	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		E SURVEY IPLETED
							С
		345529	B. WING			09	9/17/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NO			52	201 CLARKS FORK DRIVE		
	RE HEREIN GARE/NG			R	ALEIGH, NC 27616		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	(	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION DATE
F 166 SS=E	F 166 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO SS=E RESOLVE GRIEVANCES		F	166			10/15/15
	facility to resolve g	right to prompt efforts by the rievances the resident may se with respect to the behavior					
	This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to resolve grievances in regards to untimely call bell response for three of three sampled residents (Residents # 92, #18 and # 32). Findings included:			This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the provider the truth of the facts alleged or the	r of		
council mi reviewed. resident c	council minutes for reviewed. There w resident council mi	plaint reports and resident the last six months were vere five grievances and three nutes with concerns regarding esponse. On 3/5/15 a family			correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requiremen under state and federal law.		
	member indicated	that "resident waits too long the call bell." The action			F 166		
	" unit manager to s call bells. " On 3/3	/ to resolve the grievance was peak with staff in response to 30/15, a family member ther's call bell was going off for			Corrective action will be accomplished f the resident found to have been affected by the deficient practice:		
	an extended period by the facility to res counseled employe	d of time. " The action taken solve the grievance was " ees. " On 5/19/15, a resident nt not answered timely. " The			Resident #92, #18 and #32 have been re-interviewed by Social Worker and grievances have been resolved.		
	facility's action was response. " On 5/ minutes indicated	" staff educated on call bell 19/15, the resident council " residents stated issue of staff ts and turning off light before			Corrective action will be accomplished f those residents having potential to be affected by the same deficient practice:		
1	resolving the issue resident indicated	still remains. " On 7/21/15, a " the staff were slow in s. " The facility's action was "			All residents have the potential to be affected.		

Electronically Signed

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.

10/08/2015

TATEMENT (	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
IND PLAIN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING _			
		345529	B. WING			09	C )/17/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	201 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NORT			R	RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 166	Continued From page	<b>a</b> 1		166			
1 100		n 8/18/15, the resident		100	Resident interviews completed with		
		ated that " staff turning off			interviewable residents with BIMS s		
		eone will come and they don't			8-15 to ensure all grievances have		
	0,0	get a call light request in a			received. Any grievances received		
	-	8/24/15, a family member			interviews were placed on grievand		
		stated that no one answered ly manner. " The facility			and followed up per grievance polic	sy.	
	-	replaced by the nurse." On			The Administrator will review all		
		council minutes indicated "			grievances for completion within 72		
		f turning off light before			of receipt of the grievance. The res		
	-	and wait time for someone			or person filing the grievance will be		
	to answer continues.	-			informed of the finding of the invest as well as any corrective actions	igation	
	1 Resident # 18 was	admitted to the facility on			recommended within five working d	avs of	
	8/26/11. The quarter	ly Minimum Data Set (MDS) 4/15 indicated that Resident			the filing of the grievance or comple	•	
		view for mental status (BIMS)			The Administrator and/or Social Wo	orker	
	score of 12.				will follow up with resident or perso	n filing	
					the grievance weekly x 4 weeks to		
		M administrative staff #2			that grievance is resolved. Follow	up will	
	was interviewed. She				remain ongoing.		
		sident council meeting every edged that residents had			On September 25, 2015 education	bogan	
		out the untimely call bell			for all staff in response to call bell	began	
		esident #18. She indicated			response. Education to include that	t all	
		ne concerns on the minutes			staff responsible for answering call		
	and she had to give t				timely, procedure for answering cal		
		ne department head had to			including not turning off call light un	til all	
	-	ion plan to resolve the			resident; s needs are met and	11	
	concerns.				consequences for failure to answer lights and meeting residents needs		
	On 9/17/15 at 2:35 P	M, Resident #18 was			The Administrator, Department Mai	nagers,	
		ted that the issue with the			Nursing Supervisor and/or Manage		
		s still an ongoing problem.			Duty will review call light response		
		ssue had been brought up in			for timeliness and meeting of reside		
		neeting several times but			needs to include off shifts and weel		
		d. She usually had to use			daily x 4 weeks, weekly x 4 weeks	and	
	i ner call light to be pu	t back to bed because she			then monthly x 3 months.		

Facility ID: 20040007

If continuation sheet Page 2 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/19/201 FORM APPROVED OMB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 09/17/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 166	At times the staff would light and would say silwould take a long time. On 9/17/15 at 3:07 PI was interviewed. She been in-serviced on of development coordina had been monitoring she was in the buildin quality assurance and (QAPI) for it. She state with the administrator 2. Resident # 92 was 2/28/15. The significated that interview for mental sinterview for mental sinterview for mental sinterview for mental sinterview. She responsible for the remonth. She acknowle been complaining abor response including R that she mentioned the and she had to give the department head. The state interview for mental sinterview for the remonth. She acknowle been complaining abor response including R that she mentioned the and she had to give the department head. The state is the	would not answer the light. Id come and turned off the he/he will be back but it e for them to come back. M, administrative staff #1 e stated that the staff had call bell response by the staff ator. She added that she the call bell response when ng otherwise there was no d performance improvement ted that she would discuss it and would initiate a QAPI. admitted to the facility on ant change in status DS) assessment dated t Resident #92 had a brief tatus score of 15. M administrative staff #2 e stated that she was sident council meeting every edged that residents had put the untimely call bell esident #92. She indicated he concerns on the minutes he minutes to the he department head had to ion plan to resolve the	F 166		e deficient on began evance le from process ad follow 72 hours resident I be estigation g days of aplaint. Worker rson filing to ensure w up will on began II that all all lights call lights until all
	the call bell response	ted that the concerns with was still an ongoing that the issue with untimely		lights and meeting resident need The Administrator, Department N	

Facility ID: 20040007

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
						С
		345529	B. WING		0	9/17/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
JNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	-	AN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	/E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	COMPLETIO
F 166	Continued From page	e 3	F 16	6		
		d been brought up in the		Nursing Supervisor ar	-	
	resident council mee	ting several times.		Duty will review call lig		
				and meeting of reside		
	Op 0/17/15 at 3:07 P	M, administrative staff #1		off shifts and weekend weekly x 4 weeks and	-	
		e stated that the staff had		months.		
		call bell response by the staff				
		ator. She added that she		Resident interviews w	ill be completed with	
		the call bell response when		all interviewable reside		
		ng otherwise there was no		score of 8-15 monthly		
	QUARIE (QAPI) for it.	d performance improvement		assurance room round grievances have been		
				grievances have been		
				responding to call ligh		
	3. Resident #32 was readmitted 10/1/14. The			resident needs are be		
	most recent Minimun Assessment, a Quart	n Data Set (MDS) terly MDS dated 7/30/15,		turning off call light.		
		32 was cognitively intact.		Facility plans to monit		
	On 9/16/15 at 7 AM F			to make sure that solu		
		ited that staff frequently light and say they would be		The facility must deve ensuring that correction		
		else to help them but then		sustained:	on is achieved and	
	-	back at all or it would take a				
	•	indicated that was an		The Administrator will	report the findings	
	ongoing problem that	t had not been resolved.		of grievance investiga	•	
		he had verbalized her		follow up, call bell resp		
		s on numerous occasions to		summary of resident in		
	multiple staff but noth On 9/17/15 at 2:20 P	Madministrative staff #2		Quality Assurance and Improvement Commit		
	was interviewed. She			months or until a patte	-	
	responsible for the re	esident council meeting every edged that residents had		achieved.		
		out the untimely call bell		Date of Completion: (	October 15. 2015	
		Resident #18. She indicated			-,	
	that she mentioned th	he concerns on the minutes				
	and she had to give t					
		he department head had to				
	put the corrective act concerns.	tion plan to resolve the				

If continuation sheet Page 4 of 63

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/19/2015 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		NSTRUCTION		PLETED
		345529	B. WING				C 17/2015
NAME OF PF	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	_	
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH			CLARKS FORK DRIVE EIGH, 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 166 F 224 SS=E	call bell response was She added that this is the resident council m had not been resolved her call light to be put was hurting and staff At times the staff wou light and would say sh would take a long time On 9/17/15 at 3:07 PM was interviewed. She been in-serviced on c development coordina had been monitoring to she was in the buildin quality assurance and (QAPI) for it. She stat with the administrator 483.13(c) PROHIBIT MISTREATMENT/NEI The facility must develop policies and procedur mistreatment, neglect	M, Resident #18 was ed that the issue with the is still an ongoing problem. Isue had been brought up in heeting several times but d. She usually had to use back to bed because she would not answer the light. Id come and turned off the he/he will be back but it e for them to come back. M, administrative staff #1 e stated that the staff had all bell response by the staff ator. She added that she the call bell response when g otherwise there was no a performance improvement ted that she would discuss it and would initiate a QAPI. GLECT/MISAPPROPRIATN Plop and implement written es that prohibit , and abuse of residents	F 1				10/15/15
	by: Based on observation	is not met as evidenced n, record review, resident e facility failed to have an		F	-224		

Facility ID: 20040007

If continuation sheet Page 5 of 63

						0.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDI	NG		С
		345529	B. WING			
	ROVIDER OR SUPPLIER	040020		STREET ADDRESS, CITY, STATE, ZIP (		17/2015
NAME OF F	ROVIDER OR SUFFLIER			5201 CLARKS FORK DRIVE	JODE	
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 224	Continued From page	e 5	F	224		
		sistant available to check on		Corrective action will be a	complished for	
		of 7 (Resident #32, #18, #55,		the resident found to have		
		#31) of 57 residents on 300		by the deficient practice:		
		n Two) for a period of				
	between two to three			Residents #32, #18, #55, #	<sup>‡</sup> 27, #104,	
	included:	-		#132, #31 have an assigned		
	1. Resident #32 was	readmitted 10/1/14. The		assistant each shift to mee	t their needs.	
	resident ' s cumulativ	e diagnoses included				
	diabetes, spinal stend	osis, cardio vascular disease		Staff provide person cente	red care to	
	and hypertension.			include responding to all re	esident needs	
		imum Data Set (MDS)		regardless of their assigne	d area.	
		erly MDS dated 7/30/15,				
		32 was cognitively intact.		Nurse Aide #4 is no longer	employed by	
		ted Resident #32 required		facility.		
		for bed mobility, transfers,				
		I hygiene; had impairment of		Corrective action will be ac	-	
	both upper and lower			those residents having pot		
	incontinent of bladde			affected by the same defic	ient practice:	
		Plan last updated 9/3/15		All regidents have the note	ntial to be	
		re for incontinence of bowel proaches included: " give		All residents have the pote affected.		
		ne resident is incontinent "		anecieu.		
		ontinence on routine rounds		All residents have an assig	ined nursing	
	and as needed ".			assistant each shift to mee	-	
		n Two NA (Nursing Assistant)				
	Assignment for 3 PM			Staff provide person cente	red care to	
	revealed there were			include responding to all re		
		the NA 's (NA #6) was listed		regardless of their assigne		
		PM instead of 3:00 PM.				
	-	e of the residents on her		Measures put into place or	systemic	
	assignment. There w	vas no indication on the		changes made to ensure t	-	
	assignment regarding	g who would take over the		practice will not occur:		
		or the other resident 's on				
		een 3:00 PM and 6:00 PM.		On September 17, 2015 th		
	On 9/16/15 at 4:44 P	M resident #32 was		nursing received directed i		
	-	heelchair near the nurse ' s		training by the administrate		
	station speaking on a			to reporting employee abs		
		(NA #1) was also observed		tardies. The Director of Nu		
	at this time and state	d to the resident " I know		absences and tardies imm	odiatoly to unit	1

Facility ID: 20040007

If continuation sheet Page 6 of 63

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	IPLF	CONSTRUCTION	1	D. 0938-03 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			· /	PLETED
							С
		345529	B. WING				17/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				52	201 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		R	RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 224	Continued From page	e 6	F 2	224			
		e person you had isn ' t here			manager and/or nurse on duty. Staffir	na	
	yet so they are redoir				assignments will be adjusted immediate		
	On 9/16/15 at 5:00 Pl	M Nursing Assistant #4 was			to ensure person centered care deliver	ry.	
		ring the resident to her room.					
	She placed a clean in	•			On September 17, 2015 education by		
		old the resident that the signed to her would be			Staff Development Coordinator began all nursing staff in reference to reportin		
	coming in at 6 PM.	signed to her would be			absences and tardies to the Director o	-	
	-	on 9/16/15 at 5:05 PM			Nursing. Education completed Octobe		
	revealed that she was	s aware the resident was wet			12, 2015. Staff members not receiving		
	and wanted incontine	nt care. She stated that it			service education by October 12, 2015	5 will	
		abit to return to the nurse ' s			be required to receive inservice educa	tion	
		and that Resident #32			prior to beginning of scheduled shift.		
		back to bed at that time and nt care. She stated that she			Education to include staff member physically speaking to the Director of		
		2 's assigned NA for the			Nursing. If Director of nursing is unabl	le to	
		as her roommate 's NA, and			be reached staff are to report to Staff		
		e roommate incontinent care.			Development Coordinator, Unit Manag	jer,	
	On 9/16/15 at 5:25 Pl	M Resident #32 was			Nursing Supervisor and/or Administrat		
		sitting in her wheel chair.			Education also includes upon arrival to		
		vas very wet and had not			facility staff are to initial beside their na		
		care since before lunch urine odor was noted at this			on assignment sheet to indicate that the	ney	
	• ·	tated that since around 4			have reported for duty. The Unit Manager, Supervisor and/or nurse on	dutv	
		eral NA 's that she wanted to			will complete assignment for nursing	aaty	
		aid they knew that she			assistants using a resident census at t	he	
	needed to be change	d. She added that she was			beginning of each shift to ensure all		
		to her (NA #6) would be in at			residents in the facility have an assign	ed	
		her back to bed when she			nursing assistant. The Unit Manager,	1.	
	arrived.	M NA#4 stated that she was			Supervisor and/or nurse on duty will ch		
		om to feed other residents			within thirty minutes of beginning of sh that all staff members have reported for		
		ined to Resident #32 would			duty. Assignments will be adjusted at		
	be in at 6 PM and tak				time if all staff members are not preser		
	On 9/16/15 at 5:45 Pl	M NA #3 was observed in			Staff provide person centered care to		
		n adjusting the resident ' s			include responding to all resident need	ls	
		dent #32 was observed in			regardless of their assigned area.		
		rview with NA #3 revealed			On Sontomber 17, 2015 - duration 1		
	unat she had not help	ed the resident to bed but			On September 17, 2015 education by		

Facility ID: 20040007

If continuation sheet Page 7 of 63

		MEDICAID SERVICES				<u> 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	E SURVEY PLETED
			A. BUILDING	i		
		245520				С
		345529	B. WING		09	/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NOR			5201 CLARKS FORK DRIVE		
				RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 224	Continued From pag	je 7	F 22	4		
		, ake Resident #32 on her		Staff Development Coordinator b	egan for	
		asn ' t sure what time she		all nursing staff in reference to re	-	
		it was just before the dinner		absences and tardies to the Direct		
		. NA #3 added that she had		Nursing. Education completed C	ctober	
		pressing needs at that time		12, 2015. Staff members not rec	-	
		put Resident #32 back to		service education by October 12,		
	-	sident incontinent care,		be required to receive inservice e		
		lining room to help feed other		prior to beginning of scheduled s		
	residents.			Education to include staff member		
		PM Nurse #3 was interviewed.		physically speaking to the Director		
		nd 5:00 PM she had become #32 ' s NA (NA #6) was not		Nursing. If Director of nursing is be reached staff are to report to \$		
		6 PM, for the 3 - 11 PM shift.		Development Coordinator, Unit N		
		ound out NA #6 had not		Nursing Supervisor and/or Admir	-	
		sident #32 was asking who		Education also includes upon arr		
	-	e she wanted to go back to		facility staff are to initial beside th		
		Illed it was around 5:00 PM		on assignment sheet to indicate t		
	because one of the	NA ' s said the dinner trays		have reported for duty. The Unit		
	would be out soon s	o they might as well wait until		Manager, Supervisor and/or nurs		
	NA #6 came in at 6:	00 PM, as it wouldn ' t be long		will complete assignment for nurs	sing	
	and NA #6 could take care of Resident #32 then.			assistants using a resident censu	is at the	
		she had informed the NA		beginning of each shift to ensure		
		eded an assigned NA in the		residents in the facility have an a	-	
		ir care needs would be met		nursing assistant. The Unit Mana	-	
		eadjust the assignment. She		Supervisor and/or nurse on duty		
		olunteered to have Resident		within thirty minutes of beginning		
	#32 on her assignm	AM Resident #32 was		that all staff members have repor duty. Assignments will be adjust		
		ng room awaiting her lunch		time if all staff members are not p		
		Resident #32 at this time		Staff provide person centered ca		
		like being left wet in her		include responding to all resident		
		ng the previous evening while		regardless of their assigned area		
		was going to take care of				
		tired and soaking wet and just		The Director of Nursing, Staff		
		bed and it made her feel		Development Coordinator, Unit M	lanager	
	bad to wait so long.			and/or Supervisor will check assi	-	
	On 9/17/15 at 2:00 F	PM interview with		sheets daily x 4 weeks, weekly x		
	Administrative Staff	#1 revealed that NA#6 had		and then monthly x 3 months to e		
		ning of 9/16/15, that she		staff have initialed that they have		1

