PRINTED: 12/07/2017 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY	
		345529	B. WING				C 26/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	10//	20/2011	
				5	201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH		R	ALEIGH, NC 27616			
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI				(X5) COMPLETION DATE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.1E	3,1,2	
F 165	RIGHT TO VOICE GI	RIEVANCES WITHOUT	F ·	165			11/22/17	
SS=D	REPRISAL							
	CFR(s): 483.10(j)(1)							
	(j)(1) The resident ha	•						
	_	ility or other agency or entity						
		s without discrimination or						
		ear of discrimination or nces include those with						
		eatment which has been						
	•	hat which has not been						
		or of staff and of other						
		concerns regarding their LTC						
		is not met as evidenced						
	by:	n, record review, staff			F165			
		interview the facility failed to			This plan of correction constitutes a			
		ve grievances for 1 of 1			written allegation of compliance.			
	resident that was revi	-			Preparation and submission of this plar	າ of		
	(Resident #198).				correction does not constitute an	_		
					admission or agreement by the provide	r of		
	Findings Included:				the truth of the facts alleged or the correctness of the conclusions set forth	,		
	Resident #198 was a	dmitted to the facility on			on the statement of deficiencies. The pl			
		es included cerebral vascular			of correction is prepared and submitted			
	_	aphasia and cognitive			solely because of requirement under st			
	deficit.				and federal law, and to demonstrate the	Э		
					good faith attempts by the provider to			
		Data Set (MDS) dated			improve the quality of life of each reside	ent.		
		#198 identified she required with toileting, was always			ROOT CAUSE			
		ognition was moderately			This alleged noncompliance was result	ed		
	impaired.	-g			from the Center's Executive Director ar			
	•				the Director of Nursing misinterpretation			
		ance log for the past 3			of regulatory requirements related to			
		the facility Administrator,			investigation and resolving of resident's	3		
		dated 9/2/17 for Resident			grievances. The Executive Director			
	#198 that was submit				stated since Resident #198 potentially			
		e grievance documented			misplaced her dentures, the Executive			
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

11/17/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					С	
	345529	B. WING	· · · · · · · · · · · · · · · · · · ·	10	/26/2017	
NAME OF PROVIDER OR SUPP	LIER		STREET ADDRESS, CITY, STATE, ZIP C	·		
			5201 CLARKS FORK DRIVE NW			
UNIVERSAL HEALTH CAP	RE/NORTH RALEIGH		RALEIGH, NC 27616			
PREFIX (EACH D	IMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETION DATE	
F 165 Continued Fro	· ·	F 16				
tennis shoes identified combeing taken to provided with grievance addregarding glowithe floor in the wasn't being been found on The Director of investigate the dated as resocare plan mecher concerns was reviewed assignment of discussed the wig and shoes and other resistance were long and shoes were long a	#198's bottom denture, wig and were missing. The grievance also cerns regarding the resident not to the day room for her meals and supervision with eating. The ditionally documented concerns wes and hand sanitizer being left on the resident's room, that the resident to to let devery 2 hours and had an several occasions soaking wet. In off Nursing (DON) was assigned to be grievance on 9/2/17 and was alved on 9/11/17. The facility had a setting with the daughter to discuss at length, her mother's care plan and the Nursing Assistant (NA) are card was updated. The facility resident's tendency to remove her and leave them in random places dent's rooms. Stated her wig and located and returned on 9/4/17. In oted to be dry during checks with moted and she was being checked ours. A phone conversation and one sion was conducted with Resident hiter. In our dated 9/9/17 at 5:14 pm stated Resident #198 was alert with usion. She propelled herself in a ound the facility and was noted to personal belongings. Resident #198 alled the facility and stated her wer denture was missing. The aughter was informed that they were set staff were looking for her mother'		Director thought there is no should have had to do. Reconsultant re-educated the Executive director and the Nursing on 10/26/2017 on grievance policies and proof the importance of completi investigation. IMMEDIATE ACTION Resident #198 incontinent provided by Nurse Aide #6 Aide #7. Resident #198 seen a dentevaluation and has an importance filed by the responsible don 11/17/2017. grievance filed by the responsible party. IDENTIFICATION OF OTH 100% audit of all grievance residents or family member last 30 days completed by director, Director of Social and/or Director of Social and/or resolved investigated and/or resolved grievance policy grievance the investigated and/or resolved grievance policy and proces.	egional Clinical e Center Director of facility cedures and ng thorough care was and Nurse tist for denture ression Resident #198 onsible party on administrator en to include in scheduled for it care delivery grievance was ine Administrator of. No other ent #198 or her IERS es filed by rs within the the Executive Services #1 ervices #2 to nat was not ed per center's		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C	
NAME OF DE	ROVIDER OR SUPPLIER	0-10025		STREET ADDRESS, CITY, STATE, ZIP COD	•)/26/2017	
NAME OF F	COVIDER OR SUFFLIER				-		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE NW			
				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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 165	Continued From pag	ge 2	F 16	65			
