/3/14, 8/2/14, 8/2/14, 8/2/14, 8/26/14, 8/28/14, 8/29/14, 8/2/3/14, 8/2/14, 8/2/14, 8/26/14, 9/21/14, 9/1/3/14, 9/1/3/14, 8/1/5/14, 8/26/14, 9/2/14, 9/2/14, 9/2/14, 8/2/14, 8/26/14, 9/2/14, 9/2/14, 9/2/14, 8/2/14, 8/26/14, 9/2/14, 9/2/14, 9/2/14, 9/2/14, 8/26/14, 9/2/14, 9/2/14, 9/2/14, 8/2/14, 8/26/14, 9/2/14, 9/2/14, 9/2/14, 9/2/14, 8/26/14, 9/2/14, 9/2/14, 9/2/14, 8/26/14, 9/2/14, 9/2/14, 9/2/14, 8/26/14, 9/2/14, 9/2/14, 9/2/14, 8/26/14, 9/2/14, 9/2/14, 8/26/14, 9/2/14, 9/2/14, 8/26/14, 9/2/14, 8/26/14, 9/2/14, 8/26/14, 9/2/14, 8/26/14, 9/2/2/			345529	B. WING			09/25/2014	
UNIVERSAL HEALTH CARE/NORTH RALEIGH RALEIGH, NC 27616 RALEIGH, NC 27617 RALEIGH, NC 27617 RALEIGH, NC 27617 RALEIGH, NC 27617 RALEIGH, NC	NAME OF F	PROVIDER OR SUPPLIER					ODE	
PREFIX TAG       PECAL DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE       Comin DEFICIENCY)         F 318       Continued From page 26 indicated the resident required assistance with the resident the correct application of the splint and to assist her with the application according to the scheduled wearing time.       F 318       F 318         A review of the Physician's orders revealed an order dated 2/24/14 which read " Patient to wear left resting hand splint for six hours a day."       F A review of the Restorative Nursing Program Care Plan and Flow Record for the month of August 2014 was conducted. The review revealed the left hand splint was not applied on 8/1/14, 8/19/14, 8/25/14, 8/6/14, 8/6/14, 8/6/14, 8/7/14, 8/19/14, 8/25/14, 8/25/14, 8/26/14, 8/22/14, 4/22/14, 4/25/14, 1/26/14, 8/37/14, 8/20/14, 4/3/37/14, There was no documentation indicating the refusal of splint placement by Resident #37 for the month of August 2014.         A review of the Restorative Roster for the month of September 2014 was conducted. The review revealed the left hand splint was not applied on 9/3714, 9/414, 9/6/14, 9/7/14, 9/14/14 and 9/21/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of September 2014.         On 9/22/14 at 3:49 PM the resident was observed sitting in her wheelchair in her room without a splint device on her left hand.         On 9/22/14 at 3:22 PM the resident was observed jung in her bed without a splint device on her left	UNIVERS	SAL HEALTH CARE/N	IORTH RALEIGH					
<ul> <li>indicated the resident required assistance with her splints. The interventions included to teach the resident the correct application of the splint and to assist her with the application according to the scheduled wearing time.</li> <li>A review of the Physician's orders revealed an order dated 2/24/14 which read " Patient to wear left resting hand splint for six hours a day."</li> <li>A review of the Restorative Nursing Program Care Plan and Flow Record for the month of August 2014 was conducted. The review revealed the left hand splint was not applied on 8/1/14, 8/2/14, 8/3/14, 8/4/14, 8/5/14, 8/6/14, 8/7/14, 8/10/14, 8/11/14, 8/16/14, 8/17/14, 8/25/14, 8/25/14, 8/26/14, 8/28/14, 8/29/14, and 8/31/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of August 2014.</li> <li>A review of the Restorative Roster for the month of 3/2/14, 9/4/14, 9/7/14, 9/14/14 and 9/21/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of August 2014.</li> <li>A review of the Restorative Roster for the month of September 2014. was not applied on 9/3/14, 9/4/14, 9/7/14, 9/1/14, 9/1/14, and 9/21/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of September 2014.</li> <li>On 9/22/14 at 3:49 PM the resident was observed sitting in her wheelchair in her room without a splint device on her left hand.</li> <li>On 9/24/14 at 3:22 PM the resident was observed lying in her bed without a splint device on her left</li> </ul>	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO DATE