Facility ID: 20040007

If continuation sheet Page 8 of 63

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/19/201 MAPPROVE: 0.0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			09	C / <b>17/2015</b>
NAME OF PR	ROVIDER OR SUPPLIER	•	•	ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				52	201 CLARKS FORK DRIVE		
UNIVERSA	AL HEALTH CARE/NOR			R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	Continued From page		F 2	224			
	11:00 PM shift until 6 #1 indicated that she adjust the assignmen	come in for the 3:00 PM - :00 PM. Administrative Staff got busy and neglected to it to ensure each resident and that they would receive			for duty and that assignment was completed accurately to reflect staff th have reported for duty and that all residents have an assigned nursing assistant.	at	
	Administrative Staff # Staff #2 had already to address this issue to monitor staffing co	41 added that Administrative done a reeducation with her and had put a plan in place verage through the Quality rmance Improvement			Assignment sheets will be given to the Administrator for review daily x 4 weel weekly x 4 weeks and then monthly x months.	ks,	
	diagnoses including on hypertension.				On September 25, 2015 education be for all nursing staff in reference to providing assistance with ADL¿s and person centered care to include	gan	
	Assessment, a Quart revealed Resident #1 also revealed the res	mum Data Set (MDS) erly MDS dated 7/9/15, 8 was cognitively intact. It ident required extensive			responding to all resident needs regardless of assigned area. The Director of Nursing, Staff Development Coordinator, Unit Manag	ger,	
	for eating, for which s	tivities of daily living except she required supervision. ted Resident #18 was and bladder.			and/or Nursing Supervisor will comple walking rounds daily to include off shif and weekends to ensure that nursing are meeting the needs of all residents	īts staff	
	Review of the Station Assignment for 3 PM	on Two NA (Nursing Assistant)including incontinent care.M - 11 PM on 9/16/15Walking rounds will continue daily statements					
	as coming in at 6:00 Resident #18 was on assignment. There w	PM instead of 3:00 PM. e of the residents on her vas no indication on the			Facility plans to monitor its performant to make sure that solutions are sustain		
	care of Resident #18 her assignment betw	g who would take over the or the other resident ' s on een 3:00 PM and 6:00 PM. M Nurse #3 was interviewed.			The facility must develop a plan for ensuring that correction is achieved an sustained:	nd	
	She stated she had b was not going to be la 11 PM shift at around	become aware that NA #6 ate coming in for the 3 PM - I 5:00 PM. She added that			The Director of Nursing will report find of the assignment sheet checks and summary of walking rounds to the Qua	-	
	-	ssistants had suggested that ait until 6 PM when NA #6			Assurance and Performance Improvement Committee monthly for s	six	

Facility ID: 20040007

If continuation sheet Page 9 of 63

	S FOR MEDICARE &					<u>VO. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345529	B. WING			9/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		5/11/2010
				5201 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 224	Continued From page	e 0	F 22	4		
1 227			F 22		ompliance is	
	was expected to arrive since it was almost d time and NA #6 would be there soon. Nurse stated that she had informed the NA that all residents needed an assigned NA in the faci ensure their care needs would be met and th	d be there soon. Nurse #3		months or until a pattern of c achieved.	compliance is	
		assigned NA in the facility to		Date of Completion October	15, 2015.	
sh	she would readjust th	ne assignment.				
	On 9/17/15 at 2:00 P					
1 \ 7		#1 revealed that NA#6 had ing of 9/16/15, that she				
		come in for the 3:00 PM -				
		:00 PM. Administrative Staff				
	#1 indicated that she	got busy and neglected to				
		nt to ensure each resident				
	had an assigned NA	and that they would receive				
	the care they needed					
		#1 added that Administrative				
	-	done a reeducation with her				
		and had put a plan in place				
		overage through the Quality formance Improvement				
	program.					
		admitted 11/26/16 and had				
		anemia and hypertension.				
		gen for a respiratory disease.				
	The most recent Mini	imum Data Set (MDS)				
		terly MDS dated 7/2/15,				
		55 was cognitively intact. It				
		ident required extensive				
		ng, bed mobility, transfers				
		e, as well as supervision for to indicated Resident # 55				
		tinent of bowel ad bladder.				
		Two NA (Nursing Assistant)				
	Assignment for 3 PM					
	revealed there were					
		the NA 's (NA #6) was listed				
	-	PM instead of 3:00 PM.				
	Posidont #55 was on	a af the superior states and have				
		e of the residents on her vas no indication on the				

Facility ID: 20040007

If continuation sheet Page 10 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 10/19/2015 ORM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3) D	DATE SURVEY OMPLETED
		345529	B. WING				C 09/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP COD	E	
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH			1 CLARKS FORK DRIVE LEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 224	care of Resident #55 her assignment betwin On 9/16/15 at 6:50 Pl She stated she had b was not going to be la 11 PM shift at around one of the Nursing As the residents could w was expected to arrive time and NA #6 would stated that she had in residents needed an ensure their care need she would readjust th On 9/17/15 at 2:00 Pl Administrative Staff # told her, on the morni would not be able to a 11:00 PM shift until 6 #1 indicated that she adjust the assignment had an assigned NA at the care they needed Administrative Staff # Staff #2 had already of to address this issue to monitor staffing con Assurance and Perfor program. 4. Resident #27 was had diagnoses includ and arthritis. The most recent Mini Assessment, an Annu revealed Resident # 2 and required extension	g who would take over the or the other resident 's on een 3:00 PM and 6:00 PM. M Nurse #3 was interviewed. become aware that NA #6 ate coming in for the 3 PM - 15:00 PM. She added that sisistants had suggested that at until 6 PM when NA #6 re since it was almost dinner d be there soon. Nurse #3 nformed the NA that all assigned NA in the facility to eds would be met and that he assignment. M interview with f1 revealed that NA#6 had ing of 9/16/15, that she come in for the 3:00 PM - :00 PM. Administrative Staff got busy and neglected to it to ensure each resident and that they would receive until NA #6 arrived. f1 added that Administrative done a reeducation with her and had put a plan in place verage through the Quality rmance Improvement admitted on 4/17/12 and ing diabetes, hypertension mum Data Set (MDS) ual MDS dated 6/9/15 27 was cognitively impaired ve assistance with bed d personal hygiene, as well	F	224			

Facility ID: 20040007

If continuation sheet Page 11 of 63

			()(0)			
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	· · /	E SURVEY IPLETED
			A. BUILDING	i		
		345529	B. WING			C
		545525				/17/2015
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	L HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE		
				RALEIGH, NC 27616		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 224	Continued From page	e 11	F 22	4		
			1 22	-		
	indicated Resident #27 was always incontinent of bowel and bladder.					
		Two NA (Nursing Assistant)				
	Assignment for 3 PM					
	revealed there were 6 NA's listed on the					
	assignment. One of the NA 's (NA #6) was listed					
		PM instead of 3:00 PM.				
	•	e of the residents on her				
		vas no indication on the				
		g who would take over the				
	• • •	or the other resident 's on				
	her assignment betwe	een 3:00 PM and 6:00 PM.				
	-	M Nurse #3 was interviewed.				
	She stated she had b	become aware that NA #6				
	was not going to be la	ate coming in for the 3 PM -				
	11 PM shift at around	5:00 PM. She added that				
	one of the Nursing As	ssistants had suggested that				
	the residents could w	ait until 6 PM when NA #6				
	was expected to arriv	e since it was almost dinner				
	time and NA #6 would	d be there soon. Nurse #3				
	stated that she had in	nformed the NA that all				
	residents needed an	assigned NA in the facility to				
	ensure their care nee	eds would be met and that				
	she would readjust th					
	On 9/17/15 at 2:00 P	M interview with				
		1 revealed that NA#6 had				
		ing of 9/16/15, that she				
		come in for the 3:00 PM -				
		:00 PM. Administrative Staff				
		got busy and neglected to				
		t to ensure each resident				
		and that they would receive				
	the care they needed					
		added that Administrative				
		done a reeducation with her				
t	to address this issue	and had put a plan in place				
	-	verage through the Quality rmance Improvement				

If continuation sheet Page 12 of 63

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 10/19/2015 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DA	ITE SURVEY MPLETED
		345529	B. WING			(	C 09/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				520	01 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		RA	LEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	5. Resident #104 wa diagnoses including of arthritis and anxiety. under the care of hos The most recent Mini Significant Change M Resident #104 was of requires extensive as toileting and personal totally dependent for MDS also indicated F incontinent of bowel a Review of the Station Assignment for 3 PM revealed there were 6 assignment. One of the as coming in at 6:00 I Resident #104 was of as coming in at 6:00 I Resident #104 was of assignment. There was assignment regarding care of Resident #104 her assignment betwee On 9/16/15 at 6:50 PI She stated she had b was not going to be la 11 PM shift at around one of the Nursing As the residents could w was expected to arriv time and NA #6 would stated that she had in residents needed an ensure their care need she would readjust th On 9/17/15 at 2:00 PI Administrative Staff # told her, on the mornin would not be able to a	s admitted 5/1/13 and had congestive heart failure, Resident #104 was also pice services. mum Data Set (MDS), a IDS dated 7/28/15 revealed ognitively impaired and sistance for bed mobility, I hygiene, she was also transfers and eating. The Resident #104 was and bladder. Two NA (Nursing Assistant) - 11 PM on 9/16/15 5 NA ' s listed on the the NA ' s (NA #6) was listed PM instead of 3:00 PM. ne of the residents on her vas no indication on the g who would take over the 4 or the other resident ' s on een 3:00 PM and 6:00 PM. M Nurse #3 was interviewed. ecome aware that NA #6 ate coming in for the 3 PM - 5:00 PM. She added that asistants had suggested that ait until 6 PM when NA #6 re since it was almost dinner d be there soon. Nurse #3 aformed the NA that all assigned NA in the facility to vds would be met and that re assignment.	F	224			

Facility ID: 20040007

If continuation sheet Page 13 of 63

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 10/19/2015 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345529	B. WING				C / <b>17/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				52	01 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		R/	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	adjust the assignment had an assigned NA the care they needed Administrative Staff # Staff #2 had already to address this issue to monitor staffing co Assurance and Perfor program. 6. Resident #132 was diagnoses including h Alzheimer 's disease Review of the most re (MDS), an Admission Resident #132 had m significantly impaired also revealed Reside assistance for bed m toileting and persona indicated Resident #7 of bladder and freque Review of the Station Assignment for 3 PM revealed there were 6 assignment. One of as coming in at 6:00 Resident #132 was o assignment. There w assignment regarding care of Resident #132 her assignment betwe On 9/16/15 at 6:50 P She stated she had b was not going to be la 11 PM shift at around	got busy and neglected to the to ensure each resident and that they would receive until NA #6 arrived. I added that Administrative done a reeducation with her and had put a plan in place verage through the Quality rmance Improvement as admitted 8/3/15 and had hypertension, arthritis and s. ecent Minimum Data Set MDS dated 9/7/14 revealed nemory problems and decision making. The MDS nt #132 required extensive obility, transfers, eating, I hygiene. The MDS further 132 was always incontinent ently incontinent of bowel. Two NA (Nursing Assistant) - 11 PM on 9/16/15	F	224			
	the residents could w	ait until 6 PM when NA #6 e since it was almost dinner					
							1

Facility ID: 20040007

If continuation sheet Page 14 of 63

	-	ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 10/19/201 ORM APPROVE NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		DNSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345529	B. WING				09/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP COD	E	
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH			CLARKS FORK DRIVE EIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 224	stated that she had in residents needed an ensure their care needs she would readjust th On 9/17/15 at 2:00 Pl Administrative Staff # told her, on the morn would not be able to 11:00 PM shift until 6 #1 indicated that she adjust the assignment had an assigned NA the care they needed Administrative Staff # Staff #2 had already to address this issue to monitor staffing co Assurance and Perfor program. 7. Resident #31 was diagnoses including of hypertension. Review of the most re (MDS) Assessment, a 6/9/15, revealed Resi problems and signific making. The MDS al required extensive as transfers, toileting an as limited assistance indicated Resident #3 of bowel and bladder Review of the Station Assignment for 3 PM revealed there were 6 assignment. One of as coming in at 6:00	d be there soon. Nurse #3 formed the NA that all assigned NA in the facility to eds would be met and that he assignment. M interview with 41 revealed that NA#6 had ing of 9/16/15, that she come in for the 3:00 PM - :00 PM. Administrative Staff got busy and neglected to and that they would receive 1 until NA #6 arrived. 41 added that Administrative done a reeducation with her and had put a plan in place verage through the Quality rmance Improvement admitted 10/15/13 and had dementia, anxiety and ecent Minimum Data Set a Quarterly MDS dated ident #31 had memory cantly impaired decision so revealed Resident #31 ssistance for bed mobility, d personal hygiene, as well for eating. The MDS further 31 was frequently incontinent Two NA (Nursing Assistant) - 11 PM on 9/16/15	F 2	224			

Facility ID: 20040007

If continuation sheet Page 15 of 63

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/1 FORM APPF OMB NO. 0938	ROVE	
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y	
		345529	B. WING		C 09/17/2015		
NAME OF PF	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP COE	DE		
	AL HEALTH CARE/NOR	TH RALEIGH		201 CLARKS FORK DRIVE			
				ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMP E APPROPRIATE D	(X5) PLETION DATE	
F 224	Continued From page	e 15	F 224				
1 22 1		vas no indication on the	F 224				
	-	g who would take over the					
	• • •	or the other resident 's on					
	•	een 3:00 PM and 6:00 PM.					
		M Nurse #3 was interviewed.					
		become aware that NA #6 ate coming in for the 3 PM -					
	•••	5:00 PM. She added that					
		ssistants had suggested that					
		ait until 6 PM when NA #6					
		ve since it was almost dinner					
		d be there soon. Nurse #3 nformed the NA that all					
		assigned NA in the facility to					
		eds would be met and that					
	she would readjust th	-					
	On 9/17/15 at 2:00 P						
		#1 revealed that NA#6 had ing of 9/16/15, that she					
		come in for the 3:00 PM -					
		:00 PM. Administrative Staff					
		got busy and neglected to					
		nt to ensure each resident					
	had an assigned NA the care they needed	and that they would receive					
	•	1 added that Administrative					
		done a reeducation with her					
	to address this issue	and had put a plan in place					
		verage through the Quality prmance Improvement					
	program.						
F 241 SS=D	483.15(a) DIGNITY A INDIVIDUALITY	AND RESPECT OF	F 241		10/15	5/15	
		note care for residents in a					
		vironment that maintains or					
	enhances each resid	ent's dignity and respect in					
	full recognition of his						