F 165	at 4:11 pm revealed wheelchair at the nu appeared to be dry a She did not have an An interview on 10/2 revealed she was fa she had been her Nother resident 's dauge's denture being mis denture was ever for that the resident work wetter". She added frequently to make so An observation of in and NA #7 was cond 10/25/17 at 2:15 pm the care they were pwith resident transfe toilet, resident was pto use the bathroom appropriately after to applied, and no skin during the observation. An interview on 10/2 revealed she was fa She stated the resident didn't like resident didn't like applied to the resident didn't like resident didn't like applied to be denuted the resident didn't like applied the resident didn't like applied to be denuted the resident didn't like applied to be denuted the resident didn't like applied the resident didn't like applied to be denuted the resident didn't like applied to be denuted the resident didn't like applied the resident	she was sitting in a rsing station. Her clothing and no urine odor was noted. y dentures in her mouth. 24/2017 4:18 pm with NA #8 miliar with Resident #198 and A. She stated she recalled the talking about her mother ssing, but wasn 't sure if her und or replaced. NA #8 stated to briefs and was a "heavy that you needed to check her sure she was not wet. continence care by NA #6 ducted for Resident #198 on . NA #6 and NA #7 explained providing, both NA 's assisted in from her wheelchair to the provided with privacy and time . Resident #198 was cleaned bileting, a new brief was concerns were identified	F 16	grievance policy and procedu will be completed by 11/22/17 this audit will be documented grievance audit tool located a compliance binder. SYSTEMIC CHANGES Effective 11/22/2017, the cen of Social services #1, Directo services #2 and/or Executive initiated a process for reviewi grievances during daily depair meeting. The center Director services #1, Director of Social and/or Executive Director will grievances filed last 24 hours previous stand up meeting to each grievance is assigned to Department who will complete investigation, and also will eneach assigned personnel is in the investigation needed to regrievances. This systemic process will tak (Monday through Friday). Any issues will be addressed pror appropriate actions will be im by the center Director of Social services Executive Director. This procincorporated in a daily Stand Any negative findings will be	7. Findings of on the facility ter Director of Social Director, ng all filed rement heads of Social all services #2 review or from the ensure that, or a led the issure that informed of esolve each see place daily yieldentified mptly and plemented all services is #2 and/or less will be up meeting, documented		
	at 5:24 pm revealed her supper meal. He no urine odor was no	esident #198 on 10/25/2017 she was in the day room for er clothing appeared dry and oted.		on the daily "Stand up meetin maintained in the "Daily meet Director of Social services (# Executive Director, Director of (DON), Assistant Director of I (ADON) and/or Staff Develop	ting binder". 1, or #2), of Nursing Nursing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345529	B. WING _			10/	26/2017
NAME OF PR	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				52	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		R	ALEIGH, NC 27616		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 165	Continued From page	e 3	, F	165			
		aled that Resident #198 's	'	100	Coordinator (SDC) will complete 100%		
	• ,	ed her on 10/18/17 that her			education for all current facility employe		
	~	ure was missing. She stated			, to include full time, part time and as	503	
		e could not be located. SW			needed employees about facility		
	#1 added the wound				grievance policy and procedure. The		
		ent #198 's upper denture			emphasis of this education was on the		
		as causing her some mouth			importance of documenting any voiced		
		ed her daughter of that today			grievance by a resident and/or family		
		going to determine a time			member, and proper steps to be follow	ed	
		d go to the dental clinic for			order to resolve each. Any employee n		
		er denture and replacement			educated by 11/22/2017 will not be		
		SW #1 stated she was not			allowed to work until educated. This		
	aware that the Reside	ent #198 's lower denture			education will also be added on new hi	res	
	had been reported m	issing by her daughter on			orientation process for all new employe	es	
	9/2/17.				effective 11/22/2017.		
	An interview on 10/25				MONITORING PROCESS		
		ughter revealed she had			Effective 11/22/2017, Executive Director	r	
		's care plan on 9/2/17 and			and/or Director of Nursing, Assistant		
		ddressed her concerns			Director of Nursing, and/or Staff		
		vance dated 9/2/17. She			Development Coordinator, will monitor		
		wig was found, but her			compliance by completing the audit of		
		and and she had to buy her a			completed/resolved grievances to ens		
	-	198 's daughter added the			that an investigation was completed an	a	
		ssed her mother 's missing			grievance was resolved per facility		
		ad called the Administrator			grievance policy and procedure. This		
		e times after she had voiced			monitoring process will take place daily		
		y never responded to her.			(Monday through Friday) for 2 weeks the		
		reeks ago she tried to meet old they weren 't available at			3x/week for two more weeks, then wee for 2 weeks then monthly for 3 months	- 1	
		uld meet with the Social			until the pattern of compliance is	OI	
		98 's daughter stated that			maintained.		
		ould just wait until they were			mantanica.		