<ul> <li>indicated the resident required assistance with her splints. The interventions included to teach the resident the correct application of the splint and to assist her with the application according to the scheduled wearing time.</li> <li>A review of the Physician's orders revealed an order dated 2/24/14 which read " Patient to wear left resting hand splint for six hours a day."</li> <li>A review of the Restorative Nursing Program Care Plan and Flow Record for the month of August 2014 was conducted. The review revealed the left hand splint was not applied on 8/1/14, 8/2/14, 8/3/14, 8/4/14, 8/5/14, 8/6/14, 8/7/14, 8/10/14, 8/11/14, 8/16/14, 8/17/14, 8/25/14, 8/25/14, 8/26/14, 8/28/14, 8/28/14, 8/25/14, 17/14, 8/25/14, 17/14, 8/26/14,</li></ul>	F 318	Continued From pa	age 26	F 3	18			
order dated 2/24/14 which read " Patient to wear left resting hand splint for six hours a day."         A review of the Restorative Nursing Program Care Plan and Flow Record for the month of August 2014 was conducted. The review revealed the left hand splint was not applied on 8/1/14, 8/2/14, 8/3/14, 8/4/14, 8/5/14, 8/6/14, 8/7/14, 8/10/14, 8/11/14, 8/16/14, 8/17/14, 8/26/14, 8/28/14, 8/29/14, and 8/31/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of September 2014 was conducted. The review revealed the left hand splint was not applied on 9/3/14, 9/4/14, 9/6/14, 9/7/14, 9/14/14 and 9/21/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of September 2014.         On 9/22/14 at 3:49 PM the resident was observed sitting in her wheelchair in her room without a splint device on her left hand.         On 9/22/14 at 3:22 PM the resident was observed lying in her bed without a splint device on her left		indicated the reside her splints. The inter- the resident the co and to assist her w	ent required assistance with erventions included to teach rrect application of the splint ith the application according to					
Care Plan and Flow Record for the month of August 2014 was conducted. The review revealed the left hand splint was not applied on 8/11/4, 8/2/14, 8/3/14, 8/4/14, 8/5/14, 8/6/14, 8/7/14, 8/10/14, 8/11/14, 8/16/14, 8/17/14, 8/18/14, 8/19/14, 8/23/14, 8/25/14, 8/26/14, 8/28/14, 8/29/14, and 8/31/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of August 2014. A review of the Restorative Roster for the month of September 2014 was conducted. The review revealed the left hand splint was not applied on 9/3/14, 9/4/14, 9/6/14, 9/7/14, 9/14/14 and 9/21/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of September 2014. On 9/22/14 at 3:49 PM the resident was observed sitting in her wheelchair in her room without a splint device on her left hand. On 9/24/14 at 3:22 PM the resident was observed lying in her bed without a splint device on her left		order dated 2/24/1	4 which read " Patient to wear					
of September 2014 was conducted. The review revealed the left hand splint was not applied on 9/3/14, 9/4/14, 9/6/14, 9/7/14, 9/14/14 and 9/21/14. There was no documentation indicating the refusal of splint placement by Resident #37 for the month of September 2014. On 9/22/14 at 3:49 PM the resident was observed sitting in her wheelchair in her room without a splint device on her left hand. On 9/24/14 at 3:22 PM the resident was observed lying in her bed without a splint device on her left		Care Plan and Flov August 2014 was of revealed the left has 8/1/14, 8/2/14, 8/3/ 8/7/14, 8/10/14, 8/ 8/18/14, 8/19/14, 8 8/26/14, 8/28/14, 8 was no documental splint placement by	w Record for the month of conducted. The review and splint was not applied on 14, 8/4/14, 8/5/14, 8/6/14, 11/14, 8/16/14, 8/17/14, /23/14, 8/24/14, 8/25/14, /29/14, and 8/31/14. There tion indicating the refusal of					
sitting in her wheelchair in her room without a splint device on her left hand. On 9/24/14 at 3:22 PM the resident was observed lying in her bed without a splint device on her left		of September 2014 revealed the left ha 9/3/14, 9/4/14, 9/6/ 9/21/14. There was the refusal of splint	was conducted. The review and splint was not applied on 14, 9/7/14, 9/14/14 and s no documentation indicating placement by Resident #37					
lying in her bed without a splint device on her left		sitting in her wheel	chair in her room without a					
		lying in her bed wit						