Facility ID: 20040007

If continuation sheet Page 16 of 63

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 10/19/20′ RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONS		(X3) DATE SURVEY COMPLETED C	
		345529	B. WING			0	9/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		0/11/2010
	AL HEALTH CARE/NORT	H RALEIGH			ARKS FORK DRIVE		
	-			RALEIG	GH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 241	Continued From page	9 16	F	241			
	by: Based on observatio	is not met as evidenced n, record review, resident		F24	41		
	resident with dignity b to provide incontinent known to have been i sampled residents (R	e facility failed to treat a by taking more than an hour care, to a resident who was ncontinent for 1 of 3 esident #32) reviewed for knock before entering a		the by t	rective action will be accomplish resident found to have been aff the deficient practice: sident #32 is receiving incontine	ected	
	resident room for 1 of during wound care (R included:	<sup>1</sup> 1 residents observed esident #119). The findings readmitted 10/1/14. The		Res	sident #119 staff are knocking o l asking permission prior to ente resident¿s room.	n door	
	and hypertension. The most recent Mini Assessment, a Quart	osis, cardio vascular disease mum Data Set (MDS) erly MDS dated 7/30/15, 2 was cognitively intact.		re-e kno	rsing Assistant #2 was counsele educated on resident privacy to ocking on door and asking permi or to entering the resident¿s roo	include ission	
	The MDS also indicat extensive assistance toileting and personal both upper and lower	ed Resident #32 required for bed mobility, transfers, hygiene; had impairment of extremities and was		thos affe	rective action will be accomplisi se residents having potential to ected by the same deficient prac	be tice:	
	revealed a plan of car	and bowel. lan last updated 9/3/15 re for incontinence of bowel proaches included: " give		affe	residents have the potential to b ected. residents have an assigned nurs		
	perineal care when th and " assess for inco and as needed " .	e resident is incontinent " ntinence on routine rounds		ass Res	istant each shift to meet their ne	eeds.	
	would cut off her call	ted that staff frequently light and say they would be		Stat	L¿s including incontinent care. ff are knocking on resident door		
	they wouldn ' t come	else to help them but then back at all or it would take a esident attributed this in part			ing permission prior to entering ident¿s room.	the	
		ff often needed another NA		Mea	asures put into place or systemi	с	

Facility ID: 20040007

If continuation sheet Page 17 of 63

							M APPROVE <u>     0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345529	B. WING				C /17/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				52	201 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIOI DATE
F 241	Continued From page	e 17	F	241			
			1	241	changes made to ensure that the det	liciont	
		because she was heavy lived getting her in or out of			changes made to ensure that the def practice will not occur:		
		ind one of two mechanical					
		d another staff member to			On September 17, 2015 education b	eaan	
		ed that she always had a			for all nursing staff in reference to	- 30	
		the staff rotated taking care			reporting absences and tardies to the	e	
	of her and they seem	ed like they didn ' t want to			Director of Nursing. Education to inc	lude	
	do her care because	they were worried they			staff member physically speaking to	the	
	would hurt their back				Director of Nursing. If Director of nur		
	On 9/16/15 at 4:44 P				is unable to be reached staff are to re		
		heelchair near the nurse 's			to Staff Development Coordinator, U		
	station speaking on a				Manager, Nursing Supervisor and/or		
	•	(NA #3) was also observed			Administrator. Education also includ		
		d to the resident "I know			upon arrival to facility staff are to initi		
	yet so they are redoir	e person you had isn ' t here			beside their name on assignment sho indicate that they have reported for d		
		Two NA (Nursing Assistant)			The Unit Manager, Supervisor and/o		
	Assignment for 3 PM				nurse on duty will check within thirty		
	revealed there were				minutes of beginning of shift that all s	staff	
		the NA 's (NA #6) was listed			members have reported for duty.		
		PM instead of 3:00 PM. She			Assignments will be adjusted at that	time	
	-	ent #32 as well as other			if all staff members are not present.		
	-	s no indication on the			provide person centered care to inclu	ude	
		g who would take over the			responding to all resident needs		
		assigned to NA #6 between			regardless of their assigned area.		
	3:00 PM and 6:00 PM						
		M Nursing Assistant #4 was			The Director of Nursing, Staff		
		ving the resident to her room.			Development Coordinator, Unit Mana		
		ncontinent pad on the old the resident that the			and/or Supervisor will check assignm		
		signed to her (NA #6) would			sheets daily x 4 weeks, weekly x 4 w and then monthly x 3 months to ensu		
	be coming in at 6 PM				staff have initialed that they have rep		
	-	on 9/16/15 at 5:05 PM			for duty and that assignment was	0100	
		s aware the resident was wet			completed accurately to reflect staff t	hat	
		ck to bed. She stated that it			have reported for duty and that all		
		abit to return to the nurse 's			residents have an assigned nursing		
		and that Resident #32			assistant.		
	always wanted to go	back to bed at that time and					
		ent care. NA #4 stated that			Assignment sheets will be given to th		

Facility ID: 20040007

If continuation sheet Page 18 of 63

	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION	OMB NC	
	CORRECTION	IDENTIFICATION NUMBER:	· · /				PLETED
							С
		345529	B. WING			09/	17/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
JNIVERS	AL HEALTH CARE/NORT	TH RALEIGH			201 CLARKS FORK DRIVE ALEIGH, NC 27616		
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIO DATE
F 241	Continued From page	e 18	F 2	21			
		t #32 ' s assigned NA for the			Administrator for review daily x 4 weeks	e	
		as her roommate 's NA, and			weekly x 4 weeks and then monthly x 3		
	-	e roommate incontinent care.			months.		
	On 9/16/15 at 5:25 Pl						
		sitting in her wheel chair.			On September 25, 2015 education beg	an	
		vas very wet and had not			for all nursing staff in reference to		
		care since before lunch			providing assistance with ADL¿s includ		
	- · ·	urine odor was noted at this			incontinent care to be given at least even		
		tated that since around 4			2-3 hours, as requested by the resident		
		eral NA 's that she wanted to aid they knew that she			family member and as needed for visual signs of soiling and person centered ca		
	-	d. She added that she was			to include responding to all resident ne		
	told the NA assigned	to her (NA #6) would be in at her back to bed when she			regardless of assigned area.	646	
		2 also said that she was			The Director of Nursing, Staff		
		turns taking her on their			Development Coordinator, Unit Manage		
		she was physically heavy,			and/or Supervisor will complete walking	9	
		al lift for transfers, and			rounds daily to include off shifts and		
		t it took a long time to do her			weekends to ensure that nursing staff a	are	
		s so particular. Resident			meeting the needs of all residents		
	-	ncontinent care, unless it			including incontinent care.		
		nd the staff member said le to get her up again if they			Walking rounds will continue daily x 4		
	put her back to bed for				weeks and weekly thereafter.		
		M NA#4 stated that she was			,,		
		om to feed other residents			On September 25, 2015 education beg	an	
	and that NA #6 would	I be in at 6 PM and take care			for all staff as it relates to dignity and		
	of Resident #32 then.				privacy. Education to include knocking		
		M NA #3 was observed in			doors and asking permission to enter p	rior	
		n adjusting the resident 's			to entering a resident room.		
		dent #32 was observed in rview with NA #3 revealed			The Administrator Director of Nursian		
		ed the resident to bed but			The Administrator, Director of Nursing, Staff Development Coordinator, Unit		
		ke Resident #32 on her			Manager, Nursing Supervisor and/or		
		sn ' t sure what time she			Manager on Duty will make daily round	s	
	-	it was just before the dinner			to include off shifts and weekends to	-	
		NA #3 added that she had			ensure that staff are promoting dignity l	by	
	-	pressing needs at that time			knocking on doors and asking permissi	-	
		ut Resident #32 back to	1		to enter prior to entering a resident room		1

Facility ID: 20040007

If continuation sheet Page 19 of 63

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:		G		IPLETED
						С
		345529	B. WING	·····	09	0/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
				5201 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 241	Continued From page	e 19	F 24	41		
		ident incontinent care,		Daily rounds will continue	e dailv x 4 weeks.	
		ining room to help feed other		weekly x 4 weeks and the		
	residents.	•		months.	-	
		M Nurse #3 was interviewed.				
		nd 5:00 PM she had become		Facility plans to monitor i		
		#32 ' s NA (NA #6) was not		to make sure that solution		
		6 PM, for the 3 - 11 PM shift. und out NA #6 had not		The facility must develop ensuring that correction i		
		sident #32 was asking who		sustained:	s achieved and	
		she wanted to go back to				
		led it was around 5:00 PM		The Director of Nursing v	vill report findings	
	because one of the N	IA ' s said the dinner trays		of the assignment sheet	checks to the	
		they might as well wait until		Quality Assurance and P		
		0 PM, as it wouldn ' t be long		Improvement Committee		
		e care of Resident #32 then. she had informed the NA		months or until a pattern achieved.	or compliance is	
		ded an assigned NA in the		achieved.		
	facility and that she w			The Director of Nursing v	vill report the	
		#3 volunteered to have		summary of walking roun	-	
		assignment at that time.		Assurance and Performa	ince	
		AM Resident #32 was		Improvement Committee	•	
		g room awaiting her lunch		months or until a pattern	of compliance is	
		Resident #32 at this time		achieved.		
		like being left wet in her g on 9/16/14 while they		The Administrator will rep	ort the findings	
		going to take care of her.		of the dignity rounds to th	•	
		nd soaking wet and just		Assurance and Performa		
	wanted to go back to	bed and it made her feel		Improvement Committee	monthly for six	
	bad to wait so long.			months or until a pattern	of compliance is	
	On 9/17/15 at 2:00 P			achieved.		
		1 revealed that NA #6 had		Data of completion: Octo	abor 15, 2015	
		ing of 9/16/15, that she come in for the 3:00 PM -		Date of completion: Octo	JUCI 10, 2010	
		:00 PM. Administrative Staff				
		got busy and neglected to				
		t to ensure each resident				
	had an assigned NA	and that they would receive				
	the care they needed					
	Administrative Staff #	41 added that Administrative				

Facility ID: 20040007

If continuation sheet Page 20 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345529	B. WING				C 17/2015
NAME OF PI	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
UNIVERS	AL HEALTH CARE/NORT	'H 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 241	to address this issue to monitor staffing cov Assurance and Perfor program. 2. Resident # 119 was 5/29/13 with multiple Alzheimer's disease. Data Set (MDS) asse indicated that Resider cognition and had a p On 9/16/15 at 2:55 PI observed during a dre treatment nurse was the pressure ulcer, N entered the room with permission to enter th to enter the room and the bed of the roomm On 9/16/15 at 2:58 PI interviewed. She staf staff to knock on the o added that she alread knocking and asking room. On 9/17/15 at 3:30 PI He stated that he forg before entering. He staff	done a reeducation with her and had put a plan in place verage through the Quality rmance Improvement s admitted to the facility on diagnoses including The quarterly Minimum ssment dated 8/13/15 nt #119 had impaired oressure ulcer. M, Resident #119 was essing change. While the providing the treatment to A #2 opened the door and nout knocking or asking ne room. He was observed I put a disposable brief to late.	F	241			
F 253 SS=E	483.15(h)(2) HOUSE		F	253			10/15/15
	The facility must prov	ide housekeeping and					

Facility ID: 20040007

If continuation sheet Page 21 of 63

-					FOR	D: 10/19/2015 MAPPROVED D. 0938-0391	
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COMF	PLETED	
	345529	B. WING				C 1 <b>17/2015</b>	
	TH RALEIGH	1	52	201 CLARKS FORK DRIVE		03/11/2013	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I	ЗE	(X5) COMPLETION DATE	
maintenance services sanitary, orderly, and	s necessary to maintain a comfortable interior.	F	253				
by: Based on observation staff interviews, the far shower rooms that we in 2 of 2 resident shor included: During an interview of Resident #115 he stat towel on the floor to st were so dirty in the st there was mold/mildet that there were flies a rooms that he would a sprayer to get them of	n, resident interviews and acility failed to maintain ere clean and in good repair wer rooms. The findings on 9/15/15 at 11:15AM with ted that he had staff put a stand on because the floors hower room. He stated that ew in the showers. He stated and gnats in the shower spray with his hand-held			<ul> <li>the resident found to have been affect by the deficient practice:</li> <li>Shower rooms for unit 1 and unit 2 we deep cleaned by housekeeping.</li> <li>Pest control service treated facility including shower rooms on unit 1 and 2 on September 15, 2015 for pests. F control returning to treat facility including shower rooms on unit 1 and unit 2 on</li> </ul>	ed re unit 'est		
Observations of the s 9/15/15 at 11:42 AM. A. The shower room 400 halls was observ -There were 2 pillows pair of soiled gray sw upholstered chair in t were loose and not in (NA) #2 saw the pillow stated she did not know that they shouldn't be items from the bathroo -A used bed sheet an ball in the tub. They There was a light broo towel.	that serviced the 300 and ed: s, without pillow cases, and a reatpants sitting in an he shower room. All items a plastic bag. Nurse Aide ws and sweatpants and ow whose they were and e in the chair. She removed hom. Id white towel were lying in a were not in a plastic bag. wn stain observed on the			<ul> <li>Shower curtains were placed in shower rooms on unit 1 and unit 2.</li> <li>Maintenance will replace all broken tile unit 1 and unit 2 shower rooms.</li> <li>Maintenance will repair in plumbing in 1 and unit 2 shower rooms.</li> <li>Corrective action will be accomplished those residents having potential to be affected by the same deficient practice.</li> <li>All residents have the potential to be affected.</li> </ul>	e to unit I for e:		
	S FOR MEDICARE & S FOR MEDICARE & S FOR DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER AL HEALTH CARE/NORT SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page maintenance services sanitary, orderly, and This REQUIREMENT by: Based on observatio staff interviews, the fa shower rooms that we in 2 of 2 resident sho included: During an interview of Resident #115 he stat towel on the floor to s were so dirty in the sl there was mold/milded that there were flies a rooms that he would sprayer to get them of was in there. Observations of the s 9/15/15 at 11:42 AM. A. The shower room 400 halls was observer -There were 2 pillows pair of soiled gray sw upholstered chair in t were loose and not in (NA) #2 saw the pillor stated she did not known that they shouldn't be items from the bathrop -A used bed sheet and ball in the tub. They There was a light brootowel.	CORRECTION       IDENTIFICATION NUMBER:         345529         ROVIDER OR SUPPLIER         AL HEALTH CARE/NORTH RALEIGH         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 21 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.         This REQUIREMENT is not met as evidenced by:         Based on observation, resident interviews and staff interviews, the facility failed to maintain shower rooms that were clean and in good repair in 2 of 2 resident shower rooms. The findings included:         During an interview on 9/15/15 at 11:15AM with Resident #115 he stated that he had staff put a towel on the floor to stand on because the floors were so dirty in the shower room. He stated that there was mold/mildew in the showers. He stated that there were flies and gnats in the shower rooms that he would spray with his hand-held sprayer to get them out of the shower while he was in there.         Observations of the shower rooms were made on 9/15/15 at 11:42 AM. A. The shower room that serviced the 300 and 400 halls was observed: -There were 2 pillows, without pillow cases, and a pair of soiled gray sweatpants sitting in an upholstered chair in the shower room. All items were loose and not in a plastic bag. Nurse Aide (NA) #2 saw the pillows and sweatpants and stated she did not know whose they were and that they shouldn't be in the chair. She removed items from the bathroom. -A used bed sheet and white towel were lying in a ball in the tub. They were not in a plastic bag. There was a light brown stain observed on the	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILD         345529       B. WING         ROVIDER OR SUPPLIER       345529       B. WING         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREF TAG         Continued From page 21       F         maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.       F         This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews and staff interviews, the facility failed to maintain shower rooms that were clean and in good repair in 2 of 2 resident shower rooms. The findings included:       During an interview on 9/15/15 at 11:15AM with Resident #115 he stated that he had staff put a towel on the floor to stand on because the floors were so dirty in the shower room. He stated that there was mold/mildew in the shower. He stated that there were flies and gnats in the shower rooms that he would spray with his hand-held sprayer to get them out of the shower while he was in there.       Observations of the shower room. All items were loose and not in a plastic bag. Nurse Aide (NA) #2 saw the pillows, without pillow cases, and a pair of soiled gray sweatpants sitting in an upholstered chair in the shower room. All items were loose and not in a plastic bag. Nurse Aide (NA) #2 saw the pillows and sweatpants and stated she did not know whose they were and that they shouldn't be in the chair. She removed items from the bathroom. -A used bed sheet and white towel were lying in a ball in the tub. They were no	S FOR MEDICARE & MEDICAID SERVICES         pr DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING	S FOR MEDICARE & MEDICAID SERVICES         0 FORMEDINOUS       (x1) PROVIDERSPECTION         0 STREETADDRESS, CITY, STATE, ZIP CODE         345529       8. WING         200/DER OR SUPPLIER       STREETADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES       STREETADDRESS, CITY, STATE, ZIP CODE         RESULATORY OR LSC DEMTFYING INFORMATION       PROVIDERS PLAN OF CORRECTIVE ACTION INSUES PLAN OF CORRECTIVE ACTION INSUED PROVIDERS PLAN OF CORRECTIVE ACTION INSUED IN	WENT OF HEALTH AND HUMAN SERVICES       FOR MEDICARE & MEDICALD SERVICES       ONB NC         SP DERICENCIES       ONB NC       OND NC       OND NC         PEDERICENCIES       OND NC       NUM       STREET ADDRESS, CITY, STREET ADDRESS, CITY	