		ally the Administrator and			Any issues identified during this		
		he stated during the meeting			monitoring process will be addressed		
		her the facility wasn 't liable			promptly. Findings from this monitoring		
		her 's denture and she hadn			process will be documented on a		
		e back from the facility until			grievance audit form and filed in the		
		about making arrangements			facility compliance binder effective		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C 10/26/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10.20.20.1	$\overline{}$
				5201 CLARKS FORK DRIVE NW		
UNIVERSA	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ON
F 165	Continued From page	· 4	F 16	35		
F 166 SS=C	for her mother to be sher mother was still in bathroom and she did soaking wet when she. An interview on 10/26 Administrator reveale extensive conversation daughter. The Administrator and the resist have concerns with heat the date) and the resist have concerns with heat the date on the 9/2/1 Administrator reviewe 9/2/17 that had been acknowledged that as ongoing concerns regand continence care. searched for the dent She did not know why heard about the missis when it had been ider grievance. The Administrator the daugh should have been do and formally investigated RIGHT TO PROMPT GRIEVANCES CFR(s): 483.10(j)(2)-6	deen by a dentist. She added on being taken to the doccasionally find here a came to visit. In at 11:14 am with the doshe had multiple, ans with Resident #198's strator stated she and the ar recently (wasn't sure of dents daughter continued to the er mother's missing the care. She explained she as a new grievance as a new grievance as an ew grievance as an ew grievance dated submitted and as of 10/26/17 there were parding the missing denture. She stated the facility had the put it was not found. In SS #1 stated the first she and denture was on 10/18/17 thiffied on the 9/2/17 histrator added that Resident I so many complaints and the state of the	F 10	11/22/2017. Effective 11/22/2017, Director of Social Services (#1 or #2), and/or Executive Director will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. To QAPI committee can modify this plan the ensure the facility remains in substantic compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Execut Director and the Director of Nursing with be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 11/22/2017	ty ne ne ne o al	
	must make prompt ef	s the right to and the facility forts by the facility to resolve nt may have, in accordance				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING _				26/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 10//	20/2011	
				52	201 CLARKS FORK DRIVE NW			
UNIVERSA	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 PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 166	Continued From page	e 5	F f	166				
	with this paragraph.							
		t make information on how complaint available to the						
	to ensure the prompt regarding the residen paragraph. Upon requ	t establish a grievance policy resolution of all grievances ts' rights contained in this uest, the provider must give ce policy to the resident. The t include:						
	postings in prominent facility of the right to the (meaning spoken) or grievances anonymous of the grievance official can be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the confidependent entities to be filed, that is, the polymer of the polymer o	in writing; the right to file usly; the contact information ial with whom a grievance is or her name, business email) and business phone e expected time frame for v of the grievance; the right cision regarding his or her ontact information of with whom grievances may ertinent State agency, Organization, State Survey ing-Term Care Ombudsman in and advocacy system;						
	receiving and tracking conclusions; leading by the facility; mainta information associate	rance Official who is eeing the grievance process, g grievances through to their any necessary investigations ining the confidentiality of all d with grievances, for of the resident for those						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED		
		345529	B. WING			C	
	ROVIDER OR SUPPLIER] B. Wille	STREET ADDRESS, CITY, STATE, ZIP 5201 CLARKS FORK DRIVE NW	CODE	10/26/2017	
UNIVERSA	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 O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 166	, ,		F	166			
	written grievance dec	anonymously, issuing isions to the resident; and e and federal agencies as specific allegations;					
		ing immediate action to tial violations of any resident diviolation is being					
	reporting all alleged v abuse, including injur and/or misappropriati anyone furnishing ser	483.12(c)(1), immediately iolations involving neglect, ies of unknown source, on of resident property, by vices on behalf of the histrator of the provider; and aw;					
	include the date the g summary statement of the steps taken to invi- summary of the pertir regarding the residen as to whether the grie confirmed, any correc- taken by the facility as	rritten grievance decisions rievance was received, a of the resident's grievance, estigate the grievance, a nent findings or conclusions t's concerns(s), a statement evance was confirmed or not cive action taken or to be a result of the grievance, en decision was issued;					
	of the residents' rights or if an outside entity the State Survey Age Organization, or local	e law if the alleged violation is is confirmed by the facility having jurisdiction, such as ncy, Quality Improvement law enforcement agency or any of these residents'					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 501251	_		Ι,	С	
		345529	B. WING				26/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				5	201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		R	RALEIGH, NC 27616			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 166	Continued From page	e 7	F	166				
		ence demonstrating the		100				
	, , ,	es for a period of no less than						
	_	ance of the grievance						
	decision.	ande of the ghevance						
		Γ is not met as evidenced						
	by:							
	•	iew and staff interviews the			F166C			
	facility 's grievance p	policy failed to include the			ROOT CAUSE			
	grievance official 's p	physical address and			This alleged noncompliance was result	ed		
	business e-mail addr	ess.			from the Center's Executive Director as	nd		
					the Director of Nursing misinterpretatio	n		
	Findings Included:				of regulatory requirements related to			
					posting of information specifically the			
		ed "Filing Grievances /			grievance official name, address and			
	1 -	evision date of March 2017,			business e-mail address. The center			
		facility Administrator. The cility will assist residents,			executive director indicated that the	4		
	1	other interested family			Grievance official name was posted bu she did not post the address and e-ma			
	1	tes in filing grievances or			address as those two items were not	11		
		h requests are made." The			included in the facility grievance policy			
	1	Grievance Official has the			and procedure.			
		rsight of the grievance and /						
	or complaint investiga				IMMEDIATE ACTION TAKEN			
		·			On 11/20/2017, Regional clinical			
	The facility procedure	e titled "Grievances" was			consultant added an addendum to the			
	1 .	ty Administrator and was not			facility current grievance policy and			
	I -	e stated "If you have any			procedures to include the posting			
	concerns, please cor				requirements that notates the name,			
	_	Administrators Name and a			physical address and business email			
		ysical address and business			address of the grievance official.			