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STATEMENT	OF DEFICIENCIES OF CORRECTION	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		345529	B. WING		C 09/25/2014	
	PROVIDER OR SUPPLIER	NORTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP ( 5201 CLARKS FORK DRIVE RALEIGH, NC 27616	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 318	sitting in her wheel splint device on he An interview was c Staff #2 on 9/25/14 restorative aide wa per week, not inclu times, the restorati from her duties in r instructed to work a resident hall. She s often the restorativ as a NA because s when it occurred. A the nurses on the r place the left hand the restorative nursing nurses observed th in place, they shou stated the nursing restorative nursing restorative aide wa restorative aide wa restorative aide wa placement on the F Flow Record. The to document if the splint placed on the Flow Record. An interview was c #1 on 9/25/14 at 10 stated she had bee nursing duties and a resident hall app She stated she did #2 when she was r	chair in the dayroom without a	F 31	18		

Facility ID: 20040007

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
			A. BUILDIN	NG	С	
	PROVIDER OR SUPPLIER	345529	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	25/2014
	SAL HEALTH CARE/N	ORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIOI DATE
F 318 F 431 SS=D	splint placement, th expected to docum record and to notify restorative aide wor An interview was co Staff #1 on 9/25/14 Staff #1 stated the in place the left arm s was not applied by 483.60(b), (d), (e) ID LABEL/STORE DR The facility must en a licensed pharmac	a resident refused to allow e restorative aide was ent the refusal on the flow the hall nurse. She stated the rks Monday through Saturday. onducted with Administrative at 9:10 AM. Administrative nursing staff was expected to plint on Resident #37 when it the restorative aide.	F 3 <sup>.</sup> F 4:			10/20/14
	controlled drugs in a accurate reconciliat records are in order controlled drugs is a reconciled. Drugs and biologica labeled in accordan professional princip appropriate access instructions, and the applicable.	sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be the with currently accepted tes, and include the				
	facility must store a locked compartmer	Il drugs and biologicals in nts under proper temperature t only authorized personnel to				
		ovide separately locked, I compartments for storage of				

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	H AND HUMAN SERVICES RE & MEDICAID SERVICES			FORM	11/03/2014 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	E SURVEY IPLETED
	345529	B. WING	i	09	C / <b>25/2014</b>
NAME OF PROVIDER OR SUPPLI	R		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERSAL HEALTH CARE/NORTH RALEIGH				201 CLARKS FORK DRIVE ALEIGH, NC 27616	
PREFIX (EACH DEFICIE)	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Comprehensive Control Act of 19 abuse, except w package drug dis quantity stored is be readily detect	isted in Schedule II of the Drug Abuse Prevention and 76 and other drugs subject to hen the facility uses single unit tribution systems in which the minimal and a missing dose can ed.		431		
by: Based on record interview, the fac insulin vial and fa (insulin (used to pulmicort (used to opened. Finding) The manufacture respule revealed can be stored for protective alumir pulmicort respule weeks of openin The facility's poli facility " dated 1 read in part " the followed for expi medications: Ins pulmicort respule aluminum packa	ENT is not met as evidenced review, observation and staff ility failed to discard expired iled to date the medications reat diabetes mellitus) and o treat asthma attacks)) when s included: rs' specification for pulmicort "pulmicort respule ampules 2 weeks after opening the um foil envelope. Throw away is ampules if not used within 2 g the protective foil envelope." cy on "medication storage in the 20/14 was reviewed. The policy following guidelines should be ation dates for open multi-dose ulin was good for 28 days and was good for 2 weeks once ge was opened. " 1:20 PM, medication cart #1 on observed. An opened Lantus ation date of 9/21/14 and an			F 431 Corrective action will be accomplished for the resident found to have been affected by the deficient practice: On September 25, 2014 one expired vial of Lantus and one undated vial of Novolog 70/30 were removed and discarded from medication cart one for 300/400 halls. On September 25, 2014 three boxes of undated Pulmicort respules were removed and discarded from medication cart two from the 300/400 halls. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: On September 25, 2014 Unit Manager / Unit Coordinator checked all medication carts to ensure all expired medications had been removed and all opened vials of insulin and Pulmicort respules were dated when opened.	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVEE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY PLETED
		345529	B. WING _			C 2 <b>5/2014</b>
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
UNIVER	SAL HEALTH CARE/N	IORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	interviewed. She a Lantus vial was exp discard it. She add open the Novolog s 2. On 9/25/14 at 1: 300/400 hall was o pulmicort respules aluminum foil pack aluminum foil pack they were opened. ampules, second h had 4 ampules left. On 9/25/14 at 1:45 interviewed. She ir	medication cart #1. PM, Nurse #4 was cknowledged that the opened bired and was observed to led that the nurse who first should have dated it. 45 PM, medication cart #2 on bserved. Three boxes of were observed with opened ages. The three opened ages had no date as to when The first opened foil had 3 ad 3 ampules and the third	F 43	<ul> <li>Measures put into place or sy changes made to ensure that practice will not occur:</li> <li>On September 26, 2014 educe by the Staff Development Cool / or Director of Nursing with linurses on dating multi use via Pulmicort respules when opereview of expiration dates prive administration of medications</li> <li>Unit Manager / Unit Coordinal Supervisor, Staff Developmer Coordinator and / or Director will check all medication carts ensure all multi use vials and respules are dated when ope expired medications are remormedication carts. Medication will be completed daily x 2 we weekly thereafter.</li> <li>The Director of Nursing will reformedication cart checks dat weekly x 4 weeks, and month months.</li> <li>Facility plans to monitor its pet to make sure that solutions a The facility must develop a pl ensuring that correction is ac sustained:</li> <li>The Director of Nursing will p findings of the daily medication</li> </ul>	t the deficient cation began ordinator and censed als and ned and or to s. ttor, Nursing nt of Nursing s daily to Pulmicort med and oved from a cart checks eeks then eview results ily x 2 weeks, nly x 4 erformance re sustained. an for hieved and present on cart	

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		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES			0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
					(	C
		345529	B. WING _		09/2	25/2014
NAME OF F	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SAL HEALTH CARE/N	ORTH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 431	Continued From no	~~ 21	<b>_</b>			
F 431	Continued From pa	ge 31	F 43	compliance is obtained.		
				Date of completion: October 20, 20	14	

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PRINTED: 11/03/2014