Facility ID: 20040007

If continuation sheet Page 22 of 63

	TATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		. ,			(X3) DATE SURVEY COMPLETED		
			A. DOILD	- <sup>1</sup>		с		
		345529	B. WING			09	/17/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	AL HEALTH CARE/NORT			5	201 CLARKS FORK DRIVE			
UNIVERS	AL HEALTH CARE/NORT	H KALEIGH		F	RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 253	Continued From page	<u>&gt;</u> 22	F	253				
		er inspection, there was		200	for all nursing staff in reference to			
	urine and a moderate				cleanliness of shower rooms. Education	n		
		timeters) in the toilet upon			to include removing all items including	~		
		I on. There was no toilet			dirty linen, trash and soiled items from	the		
		nere were broken tiles at the			shower room and cleaning up of waste			
		ea that continued into the ne right in a 2 inch by 6 inch			and/or spills immediately.			
	area.				Housekeeping will check shower room	s		
		l on the right had no shower			three times daily in reference to			
		ried hair on top of the drain			cleanliness at the beginning of shift, mi	id		
	in the floor.				shift and end of shift. Checks will			
		I on the left had a white,			continue ongoing.			
		ring the drain in the floor in			The Director of Nursing Staff			
	a 3 foot by 1 foot area	ostance collected in a corner			The Director of Nursing, Staff Development Coordinator, Unit Manag	or		
		ong floor tiles throughout the			and/or supervisor will make rounds dai			
		web with a spider was			to include off shifts and weekends to	'y		
	located in the left corr	-			monitor cleanliness of shower rooms a	nd		
	-The last shower stall	on the right had water			any areas in need of repair. Shower ro	om		
		from the shower head at a			rounds will be done daily x 4 weeks,			
		op every second. There			weekly x 4 weeks and then monthly x 3	3		
	•	" tape across the entrance			months.			
		dew/mold was noted in the						
		an area of broken tiles in an			The Maintenance supervisor will monit			
	approximately 2 squa				shower rooms on unit 1 and unit 2 wee	-		
	B. The shower room 200 halls was observed	that serviced the 100 and			for needed repairs. Rounds will continu			
		eo: r stalls with curtains. Water			ongoing with preventative maintenance rounds.	-		
	was dripping from bot							
	curtains.				Measures put into place or systemic			
		l/mildew covering the bottom			changes made to ensure that the defici	ient		
	tiles in the shower sta				practice will not occur:			
	-There were broken ti	iles across the bottom of the						
	rear wall of the showe				On September 25, 2015 education beg	jan		
		ducted with the Account			for all nursing staff in reference to			
	-	at 12:03 PM. The Account			cleanliness of shower rooms. Education	on		
		ne was the Housekeeping			to include removing all items including			
	-	that there were 2 shower he 100/200 hall shower			dirty linen, trash and soiled items from shower room and cleaning up of waste			

Facility ID: 20040007

If continuation sheet Page 23 of 63

TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DA	<u>IO. 0938-039</u> TE SURVEY MPLETED
		0.45500	B. WING			С
		345529	D. WING			9/17/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETION DATE
F 253	Continued From page	e 23	F 25	53		
			1 20			
		0 hall shower room). He nower rooms were utilized.		and/or spills immediately.		
				The Director of Nursing, Sta	ff	
	An interview with the	Maintenance Director was		Development Coordinator, U		
		5 at 10:30AM. He stated that		and/or supervisor will make	•	
	3 of the 4 shower sta	lls in the 100/200 hall		to include off shifts and weel	kends to	
	shower room were be	eing utilized and 3 of the 4		monitor cleanliness of showe		
		00/400 hall shower room		any areas in need of repair.	•	
	-	He stated that there were 4		will be done daily x 4 weeks,		
		e 100/200 hall shower room		weeks and then monthly x 3	months.	
		hall shower room) that have				
		with tiles breaking. He		Shower rooms will be checked during Quality Assurance Ro		
		east 7 years he had been en they broke, but they		for cleanliness and areas in		
	· •	the same places. He stated		repair. Checks will continue		
		ape had been secured in the			0	
		room for over a month. He		Housekeeping will check sho	ower rooms	
	revealed that plumbir	ng issues had also been		three times daily in reference		
	ongoing for several n	nonths. He stated that he		cleanliness and areas in nee	d of repair at	
		ne issues to the best of his		the beginning of shift, mid sh		
	ability, but that the pl			shift. Checks will continue o	ngoing.	
		sional plumber. He stated		The Maintenance supervisor	will monitor	
	over \$500 needed to	e request estimated to cost be authorized by the		shower rooms on unit 1 and		
		stated that he contacted the		for needed repairs. Rounds		
		It a week ago regarding the		ongoing with preventative ma		
		broken tiles. He revealed		rounds.		
	that corporate staff ca	ame to the facility on 9/15/15				
	to view the issues. H			Facility plans to monitor its p		
		prized the Maintenance		to make sure that solutions a		
	Director to obtain price			The facility must develop a p		
		plumbing problems and to		ensuring that correction is ac	chieved and	
		with broken tiles. The stated that 3 contractors		sustained:		
		ome to the facility that day,		The Director of Nursing and		
	9/16/16.	sine to the facility that day,		Housekeeping Director will r	eport findings	
				of the shower room rounds to		
	A second interview w	ith the Account Manager		Assurance and Performance	-	
		16/15 at 11:00AM. He stated		Improvement Committee mo		

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 24 of 63

STATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY MPLETED
		345529	B. WING _			C 09/17/2015
	ROVIDER OR SUPPLIER	TH RALEIGH				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 253	that the housekeepin cleaning the shower is shower rooms were of 7:00AM. He stated the cleaned during the da notified of a problem. a common occurrence need to clean the sho day. He stated that the completed a walkthrow the end of their shift a he was not aware of cleanliness of the sho An interview with the conducted on 9/17/18 Director indicated that been discussed in the She stated that the sh hall was indicated to believed this issue ca ago and it was again stated that she report Nursing and to the Ad she " wanted nursing already know that rest bathroom that they the A review of the Resid 9/16/15 indicated that shower room at station shower room) needing An interview was con- 9/17/15 at 9:35AM. F sometimes there was toilet in the shower room	g staff was responsible for rooms. He stated that the cleaned every morning at hat the shower rooms were ay if housekeeping was . He stated that this was not ce that housekeeping would ower rooms again during the he housekeeping staff ough of the shower rooms at around 2PM. He stated that any issues regarding the ower rooms. Activities Director was 5 at 8:45AM. The Activities at the shower rooms had e resident council meetings. hower room on the 300/400 be dirty. She stated that she ame up a couple of months brought up yesterday. She ted this to the Director of ccount Manager because g to know if they didn't sidents were using a hink is dirty " . dent Council minutes from t residents discussed the on #2 (the 300/400 hall ing to be cleaned. aducted with Resident #28 on Resident #28 stated that as " something " left in the	F 2	<ul> <li>53 months or until a pattern achieved.</li> <li>The Maintenance Super findings of the shower rorepairs completed to the Assurance and Performation improvement Committee months or until a pattern achieved.</li> <li>The Administrator will requality assurance room to the Quality Assurance Performance Improvement compliance is achieved.</li> <li>Date of Completion Octor</li> </ul>	visor will report com rounds and e Quality ance e monthly for six n of compliance is eport findings of rounds completed e and ent Committee or until a pattern of	

If continuation sheet Page 25 of 63

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C 17/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	H 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	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253 F 278 SS=D	9/17/15 at 10:40AM. used the shower room stated that the shower to take a shower in it. most of the time. He was doo-doo on the fl A second interview wa #115 on 9/17/15 at 11 shower room had state did not drain. He state 5-6 months. He state was full of mold. He state on the floor in the sho 483.20(g) - (j) ASSES ACCURACY/COORD The assessment mus resident's status. A registered nurse mu each assessment with participation of health A registered nurse mu assessment is complet Each individual who co assessment must sign that portion of the ass Under Medicare and I willfully and knowingly false statement in a re subject to a civil mone \$1,000 for each asses willfully and knowingly	Resident #34 stated that he n on the 300/400 hall. He r room " ain't fit for nobody " He stated that it was dirty stated that one time " there oor in the shower stall. " as conducted with Resident :00AM. He stated that the nding water in the stalls that ed that this was ongoing for d that one of the showers stated that he saw "manure " ower room. SSMENT INATION/CERTIFIED t accurately reflect the ust conduct or coordinate n the appropriate professionals. ust sign and certify that the eted.	F 2				10/15/15

Facility ID: 20040007

If continuation sheet Page 26 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 10/19/2015 APPROVED . 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED C			
		345529	B. WING				, 17/2015	
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 000		
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH			201 CLARKS FORK DRIVE ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 278	<ul> <li>penalty of not more thassessment.</li> <li>Clinical disagreement material and false states that the second reverse of the s</li></ul>	is subject to a civil money han \$5,000 for each t does not constitute a itement. is not met as evidenced iew and staff interview, the ately code the Minimum issments for 3 of 3 sampled et and #154) with level II hing and Resident Reviews sampled resident with a lent # 119). The findings nitially admitted to the facility admitted to the facility on e diagnoses that included /e vascular disease with depressive disorder. ed 5/5/14 indicated a " No " hich asked if Resident #1 by a level 2 PASRR and serious mental illness ation or a related condition. ted that Resident #1 was a dent #1's level 2 PASRR	F	278	F 278 Corrective action will be accomplished the resident found to have been affected by the deficient practice: Resident #1, #9 and #154 assessment were modified to reflect accurate PASF level. Resident #119 assessment was modifi to reflect accurate status of pressure ulcer. Corrective action will be accomplished those residents having potential to be affected by the same deficient practice All residents have the potential to be affected. On September 21, 2015 all resident wi level two PASSR were reviewed for accuracy with modifications to MDS do	ed ts RR ied for e:		
		S Coordinator. She stated e for answering question			as indicated. On September 18, 2015 audit of all residents with pressure ulcers were reviewed for accuracy with modification	ns		

Facility ID: 20040007

If continuation sheet Page 27 of 63

		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 10/19/201 RM APPROVE NO. 0938-039
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DA	ATE SURVEY
		345529	B. WING				C )9/17/2015
NAME OF PR	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				520	01 CLARKS FORK DRIVE		
UNIVERSA	AL HEALTH CARE/NORT			RA	LEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From page	e 27	F 27	78			
	revealed that if quest	ion A1500 indicated a " no " vered the question " no " .	/		to MDS done as indicated.		
					Audit of most recent MDS for all activ	-	
		admitted to the facility on			residents completed to ensure coding		
	-	diagnoses that included			accuracy.		
	muscular dystrophy a	and depressive disorder.			Measures put into place or systemic		
	The annual MDS date	ed 7/23/15 indicated a "No "			changes made to ensure that the defi	cient	
		nich asked if Resident #9			practice will not occur:		
	had been evaluated b	by a level 2 PASRR and					
		serious mental illness			On September 20, 2015 education wa		
	and/or mental retarda	ation or a related condition.			completed with MDS nurse, Business		
	Pocord roviow indica	ted that Resident #9 was a			Office Manager and Admissions Coordinator. Education completed us	sina	
		ident #9's level 2 PASRR			state RAI coordinator education mate	-	
	was initially received				on the MDS assessment and care pla process, how to identify level two PAS	in	
	An interview was con	ducted on 9/16/15 at			numbers and entry into electronic rec	ord.	
		S Coordinator. She stated					
		le for answering question			Beginning September 21, 2015 upon		
	A1500 on the MDS for	ion A1500 indicated a " no "			admission Business Office Manager and/or Admission Coordinator will ent	or	
		vered that question " no " .			PASSR numbers into the electronic re	-	
					and provide hard copy of level two PA		
	3. Resident #154 was	s admitted to the facility on			numbers to MDS coordinator to ensur		
	4/23/15 with multiple	diagnoses that included			accurate coding to MDS.		
		rt disease, altered mental					
	status, and anxiety st	ate.			MDS nurse to use wound report and		
	The admission MDS	dated 4/30/15 indicated a "			nursing wound assessment prior to co of section M.	baing	
		dated 4/30/15 indicated a "					
		ated by a level 2 PASRR			Director of Nursing will review coding	of	
		ave a serious mental illness			PASSR and Section M of MDS for		
	and/or mental retarda	ation or a related condition.			accuracy prior to closing of assessme Review will continue daily x 4 weeks,	ent.	
		ted that Resident #154 was			weekly x 4 weeks, monthly x 3 month	s.	
	a level 2 PASRR. Re						
	PASRR was initially r	eceived 4/22/15.			Facility plans to monitor its performant to make sure that solutions are sustained.		