	e-mail address was r	not provided on the			On 11/20/2017, the grievance addendu			
	procedure.				was added on the policy and procedure	es:		
	The facility "Desident	/Eamily Criovance and			located in the facility new admission	ont		
	_	t/Family Grievance and re" was provided by the			package, at the binder located at the fr desk and in the facility compliance bind			
	1	and was not dated. The			desk and in the facility compliance bill	ICI.		
	_	ur intention is to always			IDENTIFICATION OF OTHERS			
	-	are to our residents and their			On 11/22/2017 All regulatory required			
	-	have concerns, grievances			policy and procedures to include			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C 10/26/2017
	ROVIDER OR SUPPLIER AL HEALTH CARE/NOI	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		10/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 166	or compliments we facility social worke number listed)." Thi the facilities current An interview on 10/2 Administrator revea Grievance Official. Sprocedure was review process and the prothe grievance form The Administrator and address and busine Grievance Official workers.	ask that you contact the r or our Care line (toll free s procedure was located in	F 16	grievance policy and procedures prohibition policy and procedures Admission, transfer and discharg and procedures reviewed by the Clinical consultant to ensure they the intent of requirements of part All other reviewed policies and/or procedures noted to meet the intent regulation. SYSTEMIC CHANGES Effective 11/22/2017, any revised and/or procedure will be reviewed Quality Assurance and Performa Improvement Committee (QAPI) ensure each policy meet the interegulation before implementation Committee will include the minim The Facility Medical Director, Dir Health Services, Executive Direct Licensed Pharmacist and at leas other members. Effective 11/22/2017 information grievance official to include name physical address, phone number business e-mail will be discussed new admission process by the Addinistrative staff who complete admission package during admis Effective 11/22/2017 The Grievar official information is publicly posprominent locations in the facility information include grievance offiname, physical address, phone results of the process of the programment of the process of the prominent of the process of the programment of the process of the prominent of the process of the proc	s and ge policy Regional y meet dicipation. r ent of d policy d by the nce to nt of the tor, t three for e, and d during dmission er and/or e ssion. nce sted on . Posted icial	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE			26/2017	
UNIVERS	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS RALEIGH, NO	FORK DRIVE NW C 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 166	Continued From pag	e 9	F	Executive (DON), A (ADON) Coordinate ducation, to include needed of grievance emphasis important aware of where the located. A 11/22/20 until educated or for all needed or fo	e Director, Director of Nursing Assistant Director of Nursing and/or Staff Development ator (SDC) will complete 100% in for all current facility employed full time, part time and as employees about facility e policy and procedure. The sof this education was on the ace of ensuring each staff is who the grievance official is a e posting of such information Any employee not educated by 17 will not be allowed to work cated. This education will also in new hires orientation process we employees effective 17. PRING PROCESS 11/22/2017, Executive Director Staff Development Coordinate of Social Services (#1 or #2), 5 the posting of Grievance off ominent locations daily (Monday Friday) to ensure that such on remain in place. Findings for itoring process will be nated on a "daily posting ion form." This monitoring will take place daily (Monday Friday) for 2 weeks then 3x/we have weeks, then weekly for 2 ten monthly for 3 months or union of compliance is maintained 11/22/2017, Director of Social (#1 or #2), and/or Executive will report findings of this	orees and are by be s or, of or, will icial ay rom eek atil d.		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345529	B. WING _				26/2017
NAME OF P	ROVIDER OR SUPPLIER		ı	Sī	TREET ADDRESS, CITY, STATE, ZIP CODE	107	20,2017
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH			201 CLARKS FORK DRIVE NW		
0(0)15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	ID		ALEIGH, NC 27616 PROVIDER'S PLAN OF CORRECTION		(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 166	Continued From page	e 10	F	166	monitoring process to the facility Qualit Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly X3 months, or until th pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Execution Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 11/22/2017	e ne o al tive I	
F 241 SS=D	CFR(s): 483.10(a)(1) (a)(1) A facility must tresident in a manner promotes maintenancher quality of life recoindividuality. The facility promote the rights of This REQUIREMENT by: Based on observation interview the facility famanner to maintain thanswering call bells to assistance with activity #133 and Resident #	reat and care for each and in an environment that be or enhancement of his or gnizing each resident's lity must protect and	F2	241	F241D ROOT CAUSE This alleged noncompliance was result from the facility staff failed to answer cabell in a timely manner and attend to th resident's need. This was also resulted from facility failure to divide assignment	all e	11/22/17

PRINTED: 12/07/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		,	
		345529	B. WING			10/	26/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
LINIVEDS:	NI HEALTH CARE/NORT	U BAI EICU		52	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	n RALEIGN		R	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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page Resident #126). This residents reviewed for Findings included: 1. Resident # 126 w 9/18/17 with diagnose congestion heart failured A review of Resident date set (MDS) dated resident was cognitive required extensive as transfers, toilet use w assist, and with locompersonal hygiene she assistance with two puring an interview w 10/25/2017 at 11 AM, Sunday 10/8/17 she was 10/8/12 hours for staff to change she soiled herse #126 indicated that he Nursing Assistant (NA)	e 11 was evident by 3 of 3 r dignity. as admitted to the facility on es of hypertension and re. #126 quarterly minimum 10/16/2017, revealed the ely intact. Resident #126 sistance with bed mobility, ith two person, physical notion, dressing and required extensive		241		y, 7. y, 7. ent and	
	Resident #126 indicar it took because her potime on it. Resident # bad feeling waiting so Resident #126 reveal lot in the facility because her ported to the facility because her reported to the facility because her potential facili	ted that she knew how long ersonal cell had the correct 126 indicated that was a long to be changed. ed she felt sad and down a use staff were so slow. ed that all her concerns had facility.			100% audit of all grievances filed by residents or family members within the last 30 days completed by the Executive director, Director of Social Services #1 and/or Director of Social Services #2 to determine any grievance that involve resident being wet for extended period time and determine whether or not succept grievances were investigated and/or resolved per center's grievance policy procedures.	of h	

Facility ID: 20040007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 10/26/2017		
NAME OF P	ROVIDER OR SUPPLIER	ı		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 .07	20.20	
				52	01 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH			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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 241	Continued From page	e 12	F 2	241				
	During an interview w 10/25/2017 at 11:30 / Resident #126 had sl and had issues about her not providing care bell. SW indicated that terminated of becaus Resident #126 and sc During an interview w (DON) on 10/25/17 a his expectation were bell within 3-5 minute that all staff treat residignity all at times an treatment. 2. Resident #133 winim 10/25/17 revealed that intact without short or resident required extembility transfers and physical assist. The rincontinent of bladded An observation of Re 2017 at 7:15 PM reveher bed with her call of the control of	with the Social Worker on AM, SW indicated that hared this incident with her to the staff mistreatment of e and not answering her call at the NA #2 had been e of the incident with everal others. With Director of Nursing to 4:30PM he indicated that for all staff to answer call es. His expectation would be dents with respect and do provide care and Was admitted to the facility es of hypertension, diabetes, restless legs syndrome. In um Data Set (MDS) dated at resident was cognitively relong memory issues. The ensive assistance with bed at toilet use with two + person esident was always rand bowels sident #133 on October 22, asled she was sitting beside bell on. Cotober 22, 2017 at 7:45 PM 33's call bell remained on y the door.	F 2	241	The audit revealed that all other grievances related to incontinent care a call bell responses filed within the last 3 days were investigated and resolved possible facility grievance policy and procedure. This audit will be completed by 11/22/1 Findings of this audit will be documented on grievance audit tool located at the facility compliance binder. On 11/20/2017, the Center Executive Director, Director of Social services (#1 #2), Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator conducted the 100% observation of all current residents in the facility to determine if any other resident has any sign or indication of being soiled (with urine). The observation revealed no other resident identified to be soiledd (with urine). Findings of this audit will be documented on "resident observation to located at the facility compliance binder SYSTEMIC CHANGES Effective 11/22/2017, Resident #198 is being toileted per plan of care and has evidenced unmet needs related to call light response. On 11/20/2017, the Regional Clinical Consultant revised facility nursing assistant assignment to ensure that the staffing pattern corresponds with the acuity level.	30 er 7. ed or ctor ne nt ed that e ool" r.		
	October 22, 2017 at 3 been waiting since 6:	7:47 PM she stated she had 30 PM to be put to bed. led that she put her call bell			Effective 11/22/2017, the facility will util the revised assignment sheet and ensuthat each assignment's acuity level is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		، ا	С	
		345529	B. WING				26/2017	
NAME OF PI	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	107	20/2011	
				5	201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		R	ALEIGH, NC 27616			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG				COMPLETION DATE	
F 241	Continued From page	e 13	F:	241				
		and the staff cut it off. She			maintained. The Director of Nursing,			
		er they would be back in a			Assistant Director of Nursing, Staff			
		er to bed. Resident #133			Development Coordinator and/or Unit			
		r an hour age and I'm tired			Coordinators will adjust the assignmen	t		
	and ready to go to be	ed."			sheets whenever necessary to ensure	that		
					the acuity level is maintained effective			
	_	vith Nursing Assistant (NA)			11/22/2017.			