Facility ID: 20040007

If continuation sheet Page 28 of 63

		MEDICAID SERVICES			OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 09/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET
F 278	An interview was con 4:10PM with the MDS that she is responsibl A1500 on the MDS for revealed that if quest answer that she answ 4. Resident # 119 wa 5/29/13 with multiple Alzheimer's disease.	ducted on 9/16/15 at S Coordinator. She stated le for answering question or all residents. She ion A1500 indicated a " no " wered the question " no " . as admitted to the facility on diagnoses including The quarterly Minimum	F 27	8 The facility must develop a plan for ensuring that correction is achiever sustained: The Director of Nursing will preser findings of the MDS accuracy audi relates to coding of level two PASS section M to the Quality Assurance Performance Improvement Comm monthly for six months or until a pr compliance is obtained.	ed and ht the its as it SR and e and ittee
	indicated that Reside cognition and had 2 s pressure ulcers.	essment dated 8/13/15 ent #119 had impaired stage II and 1 stage III		Date of Completion: October 15, 2	2015.
	reviewed. The asses Resident #119 had de ulcer on the left heel Resident #119 had de ulcer on his sacrum. that during the period	eveloped a stage III pressure on 12/2/04. On 7/9/15, eveloped a stage II pressure The assessments revealed d of the quarterly assessment ent #119 had 1 stage III and			
F 280	interviewed. She rev indicated that it was a Resident #119 had 1 pressure ulcer and sh assessment.	stage III and 1 stage II ne would correct the	F 28	ο	10/15/1
SS=D	PARTICIPATE PLAN The resident has the incompetent or other	NING CARE-REVISE CP right, unless adjudged			

Facility ID: 20040007

If continuation sheet Page 29 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345529	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
UNIVERS	AL HEALTH CARE/NORT	'H 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 280	changes in care and the A comprehensive care within 7 days after the comprehensive assess interdisciplinary team physician, a registere for the resident, and control disciplines as determined and, to the extent prather resident, the resident and the resident an	g care and treatment or treatment. e plan must be developed	F	280			
	by: Based on record revi facility failed to review 32, and #84) of 14 ca activities of daily living findings included: 1. Resident #32 was resident's cumulative diabetes, spinal stend and hypertension. The most recent Mini Assessment, a Quart revealed Resident #3 required extensive as and transfers. The M resident used a whee totally dependent for impairment of her upp	osis, cardiovascular disease mum Data Set (MDS) erly MDS dated 7/30/15, 2 was cognitively intact and sistance for bed mobility			F 280 Corrective action will be accomplished the resident found to have been affected by the deficient practice: Resident #32 care plan was revised to reflect the current resident status relates to activities of daily living. Resident #84 care plans was revised to reflect the current status as it relates to medication therapy. Corrective action will be accomplished those residents having potential to be affected by the same deficient practice	ed ed p for	

Facility ID: 20040007

If continuation sheet Page 30 of 63

		MEDICAID SERVICES				T T	O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	1 Y /	E SURVEY PLETED
							С
		345529	B. WING			09	/17/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	AL HEALTH CARE/NOR			52	01 CLARKS FORK DRIVE		
	AL HEALTH CARE/NOR	TH RALEIGH		R/	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 280	Continued From page	e 30	F 2	280			
	revealed a plan of ca for all ADL (Activities Interventions include				All residents have the potential to be affected.		
	showers, I prefer even bathing in the tub in t in the tub in the even Occupational Therap	ning showers, I prefer he morning, I prefer bathing ing, I prefer a bed bath " , " ist to work with me on			Audit of all resident care plans were completed to ensure that care plan is person centered and reflects current resident status.		
	Interview with Admini at 2:45 PM revealed	htton ", Occupational h me on ADL retraining " . istrative Staff #1 on 9/17/15 Resident #32 was not able to ed a mechanical lift. She			Measures put into place or systemic changes made to ensure that the defic practice will not occur:	cient	
	OT on ambulation, tra during a previous adr been a long time ago interventions were no	ent could have worked with ansfers and self ADL care mission but that would have b. She stated that these b longer accurate and the needed to be updated for			On September 21, 2015 education wa completed with interdisciplinary team related to accuracy of care plans. Education completed using the state F coordinator education materials on the MDS assessment and care plan proce	RAI 9	
	accuracy. In addition Resident #32 current on third shift around 4 's preference. Admin the conflicting bathing be updated in the car On 9/17/15 at 11:57	n she acknowledged that ly received a bed bath daily 4 AM which was the resident nistrative Staff #1 added that g preferences also needed to			The Unit Manager, Nursing Supervisor Staff Development Coordinator, MDS coordinator and/or Director of Nursing review all admission and readmission charts within 24 hours to verify care pla is person centered and reflects current resident status.	r, will an	
	around 4 AM every m were aware of this ar daily. On 9/17/15 at 1:15 P was interviewed. Sho was not physically ca required a mechanica Interview with the ME PM revealed that sho	norning. She indicated staff nd she did get her bed bath M Occupational Therapist #1 e stated that the resident upable of ambulating and			The MDS nurse will review telephone orders daily during clinical meeting for changes in care including medication changes. Upon receipt of telephone orders care plans will be updated by th MDS coordinator to reflect changes in resident status. Acute episodes will be reviewed daily		
	time she updated the were done on 3/13/1	care plan. The updates 5, 6/6/15, 6/25/15 and 9/3/15 d written note on the care			during clinical meeting. MDS coordina will update care plans at that time to reflect current resident status.	ator	

Facility ID: 20040007

If continuation sheet Page 31 of 63

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	· · ·	TE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED	
		345529	B. WING			C 9/17/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	Continued From page	e 31	F 28				
	would correct the car 2. Resident #84 was cumulative diagnoses ischemic heart diseas dementia. The most recent Mini Assessment, a Quart revealed Resident # Review of the care pl revealed a plan of ca bleeding due to antip one of the approache administer my antico physician " Review of the physic through 9/17/15 reve During interview with 9/17/15 at 2:45 PM s had been on Plavix of that in reviewing the since his most recent had not been any or discontinued during h Interview with the ME PM revealed that she inaccuracy in the care done on 3/13/15, 6/6 according to her han	a readmitted 2/23/15 and had s that included chronic se, atrial fibrillation and imum Data Set (MDS) terly MDS dated 8/25/15 84 was cognitively impaired. lan last updated 9/3/15 re for " I am at risk for latelet therapy (Plavix) " , es for this plan of care was " agulant as ordered by my ian ' s orders from 2/23/15 aled no orders for Plavix. Administrative Staff #1 on he indicated that the resident on a previous admission but, resident ' s medical record t admission on 2/23/15, there ders for Plavix as it had been his last hospitalization. DS Nurse on 9/17/15 at 2:45 e did not know how the e plan was missed each time e plan. The updates were /15, 6/25/15 and 9/3/15 d written note on the care it was an oversight and she		<ul> <li>The MDS coordinator will review resident care plans monthly x of verify that care plan is person of and reflects current resident static including areas of ADL care and medication therapy.</li> <li>After six months the MDS coordination review all resident care plans at quarterly to ensure that care plaperson centered and reflect curresident status including areas care and medication therapy.</li> <li>The Director of Nursing will revicare plan review related to ensuplans are person centered and current resident status including ADL care and medication theration theration accuracy monthly x 6 months.</li> <li>Facility plans to monitor its pertor make sure that solutions are the facility must develop a platensuring that correction is achieved and medication theration sustained:</li> <li>The Director of Nursing will represent the solution of the 24 hour admission readmission chart audit and MI care plan reviews to the Quality Assurance and Performance Improvement Committee month months or until a pattern of corrobtained.</li> </ul>	S months to centered atus d dinator will at least ans are rrent of ADL view MDS uring care reflect g areas of apy for formance s sustained. n for eved and port the n DS monthly ty hly for six		

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 32 of 63

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 10/19/2015 M APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345529	B. WING				0 /17/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	'H 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 PROVIDER'S PLAN ( PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED TO DEFICIE			(X5) COMPLETION DATE
F 281	Continued From page	e 32	F	281			
F 281 SS=E	483.20(k)(3)(i) SERV PROFESSIONAL ST	ICES PROVIDED MEET ANDARDS	F	281			10/15/15
		d or arranged by the facility al standards of quality.					
	by: Based on record revi facility failed to accur administer a blood pr ordered by the physic resident (Resident #6 Resident #63 was ac and readmitted on 6/ discharged to hospita diagnoses included: chronic kidney diseas A hospital discharge s reviewed and reveale hydralazine 100 millig (8) hours. Hydralazin treatment of moderate (high blood pressure) failure. Facility physician orde hydralazine 50 milligr (8) hours. A review of the Medic Records (MARS) for September 2015 were Resident #63 receive	essure medication as cian for one of one sampled (3). The findings included: dmitted to the facility 5/19/15 10/15. Resident #63 was of on 9/11/15. Cumulative congestive heart failure, se and hypertension. summary dated 6/10/15 was of a physician's order for grams by mouth every eight re is medication used for the e to severe hypertension and congestive heart ers dated 6/10/15 stated ams by mouth every eight			F 281 Corrective action will be accomplished the resident found to have been affected by the deficient practice: Resident #63 orders were clarified with the physician. Resident is receiving medications per physician order. Corrective action will be accomplished to be affected by the same deficient practice: All residents having potential to be affected. On September 17, 2015 all current residents admitted or readmitted since March 1, 2015 orders were verified and transcribed correctly. Orders clarified we physician as indicated. The Director of Nursing, Staff Development Coordinator, Unit Manage and/or Nursing Supervisor will review a admissions or readmission physician orders within 24 hours to ensure orders were verified and transcribed correctly.	d for : vith er II	

Facility ID: 20040007

If continuation sheet Page 33 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/19/2015 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345529	B. WING				/17/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
UNIVERS	AL HEALTH CARE/NORT	'H 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 PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 281	Continued From page	9 33	F2	281			
	9/11/15.				at that time. Review will remain ongoi	ng.	
	interviewed. On 09/17/2015 at 9:5	Vs: 3/65 5/73 2/71 67 70 0/80 8/80 2/65 5/72 55 8/62 74/90 /89 /86 5/73 80 hable to be contacted and 56 AM, Nurse #1 stated a resident being admitted to			Measures put into place or systemic changes made to ensure that the defice practice will not occur: Education began September 25, 2015 all nursing staff related to admission a readmission orders. Education to inclu- process for reconciliation of physician orders to determine accuracy, verificat of orders, comparison of orders on readmission with previous orders, transcription of orders and process for second check of admission and readmission orders. The Director of Nursing, Staff Development Coordinator, Unit Managa and/or Nursing Supervisor will review a dmissions or readmission physician orders within 24 hours to ensure order were verified and transcribed correctly Orders will be clarified with the physici at that time. Review will remain ongoi	for nd ude ion ion s all s an ng.	
	orders were written fr discharge summary a by the physician via to	She stated the physician om the orders noted on the ind all orders were verified elephone. Any changes n would be clarified by a			to make sure that solutions are sustain The facility must develop a plan for ensuring that correction is achieved an sustained:		
	the physician's order been written as noted summary for hydralaz every eight hours. Nu had a physician's ord	n's order. Nurse #1 stated for hydralazine should have I on the hospital discharge zine 100 milligrams by mouth urse #1 stated Resident #63 er for hydralazine 50 t hours when she was in the			The Director of Nursing will present the findings of the admission / readmission physician order verification and transcription audit to the Quality Assurance and Performance Improvement Committee monthly for s months or until a pattern of compliance	n .ix	

Facility ID: 20040007

If continuation sheet Page 34 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/19/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 09/17/2015
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	AL HEALTH CARE/NORT	'H 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 281	reactivated the previo		F 28	0 obtained. Date of completion: October 15, 20	15
F 312 SS=D	#1 stated she expected hospital discharge su admission orders for a and verify the orders order if a medication discharge summary of should have received		F 31	2	10/15/15
	daily living receives th	ble to carry out activities of ne necessary services to on, grooming, and personal			
	by: Based on observatio and resident interview incontinent care to a have been incontinent sampled residents an (Resident #120) of 1 reviewed for activities findings included: 1. Resident #32 was resident ' s cumulative	sampled male resident, of daily living care. The readmitted 10/1/14. The		F 312 Corrective action will be accomplish the resident found to have been affe by the deficient practice: Resident #32 is receiving incontiner Resident #120 was shaved. Nurse Aide #4 is no longer employe	ected nt care.

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 35 of 63

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345529	B. WING		C 09/17/2015		
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
				52	201 CLARKS FORK DRIVE		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 212	Continued From near	- 25	Í –	040			
F 312	Continued From page	8 30	F:	312			
	and hypertension.				facility.		
		mum Data Set (MDS)					
		erly MDS dated 7/30/15,			Nurse Aide #1 was counseled and		
		2 was cognitively intact. ted Resident #32 required			re-educated on providing assistance ADL¿s including shaving of residents		
		for bed mobility, transfers,				•	
		I hygiene; had impairment of			Corrective action will be accomplishe	d for	
	both upper and lower				those residents having potential to be		
		r and bowel. In addition, the			affected by the same deficient practic		
	MDS revealed the res	sident did not refuse care.					
	Review of the Care P	lan last updated 9/3/15			All residents have the potential to be		
	-	re for incontinence of bowel			affected.		
		proaches included: " give					
	· ·	ne resident is incontinent "			On September 16, 2015 all residents	were	
		ontinence on routine rounds			observed for completion of ADL¿s to		
	and as needed. " On 9/16/15 at 4:44 Pl	M regident #22 was			include incontinent care and shaving.		
		heelchair near the nurse ' s			Measures put into place or systemic		
	station speaking on a				changes made to ensure that the def	cient	
		(NA #3) was also observed			practice will not occur:	oloni	
	-	d to the resident "I know					
		e person you had isn ' t here			On September 25, 2015 education be	egan	
	yet so they are redoir				for all nursing staff in reference to	0	
		Two NA (Nursing Assistant)			providing assistance with ADL¿s inclu	uding	
	Assignment for 3 PM				incontinent care to be given at least e	every	
	revealed there were 6				2-3 hours, as requested by the reside		
	-	the NA's (NA #6) was listed			family member and as needed for vis		
	-	PM instead of 3:00 PM. She			signs of soiling, shaving of residents	•	
	-	ent #32 as well as other			and/or as needed for increased facial	naır	
	residents. There was				and person centered care to include		
		g who would take over the			responding to all resident needs regardless of assigned area.		
	3:00 PM and 6:00 PM	assigned to NA #6 between			regardiess of assigned died.		
		on 9/16/15 at 5:05 PM			The Director of Nursing, Staff		
		s aware the resident was wet			Development Coordinator, Unit Mana	aer	
		ck to bed. She stated that it			and/or Supervisor will complete walki	-	
		abit to return to the nurse 's			rounds daily to include off shifts and		
		and that Resident #32			weekends to ensure that nursing staf	fare	
		back to bed at that time and			meeting the needs of all residents		

Facility ID: 20040007

If continuation sheet Page 36 of 63

	S FOR MEDICARE &		0.00			<u>)38-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
					С	
		345529	B. WING		09/17/2	2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
	AL HEALTH CARE/NORT			5201 CLARKS FORK DRIVE		
				RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE CO THE APPROPRIATE	(X5) MPLETION DATE
F 312	Continued From page	e 36	F 3	12		
		nt care. She stated that she 2 ' s assigned NA for the		including incontinent care a	and shaving.	
	<ul> <li>shift, although she was her roommate 's NA, and had already given the roommate incontinent care. On 9/16/15 at 5:25 PM Resident #32 was observed in her room sitting in her wheel chair. She stated that she was very wet and had not received incontinent care since before lunch when she got up. A urine odor was noted at this time. Resident #32 stated that since around 4 PM she had told several NA 's that she wanted to go back to bed and said they knew that she needed to be changed. She added that she was told the NA assigned to her (NA #6) would be in at 6 PM and would put her back to bed when she arrived.</li> <li>On 9/16/15 at 5:30 PM NA#4 stated that she was going to the dining room to feed other residents and that the NA assigned to Resident #32 would be in at 6 PM and take care of her then. On 9/16/15 at 5:50 PM during interview with Administrative Staff #1 she indicated that she expected all residents to have an assigned NA, expected residents to receive incontinent care when they needed it, and expected residents to be assisted in going back to bed, or getting up, according to their preferred schedule keeping in mind the needs of other residents. On 9/16/15 at 7 PM NA#4 was interviewed. She</li> </ul>			Walking rounds will continu weeks and weekly thereaft		
				to make sure that solutions The facility must develop a ensuring that correction is sustained: The Director of Nursing wil summary of the walking rou Quality Assurance and Per Improvement Committee m months or until a pattern of obtained. Date of Completion: Octob	plan for achieved and I present a unds to the formance nonthly for six i compliance is	
	stated that she had p Resident #32 before because the Residen wasn ' t going to be ir needed to cover that	VA #4 was interviewed. She rovided incontinent care to going to the dining room t ' s originally assigned NA n until 6:00 PM and someone assignment. NA #4 also #32 was very wet when she				