		017 at 8 PM she revealed				_		
		lent #133 call bell off around			Director of Nursing, Assistant Director			
		e would be back to put her to			Nursing, Staff Development Coordinate	or		
		cated that she had to wait to			and/or Unit Coordinators will complete			
		ent #133 to bed because she st. NA #4 indicated that she			100% education for all current facility employees, to include full time, part time	10		
		omeone to help her put			and as needed employees about call b			
	Resident #133 back	·			responses. The emphasis of this	Cii		
	Trooladiic ii 100 badii				education was on the importance of			
	Observation of Resid	lent #133 on October 22,			responding to resident's call bell when			
		ealed she was being put to			activated and ensure resident's needs	are		
	bed.	-			anticipated. Any employee not educate	d		
					by 11/22/2017 will not be allowed to wo	ork		
		vith Resident #133 on			until educated. This education will also			
		8:25 PM she stated the staff			added on new hires orientation process	3		
		d you had to wait 30 minutes			for all new employees effective			
	or more to be put to be	ped especially on the			11/22/2017.			
	weekend.				Director of Nursing Assistant Director	- 4		
	During an interview v	with Director of Nursing			Director of Nursing, Assistant Director			
	_	vith Director of Nursing 5, 2017 at 4:30 PM he			Nursing, Staff Development Coordinate and/or Unit Coordinators will complete	ונ		
	` <i>'</i>	dent should have to wait an			100% education for all current nursing			
		to be put to bed. DON			staff to include licensed nurses and			
		alk with staff about this.			certified nurse aides, to include full time	≘.		
					part time and as needed nursing	,		
	3. Resident #198 wa	as admitted to the facility on			employees about incontinent care. The			
		es included cerebral vascular			emphasis of this education was on the			
	accident, hemiplegia	, aphasia and cognitive			importance of providing incontinent car			
			for each resident in a timely fashion an					
					ensure resident's needs are anticipated	d.		
		Data Set (MDS) dated			Any nursing staff not educated by			
	9/18/17 for Resident	#198 identified she required	1		11/22/2017 will not be allowed to work			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _				C 26/2017	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	10/	20/2017	
					2201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NO	RTH RALEIGH	RALEIGH, NC 27616					
	OLIMAN AND YOR	OTATEMENT OF DEFICIENCIES			·		0.17	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 241	Continued From pa	ge 14	F 2	241				
	extensive assistance	e with toileting, was always			until educated. This education will also	be		
		cognition was moderately			added on new hires orientation proces	S		
	impaired.				for all new nursing employees effective			
					11/22/2017.			
	During an interview	with family on 10/25/2017 at						
	6:05 PM revealed c	oncerns with call bell and			MONITORING PROCESS			
	waiting to long for c	are and treatment to be			Effective 11/22/2017, Executive Director	or,		
	provide to Resident	#198.Family indicated that we			Director of Nursing, Assistant Director	of		
	met with the team a	t Resident #198 care plan			Nursing, Staff Development Coordinate	or,		
	_	e addressed as identified in			Director of Social Services (#1 or #2),	will		
	_	ever family continued to come			complete the random audit of call light			
	in and find Residen	t # 198 soaking wet; including			response for five rooms to determine the	ne		
		hion in her chair. Family			call light response time. Executive			
		ell was put on one Sunday			Director, Director of Nursing, Assistant			
	·	0 45 minutes to hour for care			Director of Nursing, Staff Development			
		esident # 198. This is not a			Coordinator, Director of Social Service	S		
		vaiting so long for someone to			(#1 or #2), will activate the call bell in			
	-	Il and provide the care and			resident's room/bathroom and observe			
		tated staffing is a big concern.			and document response time. Findings	;		
	_	ted a few weeks ago (wasn't			from this monitoring process will be			
		e turned the call light on for			documented on a "Call light response			
		no one came; after 45			audit form" maintained in the facility			
		ad to go out to the hallway neone. The nurse stated she			compliance binder." This monitoring			
		NA to help them. The Family			process will take place daily (Monday through Friday) for 2 weeks then 3x/we	ack.		
		nderstand why the nurse			for two more weeks, then weekly for 2	CK		
	couldn't just help W				weeks then monthly for 3 months or ur	ı+il		
	Codidit i just tielp vv	itii Nesidelit #190.			the pattern of compliance is maintained			
	The Nursing Assists	ant (NA) #2 who had been			the pattern of compliance is maintained	J.		
		#198 been terminated.			Effective 11/22/2017, Executive Director	or		
	22010g.100 1 (00100111				Director of Nursing, Assistant Director			
	During an interview	with the Social Worker on			Nursing, Staff Development Coordinate			
		AM, SW indicated that			Director of Social Services (#1 or #2),			
		ly had shared concerns about			report findings of this monitoring proce			
		the call bell. SW indicated that			to the facility Quality Assurance and	- -		
		terminated of because of the			Performance Improvement Committee	for		
		ent #198 and several others.			any additional monitoring or modification			
					of this plan monthly for three months, of			
	During an interview	with Director of Nursing			until the pattern of compliance is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			С	
NAME OF F	DOMBED OD OUDDINED	343329	B. WING_	OTDEET ADDRESS SITV STATE 71D SS		10/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	JE		
UNIVERS	AL HEALTH CARE/NOF	RTH RALEIGH		5201 CLARKS FORK DRIVE NW			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 241	his expectation were bell within 3-5 minut that all staff treat res	ge 15 at 4:30PM he indicated that e for all staff to answer call tes. His expectation would be sidents with respect and ind provide care and	F 2	maintained. The QAPI commodify this plan to ensure the remains in substantial complex RESPONSIBLE PARTY Effective 11/22/2017, the cere Director and the Director of Note ultimately responsible to a implementation of this plan of for this alleged noncompliant the facility remains in substate compliance.	e facility liance. Inter Executive Nursing will ensure of correction ce to ensure		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X:	(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 10/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER	l.	<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE	'	10/20/2011	
UNIVERSA	AL HEALTH CARE/NOR	TH RAI FIGH		5201 CLARKS FORK DRIVE NW			
ONIVERSA	AL HEALTH CARE/NOR	MALLIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY 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	(X5) COMPLETION DATE	
F 241	Continued From page	e 16	F 2	41			
F 242 SS=D	SELF-DETERMINAT CHOICES CFR(s): 483.10(f)(1)-	ION - RIGHT TO MAKE	F 2	42		11/22/17	
	schedules (including health care and provi consistent with his or	is a right to choose activities, sleeping and waking times), iders of health care services ther interests, assessments, other applicable provisions					
		es a right to make choices or her life in the facility that resident.					
	members of the community activities facility.	is a right to interact with munity and participate in both inside and outside the Γ is not met as evidenced					
	Based on observation interviews the facility choice to go back to failed to honor a residued early (Resident # reviewed for choices) Findings included:	failed to honor a resident's bed (Resident #133) and dent's choice to get out of #162) for 2 of 3 residents		F242D ROOT CAUSE This alleged noncompliance w from the facility staff failed to h resident's choices to go to bed waking up in the morning. This resulted from facility failure to assignments according to acu meet residents' need.	nonor d and s was also divide		
	February 19, 2016 w hypertension, diabete restless leg syndrom	es, muscle weakness and e. mum Data Set (MDS) dated		IMMEDIATE ACTION TAKEN Resident #133 is no longer in resident was discharged on 1' No other actions taken for this Resident #162 is getting out o	1/10/2017. resident.		

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	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
					(С
	345529	B. WING _			10/	26/2017
ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	THE DATE STOLL		52	201 CLARKS FORK DRIVE NW		
AL HEALTH CARE/NOR	TH RALEIGH		R	ALEIGH, NC 27616		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFII TAG	x			(X5) COMPLETION DATE
cognitively intact and known to staff. Resite to total assistance frall her activities of dresident #133 was and bowel. An observation of R 2017 at 7:15 PM reverse her bed with her call. An observation on Corevealed Resident # and she was sitting. During an interview October 22, 2017 at been waiting since Resident #133 reverse on around 7:00 PM added the staff told few minutes to put he stated "That was owand ready to go to be considered by the staff told few minutes to put he stated "That was owand ready to go to be considered by the put Resident #133 back was two person ass was still waiting on seed the put and told her side the put Resident #133 back. Observation of Resident #133 back.	d able to make her needs dent #133 needed extensive om staff for the completion of aily living except for eating. always incontinent of bladder esident #133 on October 22, realed she was sitting beside bell on. October 22, 2017 at 7:45 PM 133's call bell remained on by the door. with Resident #133 on 7:47 PM she stated she had 6:30 PM to be put to bed. aled that she put her call bell and the staff cut it off. She her they would be back in a her to bed. Resident #133 er an hour age and I'm tired ed." with Nursing Assistant (NA) 2017 at 8 PM she revealed dent #133 call bell off around he would be back to put her to cated that she had to wait to dent #133 to bed because she ist. NA #4 indicated that she someone to help her put to bed. dent #133 on October 22,	F2	242	morning per choice effective 10/22/201 IDENTIFICATION OF OTHERS 100% choices and preferences audit completed by the Director of Social Services #1 and/or Director of Social Services #2 on 11/15/2017, 11/16/2017 11/17/2017 to determine each residents choices and preferences, specifically in relation to waking up in the morning an going to bed at night. This audit was completed by interviewing the facility current alert and oriented residents. Each resident's voiced choices and preferences related to preferences on waking up in the morning and going to bed at night was added in each resider care plan and anticipated effective 11/17/2017. Findings of this audit are documented on "Resident Choices Auditool" located in the facility compliance binder. SYSTEMIC CHANGES Effective 11/22/2017, moving forward a current nursing assistants will be responsible to honor resident's choices waking up in the morning and going to bed at night during their shift and as appropriate. Effective 11/22/17, Resident choices ar preferences to include choices of wakin up in the morning and going to bed at night will be assessed on	7, & s of day	