If continuation sheet Page 37 of 63

CENTERS FOR MEDICARE & MEDICAID SERVICES     OMB NO. 0938-039       STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A. BUILDING     (X3) DATE SURVEY COMPLETED       OMB NO. 0938-039       STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A. BUILDING     (X3) DATE SURVEY COMPLETED       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       S201 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OMPLETION DATE       F 312     Continued From page 37     F 312     F 312     ID     F 312       2. Resident #120 was re-admitted to the facility on 2/5/13 with multiple diagnoses including muscle weakness and difficulty walking. The     F 312     ID     F 312			ND HUMAN SERVICES				FORM	D: 10/19/2015 MAPPROVED
A. BUILDING     C       345529     B. WING     09/17/2015	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE		(X3) DATE	SURVEY
Image: Name of provider or supplier     345529     B. WING     09/17/2015       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     5201 CLARKS FORK DRIVE       UNIVERSAL HEALTH CARE/NORTH RALEIGH     STREET ADDRESS, CITY, STATE, ZIP CODE     5201 CLARKS FORK DRIVE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     (X5)       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION SHOULD BE     COMPLETION       TAG     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     TAG     (EACH CORRECTIVE ACTION SHOULD BE     COMPLETION       F 312     Continued From page 37     F 312     F 312     F 312     F 312     F 312       2. Resident #120 was re-admitted to the facility on 2/5/13 with multiple diagnoses including muscle weakness and difficulty walking. The     F 312     F 312     F 312	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         UNIVERSAL HEALTH CARE/NORTH RALEIGH       STREET ADDRESS, CITY, STATE, ZIP CODE         (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 OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (x5) COMPLETION DATE         F 312       Continued From page 37       F 312         2. Resident #120 was re-admitted to the facility on 2/5/13 with multiple diagnoses including muscle weakness and difficulty walking. The       F 312			345529	B. WING				
UNIVERSAL HEALTH CARE/NORTH RALEIGH       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 312       Continued From page 37       F 312         2. Resident #120 was re-admitted to the facility on 2/5/13 with multiple diagnoses including muscle weakness and difficulty walking. The       F 312	NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
(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 312       Continued From page 37       F 312         2. Resident #120 was re-admitted to the facility on 2/5/13 with multiple diagnoses including muscle weakness and difficulty walking. The       F 312	UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH					
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION DATE         F 312       Continued From page 37       F 312       F 312       Image: Continued From page 37       F 312       Image: Continued From page 37       F 312       Image: Continued From page 37       Image: Continue					R	, 1		
2. Resident #120 was re-admitted to the facility on 2/5/13 with multiple diagnoses including muscle weakness and difficulty walking. The	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
on 2/5/13 with multiple diagnoses including muscle weakness and difficulty walking. The	F 312	Continued From page	ə 37	F	312			
on 2/5/13 with multiple diagnoses including muscle weakness and difficulty walking. The		2. Resident #120 was	s re-admitted to the facility					
		on 2/5/13 with multiple	le diagnoses including					
quarterly Minimum Data Set (MDS) assessment								
dated 7/7/15 indicated that Resident #120 had		dated 7/7/15 indicated	d that Resident #120 had					
severe cognitive impairment and needed								
extensive assistance with personal hygiene. The assessment also indicated that Resident #120 did								
not resist care.								
The care plan dated 7/7/15 indicated that " I need assistance of one staff to perform my								
activities of daily living related to history of stroke and left hemiparesis. "		activities of daily living	g related to history of stroke					
On 9/14/15 at 1:28 PM, Resident #120 was		On 9/14/15 at 1:28 Pt	M. Resident #120 was					
observed up in wheelchair in his room unshaven.		observed up in wheel	lchair in his room unshaven.					
His beard was approximately ½ inch in length.		His beard was approx	kimately 1/2 inch in length.					
On 9/15/15 at 8:51 AM, a family member of		On 9/15/15 at 8:51 Al	M, a family member of					
Resident #120 was interviewed. The family								
member indicated that when she came to visit, she found Resident #120 not shaved. She added								
that she had discussed this issue with the		that she had discusse	ed this issue with the					
administrative staff. She added that Resident #120 did not want his beard long.								
			beard long.					
On 9/16/15 at 11:42 AM and 3:05 PM, Resident								
#120 was observed up in wheelchair in his room still not shaved, his beard was approximately ½								
inch in length.								
On 9/16/15 at 3:05 PM, NA (nurse aide) #1 was		On 9/16/15 at 3:05 PI	M, NA (nurse aide) #1 was					
interviewed. He stated that he was assigned to		interviewed. He state	ed that he was assigned to					
Resident #120. He indicated that the resident was scheduled to have a shower on Thursday								
and Saturday. He added that he had given			-					
Resident #120 a bed bath that morning but did not shave him. He agreed that the resident		Resident #120 a bed	bath that morning but did					

Facility ID: 20040007

If continuation sheet Page 38 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/19/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING _		C 09/17/2015
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZI 5201 CLARKS FORK DRIVE RALEIGH, NC 27616	P CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 312	needed a shave and beard was that long. On 9/16/15 at 3:10 Pl interviewed. She stat Resident #120 and a	he didn ' t realize that his M, Nurse #1 was ed that she had seen greed that he needed to be	F 3	312	
F 318 SS=D	to leave until he had a 483.25(e)(2) INCREA IN RANGE OF MOTI Based on the compre- resident, the facility n with a limited range of	SE/PREVENT DECREASE ON chensive assessment of a nust ensure that a resident of motion receives t and services to increase or to prevent further	F3	318	10/15/15
	by: Based on observatio and resident interview a hand roll/palm guar resident with a hand discharged from Occi instructions for hand The findings included Resident #15 was ad cumulative diagnoses vascular dementia an Review of the most re (MDS) Assessment, a Assessment dated 7/ #15 was cognitively in lower extremity impai	mitted 2/15/01 and had s including hemiplegia, id joint contracture. ecent Minimum Data Set a Significant Change 21/15 revealed Resident mpaired and had upper and		F 318 Corrective action will be the resident found to hav by the deficient practice: Resident #15 has hand in Corrective action will be those residents having p affected by the same der On September 17, 2015 hand rolls / palm guards All residents requiring th rolls / palm guards have guards in place.	ve been affected roll in place. accomplished for potential to be ficient practice: all residents with were reviewed. be use of hand

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 39 of 63

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	O. 0938-039
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	;	COM	IPLETED
		345529	B. WING			C 9/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	9/17/2013
				5201 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NORT	HRALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 318	Continued From page	e 39	F 31	8		
		dated 5/13/14 revealed the	1.01			
		joal " the patient will have		Measures put into place or syst	emic	
		left) hand to 6 out of 10 in		changes made to ensure that the		
		I (Range of Motion) and roll		practice will not occur:		
	-	ost appropriate modality. "				
		m goal was " the patient will with decreased pain to		On September 25, 2015 education to		
		skin breakdown " . The		for all nursing staff in relation to application of hand rolls / palm		
		lese goals were met on		Education to include restorative		
	-	ne Discharge Plans and		apply hand rolls / palm guards.	-	
	instructions section o	f this report revealed " Pt		monitor hand rolls / palm guard	s to ensure	
		m guard to L hand " and the		in place. Nurse to document or		
		tion indicated "Nursing		medication administration recor		
	staff educated on pall On 9/16/15 at 4:02 Pl			monitoring and application of ha	and rolls /	
		r wheel chair in her room.		palm guards.		
		t at the elbow and held		The Staff Development Coordir	nator. Unit	
		n a small clutch purse		Manager and / or Nursing Supe		
	underneath. Her left	wrist was bent in a		review medication administration	on record	
	· ·	nd her left hand was closed		for documentation of hand roll /		
		s flat and her thumb inside.		guard placement and to include		
		mpted to open her fingers		observation of hand roll / palm	-	
	She said she did not	but was unable to do so. think she had any problems ft palm as it felt fine but		placement daily x 2 weeks, wee weeks then monthly x 4 months	•	
		s her hand was painful. The		The Director of Nursing will rev	iew	
		l ever using a hand roll but		Medication Administration Reco		
	stated " it might help	-		and observations of hand roll /		
	On 9/17/15 at 1:20 Pl	M interview with		placement daily for compliance	. Review	
		ist #1 (OT #1) revealed		will be done daily x 2 weeks, we	-	
		en on the Occupational		weeks, then monthly x 4 month	S.	
		ad most recently in 2014. #15 had been picked up by		The Rehab Director will deliver	new	
		of left hand pain and after		restorative referrals including		
		were able to increase her		recommendations for hand rolls	s / palm	
		gh so she could comfortably		guards to Director of Nursing da	-	
	use a hand roll. OT #	1 stated that the resident		clinical meeting.		
	was then referred to I ongoing assistance w	Restorative Therapy for				
				Facility plans to monitor its perf		

Facility ID: 20040007

If continuation sheet Page 40 of 63

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION		NO. 0938-039 DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,		· · ·	OMPLETED
						С
		345529	B. WING			09/17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 318	On 9/17/15 at 3:30 P Administrative Staff # not locate a Restorat resident that would h the resident with a ha acknowledged the re these devises and did breakdown occurred. stated that there were worked in the facility	M interview with 1 revealed that she could ive Nursing Referral for the ave instructed staff to assist and roll/palm guard. She sident had not been using d not know where the Administrative Staff #1 e two Restorative Aides that and she provided their owever they could not be	F 31	<ul> <li>to make sure that solutions are The facility must develop a pla ensuring that correction is ach sustained:</li> <li>The Director of Nursing will pre findings of the Medication Adm Record and hand roll / palm gu application audits to the Qualit Assurance and Performance Improvement Committee mont months or until a pattern of con obtained.</li> </ul>	n for ieved and esent the ninistration uard y hly for six	
F 353 SS=E	483.30(a) SUFFICIE PER CARE PLANS	NT 24-HR NURSING STAFF	F 353	Date of Completion: October 1	5, 2015.	10/15/15
	provide nursing and r maintain the highest					
	numbers of each of the personnel on a 24-ho	vide services by sufficient he following types of our basis to provide nursing n accordance with resident				
		under paragraph (c) of this ses and other nursing				
	section, the facility m	under paragraph (c) of this ust designate a licensed harge nurse on each tour of				

Facility ID: 20040007

If continuation sheet Page 41 of 63

	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY PLETED C
		345529	B. WING		0.	/17/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				5201 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NORT	H RALEIGH		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	Continued From page duty.	e 41	F 3	53		
	by: Based on observation resident and staff inter have an assigned Nuu (Resident #32, #18, # #31) of 57 residents of (Station Two), failed to staff to provide incont dependent resident have sufficient nurse dignity of a resident d incontinent care for 1 #32). The findings into This citation is cross of facility failed to have a Assistant available to needs of 7 (Resident #132 and #31) of 57 halls (Station Two) for three hours. This citation is cross of failed to provide incor who was known to have (Resident #32) of 3 sat to shave 1 (Resident for residents, reviewed for care. Resident #32 was rear resident 's cumulative diabetes, spinal stend and hypertension. The most recent Minin Assessment, a Quarter	rview, the facility failed to rsing Assistant for 7 55, #27, #104, #132 and on the 300 and 400 halls o provide sufficient nursing inent care without a aving to wait an hour or nt (Resident #32) and failed sing staff to maintain the ependent on staff for of 1 resident (Resident cluded: referenced to F224 - the an assigned Nursing check on and meet the #32, #18, #55, #27, #104, residents on 300 and 400 r a period of between two to referenced to F312 - facility ntinent care to a resident ve been incontinent for 1 ampled residents and failed #120) of 1 sampled male or activities of daily living admitted 10/1/14. The e diagnoses included usis, cardio vascular disease		<ul> <li>F 353</li> <li>Corrective action will be accommon the resident found to have been by the deficient practice:</li> <li>Residents #32, #18, #55, #27, #132, #31 have an assigned nut assistant each shift to meet the Staff provide person centered of include responding to all resider regardless of their assigned are Nurse Aide #4 is no longer empfacility.</li> <li>Corrective action will be accommon those residents having potential affected by the same deficient practice.</li> <li>All residents have the potential affected.</li> <li>All residents have an assigned assistant each shift to meet the Staff provide person centered of include responding to all resider the Staff provide person centered of include responding to all resider regardless of their assigned are Measures put into place or syst changes made to ensure that the practice will not occur:</li> </ul>	n affected #104, ursing bir needs. care to ent needs ea. bloyed by palished for al to be practice : to be nursing bir needs. care to ent needs ea. temic	

Facility ID: 20040007

If continuation sheet Page 42 of 63

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	)		PLETED
				·		С
		345529	B. WING			/17/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
				5201 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		RALEIGH, NC 27616		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	N OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE IENCY)	COMPLETIC
F 353	Continued From page	e 42	F 35	33		
	The MDS also indicat	ted Resident #32 required		On September 17, 201	5 the Director of	
		for bed mobility, transfers,		nursing received directed		
		I hygiene; had impairment of		training by the administ		
	both upper and lower			to reporting employee a		
	incontinent of bladder			tardies. The Director of		
		lan last updated 9/3/15		absences and tardies in		
	-	re for incontinence of bowel		manager and/or nurse		
		proaches included: " give		assignments will be adj		
		ne resident is incontinent " Intinence on routine rounds		to ensure person cente	red care delivery.	
	and as needed ".			On September 17, 201	5 education by	
	On 9/16/15 at 7 AM F	Resident #32 was		Staff Development Coo		
		ted that staff frequently		all nursing staff in refer	÷	
		light and say they would be		absences and tardies to		
		else to help them but then		Nursing. Education cor		
	they wouldn ' t come	back at all or it would take a		12, 2015. Staff member	ers not receiving in	
		esident attributed this in part		service education by O		
		aff often needed another NA		be required to receive i		
		because she was heavy		prior to beginning of sc		
		lved getting her in or out of		Education to include sta		
	-	nd one of two mechanical		physically speaking to t		
		d another staff member to		Nursing. If Director of r	-	
		d that she always had a the staff rotated taking care		be reached staff are to Development Coordina	•	
		ed like they didn ' t want to		Nursing Supervisor and	-	
	-	they were worried they		Education also includes		
	would hurt their back.			facility staff are to initial		
	On 9/16/15 at 4:44 PI	M resident #32 was		on assignment sheet to		
	observed up in her w	heelchair near the nurse ' s		have reported for duty.	The Unit	
	station speaking on a	• •		Manager, Supervisor a	•	
	•	(NA #3) was also observed		will complete assignme		
		d to the resident " I know		assistants using a resid		
		e person you had isn ' t here		beginning of each shift		
	yet so they are redoir			residents in the facility	-	
		Two NA (Nursing Assistant)		nursing assistant. The		
	Assignment for 3 PM revealed there were 6			Supervisor and/or nurse within thirty minutes of	-	
		the NA's (NA #6) was listed		that all staff members h		
		$\pi \sigma (\pi \pi \sigma)$ was listed		duty. Assignments will	•	

Facility ID: 20040007

If continuation sheet Page 43 of 63

		MEDICAID SERVICES					D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			1 Y /	E SURVEY PLETED
							С
		345529	B. WING			09	/17/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH			01 CLARKS FORK DRIVE ALEIGH, NC 27616		
	CLIMMADY C	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 353	Continued From pag	e 43	F 3	53			
		ent #32 as well as other			time if all staff members are not prese	nt	
	U	s no indication on the			Staff provide person centered care to		
		g who would take over the			include responding to all resident need	ds	
		assigned to NA #6 between			regardless of their assigned area.		
		PM Nursing Assistant #4 was			The Director of Nursing, Staff		
		ying the resident to her room.			Development Coordinator, Unit Manag	ger	
		ncontinent pad on the			and/or Supervisor will check assignme		
		told the resident that the			sheets daily x 4 weeks, weekly x 4 we		
1	Nursing Assistant as	signed to her (NA #6) would			and then monthly x 3 months to ensur		
	be coming in at 6 PN				staff have initialed that they have repo		
	•	on 9/16/15 at 5:05 PM			for duty and that assignment was		
	revealed that she was aware the resident was wet				completed accurately to reflect staff th	at	
	and wanted to go ba	ck to bed. She stated that it			have reported for duty and that all		
	was the resident 's l	nabit to return to the nurse ' s			residents have an assigned nursing		
	station around 4 PM	and that Resident #32			assistant.		
	always wanted to go	back to bed at that time and					
	would need incontine	ent care. NA #4 stated that			Assignment sheets will be given to the	•	
	she was not Resider	nt #32 ' s assigned NA for the			Administrator for review daily x 4 week	κs,	
	shift, although she w	as her roommate 's NA, and			weekly x 4 weeks and then monthly x	3	
	had already given th	e roommate incontinent care.			months.		
	On 9/16/15 at 5:25 F	PM Resident #32 was					
		n sitting in her wheel chair.			On September 25, 2015 education beg	gan	
		was very wet and had not			for all nursing staff in reference to		
	received incontinent	care since before lunch			providing assistance with ADL¿s and		
	when she got up. A	urine odor was noted at this			person centered care to include		
	time. Resident #32	stated that since around 4			responding to all resident needs		
		eral NA 's that she wanted to			regardless of assigned area.		
		said they knew that she					
	needed to be change	ed. She added that she was			The Director of Nursing, Staff		
	-	l to her (NA #6) would be in at			Development Coordinator, Unit Manag		
		her back to bed when she			and/or Nursing Supervisor will comple		
		32 also said that she was			walking rounds daily to include off shif		
		k turns taking her on their			and weekends to ensure that nursing	staff	
	-	e she was physically heavy,			are meeting the needs of all residents		
		al lift for transfers, and			including incontinent care.		
		nt it took a long time to do her					
		as so particular. Resident			Walking rounds will continue daily x 4		
	#22 donied refusing	incontinent care, unless it	1		weeks and weekly thereafter.		1

Facility ID: 20040007

If continuation sheet Page 44 of 63

		MEDICAID SERVICES					NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		NSTRUCTION	· /	TE SURVEY MPLETED
		345529	B. WING				C 19/17/2015
	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		9/17/2015
					CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH			EIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 353	Continued From page	۵ <u>۵</u> ۵	F3	353			
1 000				555			
		nd the staff member said le to get her up again if they		F	acility plans to monitor its performa	nce	
	put her back to bed for				make sure that solutions are susta		
	On 9/16/15 at 5:30 PM NA#4 stated that she was				he facility must develop a plan for		
	going to the dining ro			nsuring that correction is achieved	and		
		be in at 6 PM and take care			ustained:		
		M NA #3 was observed in		<sub>T</sub>	he Director of Nursing will report fin	dinge	
		n adjusting the resident 's			f the assignment sheet checks to th		
		dent #32 was observed in			uality Assurance and Performance		
	bed at this time. Inte	rview with NA #3 revealed			nprovement Committee monthly for	six	
	that she had not help	ed the resident to bed but			onths or until a pattern of complian		
	had volunteered to ta	ke Resident #32 on her		a	chieved.		
	assignment. She was	sn ' t sure what time she					
	volunteered but said	it was just before the dinner			he Director of Nursing will report the		
	-	NA #3 added that she had			ummary of walking rounds to the Q	uality	
		pressing needs at that time			ssurance and Performance		
		ut Resident #32 back to			nprovement Committee monthly for		
		ident incontinent care,			onths or until a pattern of complian	ce is	
	residents.	ning room to help feed other		a	chieved.		
	On 9/16/15 at 6:50 Pl	M Nurse #3 was interviewed.		D	ate of Completion October 15, 201	5.	
		nd 5:00 PM she had become					
		#32 ' s NA (NA #6) was not					
		6 PM, for the 3 - 11 PM shift.					
		und out NA #6 had not					
	-	ident #32 was asking who					
		she wanted to go back to led it was around 5:00 PM					
		IA 's said the dinner trays					
		they might as well wait until					
		0 PM, as it wouldn ' t be long					
		e care of Resident #32 then.					
		she had informed the NA					
		ded an assigned NA in the					
	facility and that she w	-					
	-	t3 volunteered to have					
	Resident #32 on her	assignment at that time.					
	On 9/17/15 at 11:57 A	M Resident #32 was					

If continuation sheet Page 45 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/19/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 09/17/2015
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERS	AL HEALTH CARE/NORT	TH RALEIGH		CLARKS FORK DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
F 353 F 371 SS=E	observed in the dining meal. Interview with F revealed she did not wheelchair for so long figured out who was g She had been tired a wanted to go back to bad to wait so long. On 9/17/15 at 2:00 Pl Administrative Staff # told her, on the morni would not be able to o 11:00 PM shift until 6 #1 indicated that she adjust the assignmen had an assigned NA the care they needed Administrative Staff # Staff #2 had already to address this issue to monitor staffing co Assurance and Perfo program. 483.35(i) FOOD PRC STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and (2) Store, prepare, dis under sanitary condit	g room awaiting her lunch Resident #32 at this time like being left wet in her g on 9/16/14 while they going to take care of her. nd soaking wet and just bed and it made her feel M interview with f1 revealed that NA#6 had ing of 9/16/15, that she come in for the 3:00 PM - :00 PM. Administrative Staff got busy and neglected to at to ensure each resident and that they would receive I until NA #6 arrived. f1 added that Administrative done a reeducation with her and had put a plan in place verage through the Quality rmance Improvement DCURE, ERVE - SANITARY	F 353		10/15/15

Facility ID: 20040007

If continuation sheet Page 46 of 63

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/19/2015 APPROVED O. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		E SURVEY IPLETED C	
		345529	B. WING			09/17/2015		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE				
			1	R	ALEIGH, NC 27616		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 371	Continued From page	F	371					
		iew, observation and staff			F 371			
	food and to date the food and the	failed to discard the rotten food when thawed in one of or and the facility failed to hair with the hair net during s included:			Corrective action will be accomplishe the resident found to have been affec by the deficient practice:			
					No specific residents were named.			
	conducted. Inside the	AM, tour of the kitchen was walk in refrigerator, 3 rotten bserved and a 16 ounces			On September 15, 2015 undated, spo and expired items were discarded.	biled		
	as to when it was pul topping read " use w	being thawed with no date led. The instruction on the ithin 14 days after thawed. "			On September 15, 2015 all staff have nets being worn appropriately to cove hair completely while working in the kitchen.			
	was interviewed. He responsible for check every day. He added the walk in refrigerato	AM, administrative staff #3 stated that the cook was ing the walk in refrigerator I that the cook had checked or that morning but did not he rotten green peppers			Corrective action will be accomplishe those residents having potential to be affected by the same deficient practic All resident have the potential to be			
		indicated that he didn't ed topping should be used hawed.			affected. On September 15, 2015 Dietary Man checked walk in refrigerator and all	ager		
		ed that she had checked the at morning and should have			storage areas for undated, expired or spoiled items. No other items were for to be undated, spoiled or expired.			
	line was conducted. on the tray line. She	M, observation of the tray Dietary Aide #1 was serving was wearing a hair net but rehead were exposed.			Staff have hair nets being worn appropriately to cover hair completely while working in the kitchen. Measures put into place or systemic changes made to ensure that the defi practice will not occur:			
	On 9/17/15 at 3:25 Pl administrative staff #3	M, interview with 3 was conducted. He stated			On September 18, 2015 education do	one		

Facility ID: 20040007

If continuation sheet Page 47 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/19/2015 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345529	B. WING				C 17/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, C	CITY, STATE, ZIP CODE	1	
UNIVERS	AL HEALTH CARE/NORT	'H RALEIGH		5201 CLARKS FOR			
				RALEIGH, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH (	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page that he expected his s their hair with a hair r	staff to completely cover	F3	<ul> <li>with all dietar dating of ope undated, spo appropriate v</li> <li>Dietary Mana check walk ir items, expire items daily.</li> <li>Dietary mana monitor staff wearing hair Checks will of</li> <li>Facility plans to make sure The facility m ensuring that sustained:</li> <li>The Dietary N findings of all refrigerator c monitoring to Performance</li> </ul>	ry staff. Education to incluent items, discarding of ailed or expired items and vearing of hair nets. Ager and/or Administrator of refrigerator for dating of ditems and freshness of Checks will continue ongoing ager and/or Administrator daily to ensure all staff are nets covering entire hair. Sontinue ongoing. To that solutions are sustained that solutions are sustained at solutions are sustained at the solution is achieved and the solution is achieved and a monitoring audits includid hecks and hair net of Quality Assurance and a Improvement Committee ix months or until a patter is obtained.	will ing. will e ied. id ary ng	
F 463 SS=D	ROOMS/TOILET/BAT The nurses' station m resident calls through		F 4		pletion: October 15, 2015		10/15/15

Facility ID: 20040007

If continuation sheet Page 48 of 63

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			0	C 9/17/2015	
NAME OF P	ROVIDER OR SUPPLIER		- 1	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				52	201 CLARKS FORK DRIVE			
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		R	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 463	Continued From page	e 48	F	463				
	by:	T is not met as evidenced						
		view, observation and staff failed to maintain a properly			F 463			
		call system for 3 of 4 halls			Corrective action will be accomplishe	d for		
	•	The findings included:			the resident found to have been affect			
		M the call bell in room 415 B			by the deficient practice:			
	was checked for prop	per functioning. The call bell						
	was not functioning, t	the light outside the room			Call bells were repaired and or repla	ced		
		ation did not light up and			for rooms 104, 106, 306, 308, 315, 3			
		sound heard, when the call			400, 401 and two central bathrooms.			
	light button was press							
	On 9/14/15 at 3:27 P				Corrective action will be accomplishe			
		2. RN #2 stated that she			those residents having potential to be			
		all bell in room 415 B was not			affected by the same deficient practic	ce:		
		RN #2 contacted the			All residents have the notantial to be			
	On 9/16/15 at 10:30 /	r to repair the call bell.			All residents have the potential to be affected.			
		naintenance director. He			anecieu.			
		med a check of the call bell			On September 17, 2015 all resident	call		
	-	at each nurse's station			bells including central bathrooms, sh			
		at this check allowed him to			rooms and hallway notification lights			
	•	s on the switchboard were			checked for functioning. Call bells w			
	burnt out. He stated	that this check did not			repaired and or replaced for rooms 1	04,		
	provide information o	on the functioning of the call			106, 306, 308, 315, 318, 400, 401 ar	nd two		
	bells inside of the res	sident rooms, bathrooms, or			central bathrooms.			
		ation lights located in the						
	-	that he did not have a			Measures put into place or systemic	<b>.</b>		
		eck the functioning of call			changes made to ensure that the def	ricient		
		ns, bathrooms, or of the			practice will not occur:			
	•	ated in the hallways. He y way staff would find out if a			On September 17, 2015 education b	ogan		
		as not working would be if the			for all staff in reference to reporting of			
		call bell and it did not work.			broken call bells. Education to include			
	On 9/16/15 at 11:00 /				process for notification to maintenan			
		om 1/1/15 through 9/15/15			supervisor and/or Administrator			
		maintenance book revealed			immediately for broken call bells and			
		call bell maintenance. The			process for ensuring resident call sys			

Facility ID: 20040007

If continuation sheet Page 49 of 63

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/19/2015 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C 17/2015
NAME OF PI	ROVIDER OR SUPPLIER	•	•	ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				52	201 CLARKS FORK DRIVE		
UNIVERSA	AL HEALTH CARE/NORT			R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 463	Continued From page	<u>-</u> 49	F 46	63			
		dicated that out of those 30		00	in place		
		mpleted on the same day,			in place.		
	12 were completed o				Maintenance Supervisor and/or Manag	per	
		er, 1 was completed 3 days			on Duty will check call bell system for		
	later and 1 was comp	bleted 6 days later.			residents including common bathroom		
		AM the maintenance director			shower rooms and hallway notification		
	•	rding the maintenance book.			lights for functioning daily x 4 weeks, the	nen	
		ess of staff submitting a . He stated that if there was			weekly ongoing with preventative maintenance rounds.		
		with a resident's call bell			maintenance rounds.		
		it in the maintenance book.			Facility plans to monitor its performance	e	
		ecked the maintenance book			to make sure that solutions are sustain		
	a minimum of three ti	mes per day. He stated that			The facility must develop a plan for		
		siness hours weekly from			ensuring that correction is achieved ar	nd	
		ay and was on-call 24 hours			sustained:		
		for emergencies. He stated					
		ce needs for call bells were			The Maintenance Supervisor will report		
	fixed in the same day	was written after normal			the findings of the call bell system che to the Quality Assurance and	CKS	
		the weekend he would not			Performance Improvement Committee		
		the next business day. He			monthly for six months or until a patter		
	•	sidered a problem with a			compliance is obtained.		
		be an emergency issue and			•		
	that if an issue was for				Date of Completion: October 15, 2015	5.	
	•	nal business hours or on the					
		d to be notified by phone.					
		M the maintenance director					
	•	formation about the call bell erview. He revealed that					
		s the facility has had with call					
		properly was caused by the					
	magnetic switch pull						
		d that there were multiple					
		ne magnetic switch pull cord					
		sulted in the bathroom call					
	bell and room call be						
		cord needed to be reset in					
	order for the call bells	hat he had contacted the call					

If continuation sheet Page 50 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COMF	
		345529	B. WING				0 17/2015
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	AL HEALTH CARE/NORT	'H 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 463 F 520 SS=E	bell company about th provided with no solur On 9/17/15 at 10:30A checked for proper fu hall and 400 hall were bells that were not fur 104, 306, 308, and 40 On 9/17/15 at 12:00P provided a written rec call bell function audit The audit information four additional rooms functioning properly (f 400). The audit infor two of three central bat that were not function 483.75(o)(1) QAA COMMITTEE-MEMBI QUARTERLY/PLANS A facility must maintai assurance committee nursing services; a ph facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to and assurance activit develops and implem action to correct ident A State or the Secret	his issue in the past, but was tion. M all resident call bells were nctioning. The 100 hall, 300 e each found to have call nctioning properly (rooms 01). M the maintenance director cord of a facility wide internal the completed on 9/17/15. was reviewed and revealed with call bells that were not rooms 106, 315, 318, and mation also revealed that ath rooms had call systems ing properly. ERS/MEET Set a quality assessment and consisting of the director of hysician designated by the other members of the ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies. Fary may not require rds of such committee h disclosure is related to the		463 520			10/15/15

Facility ID: 20040007

If continuation sheet Page 51 of 63

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/19/2015 M APPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 09/17/2015	
		345529					
	ROVIDER OR SUPPLIER	TH RALEIGH		52	TREET ADDRESS, CITY, STATE, ZIP CODE 201 CLARKS FORK DRIVE ALEIGH, NC 27616	09/17/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 520		section. by the committee to identify ficiencies will not be used as	F	520			
	by: Based on observatio interview, the facility Assurance committee monitor and revise as developed for the rec 9/25/14 in order to ac compliance. The faci deficiencies on dignit maintenance (F253),	ility had a pattern of repeat y (F241), housekeeping and activities of daily living care hts (F312) and prevent			F 520 Corrective action will be accomplished the resident found to have been affect by the deficient practice: Quality Assurance and Performance Improvement Committee met Septemb 21, 2015 and reviewed and revised Q/ plans related to tags F241, F253, F312 and F318. For tag F241	ed ber API	
	failed to treat a reside more than an hour to a resident who was k incontinent, and by fa needs were addresse light and leaving their residents (Resident # failed to knock before	renced to F241 - the facility ent with dignity by taking provide incontinent care, to nown to have been illing to ensure a resident's ed before turning off the call room, for 1 of 3 sampled (32) reviewed for dignity; and e entering a resident room oserved during wound care			Resident #32 is receiving incontinent of Resident #119 staff are knocking on de and asking permission prior to entering the resident ¿s room. Nursing Assistant #2 was counseled a re-educated on resident privacy to incl knocking on door and asking permission prior to entering the resident ¿s room. For tag F253	oor g ind lude	
		renced to F253 - the facility ower rooms that were clean 2 of 2 shower rooms.			Shower rooms for unit 1 and unit 2 we deep cleaned by housekeeping. Pest control service to treat shower ro		

Facility ID: 20040007

If continuation sheet Page 52 of 63

		ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 10/19/2015 RM APPROVED IO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345529	B. WING _		0	C 9/17/2015
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
	L HEALTH CARE/NORT			5201 CLARKS FORK DRIVE		
UNIVERO/				RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page	= 52	F 5	520		
	This tag is cross refer	renced to F312 - the facility ntinent care to a resident		on unit 1 and unit 2 fc	or pests.	
	who was known to ha (Resident #32) of 3 s	ave been incontinent for 1 ampled residents and failed #120) of 1 sampled male		Shower curtains were rooms on unit 1 and u		
	-	or activities of daily living		Maintenance will repl unit 1 and unit 2 show		
	failed to provide a har	renced to F318 - the facility nd roll for 1 (Resident #15)		Maintenance will repa 1 and unit 2 shower r	· •	
		nand contracture who had n Occupational Therapy with roll application.		For Tag 312		
	An interview was con	ducted with Administrative		Resident #32 is recei	ving incontinent care.	
		t 3 PM. She stated that they		Resident #120 was sl	haved.	
	Performance Improve regards to activities o	-		Nurse Aide #4 is no lo facility.	onger employed at	
		uently and so the staff knew		Nurse Aide #1 was co	ounseled and	
	education had also be	osed to do. She added that een done on ensuring		re-educated on provio ADL¿s including shave	-	
	environment Administ	egards to the physical trative Staff #2 stated that ne to observe for sanitation		For Tag 318		
	issues. She also indi	cated that Restorative Staff to cover the unit as often as		Resident #15 has har	nd roll in place.	
	-	uld maintain resident ' s		Corrective action will those residents havin	g potential to be	
	range of motion altho monitored through Q/	ugh this was not being API.		affected by the same	deficient practice:	
				For tags F241, F253, residents have the po affected.		
				For tag F241		
				All residents have an	assigned nursing	

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 53 of 63

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	;		
		345529	B. WING			C 17/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		17/2013
				5201 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NOR			RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 520	Continued From pag	ge 53	F 52			
				assistant each shift to n	neet their needs.	
			Residents are receiving ADL¿s including incont			
			Staff are knocking on re asking permission prior resident¿s room.			
				For tag F253		
				On September 25, 2019 for all nursing staff in re cleanliness of shower re	ference to	
				Education to include re- including dirty linen, tra from the shower room a waste and/or spills imm	sh and soiled items and cleaning up of	
				Housekeeping will chec three times daily in refe cleanliness at the begin shift and end of shift. C continue ongoing.	rence to ning of shift, mid	
				The Director of Nursing Development Coordina and/or supervisor will m to include off shifts and monitor cleanliness of s any areas in need of re rounds will be done dai weekly x 4 weeks and t months.	tor, Unit Manager nake rounds daily weekends to shower rooms and pair. Shower room ly x 4 weeks,	
				The Maintenance super shower rooms on unit 1 for needed repairs. Ro	and unit 2 weekly	

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 54 of 63

CENTER	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED			
		345529	B. WING		C 09/17/2015			
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE				
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION			
F 520	Continued From pag	e 54	F 520	<ul> <li>ongoing with preventative mainter rounds.</li> <li>On October 5, 2015 education confor all members of Quality Assurate Performance Improvement Commedification and monitoring of Quality Assurance plans.</li> <li>Quality Assurance and Performare Improvement Committee will meet monthly to review all current Qual Assurance plans with modification as needed at that time.</li> <li>Measures put into place or system changes made to ensure that the practice will not occur:</li> <li>For tag F241</li> <li>On September 17, 2015 education Staff Development Coordinator be all nursing staff in reference to reabsences and tardies to the Direct Nursing. Education completed O 12, 2015. Staff members not receive inservice education by October 12, be required to receive inservice education to include staff member physically speaking to the Director Nursing. If Director of nursing is be reached staff are to report to Se Development Coordinator, Unit Members and the coordinator.</li> </ul>	In pleted Ince and Initee. It, Jality Ince St Lity Ins done Mic deficient In by egan for porting ctor of ctober eiving in 2015 will iducation hift. In por of unable to Staff			

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 55 of 63

		דופי ר	CONSTRUCTION		
				COMPLETED	
345529	B. WING	·		09/17/2015	
PPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ARE/NORTH RALEIGH					
DEFICIENCY MUST BE PRECEDED BY FU	JLL PREF	IX	(EACH CORRECTIVE ACTION SHOULD	BE COM	(X5) PLETIOI DATE
From page 55	F	520	on assignment sheet to indicate that have reported for duty. The Unit Manager, Supervisor and/or nurse or will complete assignment for nursing assistants using a resident census at beginning of each shift to ensure all residents in the facility have an assig nursing assistant. The Unit Manager Supervisor and/or nurse on duty will within thirty minutes of beginning of s that all staff members have reported duty. Assignments will be adjusted a time if all staff members are not pres Staff provide person centered care to include responding to all resident new regardless of their assigned area. The Director of Nursing, Staff Development Coordinator, Unit Mana and/or Supervisor will check assignment sheets daily x 4 weeks, weekly x 4 w and then monthly x 3 months to ensu- staff have initialed that they have rep for duty and that assignment was completed accurately to reflect staff thave reported for duty and that all residents have an assigned nursing assistant. Assignment sheets will be given to th Administrator for review daily x 4 week weekly x 4 weeks and then monthly x months. On September 25, 2015 education b for all nursing staff in reference to providing assistance with ADL¿s incl	ager hettine ent. beds ager hent eeks ure oorted that hettine kagen uding	
	ICARE & MEDICAID SERVICES S (X1) PROVIDER/SUPPLIER/S IDENTIFICATION NUMBI 345529 IPPLIER ARE/NORTH RALEIGH UMMARY STATEMENT OF DEFICIENCIES 1 DEFICIENCY MUST BE PRECEDED BY FU	IDENTIFICATION NUMBER: A. BUILE 345529 B. WING IPPLIER ARE/NORTH RALEIGH UMMARY STATEMENT OF DEFICIENCIES 1 DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION)	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING B. WING B. WING B. WING B. WING B. WING S ARE/NORTH RALEIGH S ID PREFIX TA IDEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION) IDENTIFYING INFORMATION	ICARE & MEDICAID SERVICES         s       (x1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION A BUILDING         345529       B. WING         IPPLER       STREET ADDRESS, CITY, STATE, 2IP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27618         INDEPTICIENT OFFICIENTY WAYS TATEMENT OF DEPRICENCIES INTEGRITORY OR LSC IDENTIFYING INFORMATION)       ID PREPER TAG         From page 55       F 520         From page 55       F 520         On assignment sheet to indicate that have reported for duty. The Unit Manager, Supervisor and/or nurse on will complete assignment for nurse on will complete assignment for nurse on will complete assignment for nurse on the duty will within thirty minutes of beginning of each shift to ensure all residents in the facility have an assig nursing assistant. The Unit Manager Supervisor and/or nurse on duty will within thirty minutes of beginning of each time if all staff members have reported cuty. Assignments will be adjusted a time if all staff members have reported cuty. Assignment will be adjusted a tim ef all staff members have reported care. The Director of Nursing, Staff Development Coordinator, Unit Manage super cord for duty and that all residents have an assigned area. The Director of Nursing. Staff Development Coordinator, Unit Manage super to duty and that all residents have an assigned nursing assistant. Assignment sheets will be given to th Administrator for review daity X 4 weeks and then monthy 3 months.         On September 25, 2015 education b for all nursing staff in reference to providing assistance with ADL <sub>2</sub> s in the for all nursing staff in reference to providing assistance with ADL <sub>2</sub> s	S       (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING       (X3) DATE SURVE ABUILDING         PPLER       345529       STREET ADDRESS, CITY, STATE, ZIP CODE SECIENCEMENT OF DEFIDENCIES IDENCIFY WINTS & PROPONDED FULL LATORY OR LSC IDENTIFYING INFORMATION)       ID PREER TAC       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY WINTS & PROPONDED FULL LATORY OR LSC IDENTIFYING INFORMATION)       ID PREER TAC       PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       Office CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY         From page 55       F 520       on assignment sheet to indicate that they have reported for duty. The Unit Manager, Supervisor and/or nurse on duty will complete assignment for nursing assistants using a resident census at the beginning of each shift to ensure at residents in the facility have an assigned nursing assistant. The Unit Manager, Supervisor and/or nurse on duty will check within thirty minutes of beginning of shift that all staff members have reported for duty. Assignments will be adjusted at that time if all staff members are not present. Staff provide person centered care to include responding to all resident needs regardless of their assigned area.         The Director of Nursing, Staff Development Coordinator, Unit Manager and/or Supervisor will check assignment sheets daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months to ensure staff have initialed that they have reported for duty and that assignment was completed accurately to reflect staff that have reported for duty and that all residents have an assigned nursing assistant.         Assignment sheets wil

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 56 of 63

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	(X3) DA1	IO. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	CON	<b>MPLETED</b>
		345529	B. WING			С
NAME OF P	ROVIDER OR SUPPLIER	545525		STREET ADDRESS, CITY, STATE, ZIP CO		9/17/2015
				5201 CLARKS FORK DRIVE		
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 520	Continued From pag	je 56	F 52	<ul> <li>signs of soiling and person to include responding to all regardless of assigned area</li> <li>The Director of Nursing, Sta Development Coordinator, I and/or Supervisor will comp rounds daily to include off s weekends to ensure that numeeting the needs of all ressincluding incontinent care.</li> <li>Walking rounds will continue weeks and weekly thereafter On September 25, 2015 edit for all staff as it relates to di privacy. Education to include doors and asking permissio to entering a resident room.</li> <li>The Administrator, Director Staff Development Coordination Manager, Nursing Supervis Manager on Duty will make to include off shifts and wee ensure that staff are promotion knocking on doors and asking to enter prior to entering a right back to enter prior to entering a right back to enter prior to entering a right back and then months.</li> </ul>	centered care resident needs a. aff Unit Manager blete walking hifts and ursing staff are sidents e daily x 4 er. ucation began gnity and de knocking on n to enter prior of Nursing, ator, Unit or and/or daily rounds ekends to ting dignity by ng permission esident room. aily x 4 weeks,	
				For tag F253 On September 25, 2015 ed for all nursing staff in refere		
				cleanliness of shower room	s. Education	
				to include removing all item	s including	

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 57 of 63

						0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE S COMPL	
					с	
		345529	B. WING		09/1	7/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
UNIVERS	AL HEALTH CARE/NOR	RTH RALEIGH		5201 CLARKS FORK DRIVE		
	1			RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 520	Continued From pag	ge 57	F 52	0 dirty linen, trash and soil shower room and cleani		
				and/or spills immediately		
			The Director of Nursing, Development Coordinate and/or supervisor will ma to include off shifts and v monitor cleanliness of sh	or, Unit Manager ake rounds daily weekends to nower rooms and		
			any areas in need of rep will be done daily x 4 we weeks and then monthly	eks, weekly x 4 x 3 months.		
				Shower rooms will be ch during Quality Assurance for cleanliness and areas repair. Checks will conti	e Room rounds s in need of	
				Housekeeping will check three times daily in refer- cleanliness and areas in the beginning of shift, mi shift. Checks will contine	ence to need of repair at id shift and end of	
				The Maintenance super- shower rooms on unit 1 for needed repairs. Rou ongoing with preventativ rounds.	visor will monitor and unit 2 weekly nds will continue	
				For tag F312		
				On September 25, 2015 for all nursing staff in refi- providing assistance with incontinent care to be gi- 2-3 hours, as requested family member and as n	erence to h ADL¿s including ven at least every by the resident or	

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 58 of 63

TATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	<u>NO. 0938-039</u> TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	со	MPLETED
		245500				С
	OVIDER OR SUPPLIER	345529	B. WING			9/17/2015
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 5201 CLARKS FORK DRIVE		
UNIVERSA	L HEALTH CARE/NOR	RTH RALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 520	Continued From pag	ge 58	F 52		ed facial hair include eds f nit Manager ete walking ifts and sing staff are dents d shaving. daily x 4 cation began to m guards. ive nursing to ls. Nurse to ards to ensure on cord i hand rolls / dinator, Unit opervisor will ation record I / palm ide physical m guard veekly x 4	
				The Director of Nursing will r	eview	

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 59 of 63

TATEMENT OF DI	EFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
					C
		345529	B. WING	09/17/2015	
NAME OF PROVI	DER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERSAL H	IEALTH CARE/NORT	H RALEIGH		5201 CLARKS FORK DRIVE RALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE COMPLETIO
F 520 Cc	ontinued From page	2 59	F 520		guard view r x 4 and nce. , , and nce. , , and nce. , , and nce. , , and nce. , , , and nce. , , ,

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 60 of 63

					OMB NO. 0938-039 (X3) DATE SURVEY		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
	345529		B. WING		C 09/17/2015		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	AL HEALTH CARE/NORT			5201 CLARKS FORK DRIVE			
011112110				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BEREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				OULD BE COMPLETION		
F 520	Continued From page 60		F 52	D			
				The Director of Nursing will report findings of the assignment sheet checks to the Quality Assurance and Performance Improvement Committee monthly for six months or until a pattern of compliance is achieved. The Director of Nursing will report the			
				Summary of walking rounds to the Assurance and Performance Improvement Committee monthly months or until a pattern of comp achieved.	e Quality / for six		
				The Administrator will report the to of the dignity rounds to the Qualit Assurance and Performance Improvement Committee monthly months or until a pattern of comp achieved.	ty / for six		
				For tag F253			
				The Director of Nursing and Housekeeping Director will report of the shower room rounds to the Assurance and Performance Improvement Committee monthly months or until a pattern of comp achieved.	e Quality / for six		
				The Maintenance Supervisor will findings of the shower room roun repairs completed to the Quality Assurance and Performance Improvement Committee monthly months or until a pattern of comp achieved.	ds and / for six		

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 61 of 63

PREFIX (EACH DEFIC	ORTH RALEIGH	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETION	
UNIVERSAL HEALTH CARE/I (X4) ID SUMMAI PREFIX (EACH DEFIC TAG REGULATOR	IORTH RALEIGH RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX	5201 CLARKS FORK DRIVE RALEIGH, NC 27616 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	N (X5) DBE COMPLETION	
UNIVERSAL HEALTH CARE/I (X4) ID SUMMAI PREFIX (EACH DEFIC TAG REGULATOR	ORTH RALEIGH	ID PREFIX	5201 CLARKS FORK DRIVE RALEIGH, NC 27616 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION	
(X4) ID SUMMA PREFIX (EACH DEFIC TAG REGULATOR	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX	RALEIGH, NC 27616 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION	
PREFIX (EACH DEFIC TAG REGULATOR	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETION	
F 520 Continued From	page 61	1	DEFICIENCY)	HOULD BE COMPLETIC	
		F 520			
			<ul> <li>The Administrator will report findings quality assurance room rounds comp to the Quality Assurance and Performance Improvement Committee monthly for six months or until a patter compliance is achieved.</li> <li>For tag F312</li> <li>The Director of Nursing will present a summary of the walking rounds to the Quality Assurance and Performance Improvement Committee monthly for months or until a pattern of compliant obtained.</li> <li>For tag F318</li> <li>The Director of Nursing will present th findings of the Medication Administrat Record and hand roll / palm guard application audits to the Quality Assurance and Performance Improvement Committee monthly for months or until a pattern of compliant obtained.</li> <li>All audit information will be taken to the Quality Assurance and Performance Improvement Committee monthly for months or until a pattern of compliant obtained.</li> <li>All audit information will be taken to the Quality Assurance and Performance Improvement Committee monthly for review over the next 6 months.</li> <li>The Quality Assurance and Performance Improvement Committee will review the plan monthly over the next 12 months</li> </ul>	eeern of a a be six ce is he tion six ce is he he	

Event ID: DU4911

Facility ID: 20040007

If continuation sheet Page 62 of 63

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE - COMPL COMPL			D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/19/2015 MAPPROVED D. 0938-0391	
345529     B. WING     09/*       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     5201 CLARKS FORK DRIVE       UNIVERSAL HEALTH CARE/NORTH RALEIGH     STREET ADDRESS, CITY, STATE, ZIP CODE     5201 CLARKS FORK DRIVE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION SHOULD BE       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX     CROSS-REFERENCED TO THE APPROPRIATE       F 520     Continued From page 62     F 520     meet monthly and ensure that all plans are being monitored as proposed for effectiveness.	STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         UNIVERSAL HEALTH CARE/NORTH RALEIGH         (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)         F 520       Continued From page 62       F 520       F 520         Meet monthly and ensure that all plans are being monitored as proposed for effectiveness.       meet monthly and ensure that all plans are being monitored as proposed for			345529	B. WING	B. WING			09/17/2015	
UNIVERSAL HEALTH CARE/NORTH RALEIGH       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)         F 520       Continued From page 62       F 520         meet monthly and ensure that all plans are being monitored as proposed for effectiveness.	NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)F 520Continued From page 62F 520F 520F form page 62F 520meet monthly and ensure that all plans are being monitored as proposed for effectiveness.	UNIVERSAL HEALTH CARE/NORTH RALEIGH								
meet monthly and ensure that all plans are being monitored as proposed for effectiveness.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE	
	F 520	Continued From page	e 62	F	520	meet monthly and ensure that all pla are being monitored as proposed for effectiveness.			

Facility ID: 20040007

If continuation sheet Page 63 of 63