	with Resident #133 on					
	SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page cognitively intact and known to staff. Resident to total assistance fr all her activities of d. Resident #133 was and bowel. An observation of Re 2017 at 7:15 PM reveled her bed with her call An observation on Corevealed Resident # and she was sitting During an interview October 22, 2017 at been waiting since of Resident #133 reveal on around 7:00 PM added the staff told few minutes to put he stated "That was owe and ready to go to be During an interview #4, on October 22, 20 that she cut off Resident PM and told her staff told few minutes to put he stated "That was owe and ready to go to be stated "	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 cognitively intact and able to make her needs known to staff. Resident #133 needed extensive to total assistance from staff for the completion of all her activities of daily living except for eating. Resident #133 was always incontinent of bladder and bowel. An observation of Resident #133 on October 22, 2017 at 7:15 PM revealed she was sitting beside her bed with her call bell on. An observation on October 22, 2017 at 7:45 PM revealed Resident #133's call bell remained on and she was sitting by the door. During an interview with Resident #133 on October 22, 2017 at 7:47 PM she stated she had been waiting since 6:30 PM to be put to bed. Resident #133 revealed that she put her call bell on around 7:00 PM and the staff cut it off. She added the staff told her they would be back in a few minutes to put her to bed. Resident #133 stated "That was over an hour age and I'm tired and ready to go to bed." During an interview with Nursing Assistant (NA) #4, on October 22, 2017 at 8 PM she revealed that she cut off Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resident #133 to bed because she was two person assist. NA #4 indicated that she was still waiting on someone to help her put Resident #133 back to bed. Observation of Resident #133 on October 22, 2017 at 8:15 PM revealed she was being put to	A BUILDI 345529 B. WING 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 17 cognitively intact and able to make her needs known to staff. Resident #133 needed extensive to total assistance from staff for the completion of all her activities of daily living except for eating. Resident #133 was always incontinent of bladder and bowel. An observation of Resident #133 on October 22, 2017 at 7:15 PM revealed she was sitting beside her bed with her call bell on. An observation on October 22, 2017 at 7:45 PM revealed Resident #133's call bell remained on and she was sitting by the door. During an interview with Resident #133 on October 22, 2017 at 7:47 PM she stated she had been waiting since 6:30 PM to be put to bed. Resident #133 revealed that she put her call bell on around 7:00 PM and the staff cut it off. She added the staff told her they would be back in a few minutes to put her to bed. Resident #133 stated "That was over an hour age and I'm tired and ready to go to bed." During an interview with Nursing Assistant (NA) #4, on October 22, 2017 at 8 PM she revealed that she cut off Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resident #133 to bed because she was two person assist. NA #4 indicated that she was still waiting on someone to help her put Resident #133 back to bed. Observation of Resident #133 on October 22, 2017 at 8:15 PM revealed she was being put to bed.	A BUILDING B	A BUILDING 345529 STREET ADDRESS, CITY, STATE, ZIP CODE \$201 CLARKS FORK DRIVE NW RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES (EACH ORDERCINCHY MIST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Continued From page 17 Continued From staff for the completion of all her activities of daily living except for eating, Resident #133 was always incontinent of bladder and bowel. An observation of Resident #133 on October 22, 2017 at 7:15 PM revealed she was sitting beside her bed with her call bell on. An observation on October 22, 2017 at 7:45 PM revealed Resident #133's call bell remained on and she was sitting by the door. During an interview with Resident #133 on October 22, 2017 at 7:47-7PM she stated she had been waiting since 6:30 PM to be put to bed. Resident #133 revealed that she put her call bell on around 7:00 PM and the staff cut it off. She added the staff told her they would be back to a few minutes to put her to bed. Resident #133 call bell off around 7 PM and told her she would be back to put her to- bed. NA #4 also indicated that she had to wait to get help to put Resident #133 to bed because she was two person assist. NA #4 indicated that she was still waiting on someone to help her put Resident #133 back to bed. Observation of Resident #133 on October 22, 2017 at 8:15 PM revealed she was being put to bed. Deficiency IDENTIFICATION OF OTHERS 100% choices and preferences audit completed by the Director of Social Services #1 and/or Director of Social Services #1 and/or Director of Social Services #2 on 11/15/2017, 11/16/2017 11/17/2017 to determine each resident choices and preferences, specifically in relation to waking up in the morning an going to be dat night. This sudit was completed by interviewing the facility current alert and oriented residents. Each resident's voiced choices and preferences, specifically in relation to waking up in the morning on the preferences on the preference specifically in relation to waking up in the mornin	A BUILDING 345529 345529 345529 345529 3 WING STREET ADDRESS, CITY, STATE, ZIP CODE S201 CLARKS FORK DORKE NW RALEIGH, NC 27616 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 17 Cognitively intact and able to make her needs known to staff. Resident #133 needed extensive to total assistance from staff for the completion of all her activities of daily living except for eating. Resident #133 and Salways incontinent of binder and bowel. An observation on October 22, 2017 at 7.45 PM revealed she was sitting beside her bed with her call bell on. During an interview with Resident #133 on October 22, 2017 at 7.47 PM she stated she had been waiting since 6:30 PM to be put to bed. Resident #133 revealed that she put her call bell on around 7:00 PM and the staff cut it off. She added the staff told her they would be back in a few minutes to put her to bed. Na #4 also indicated that she put her call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resident #133 call bell off around 7 PM and told her she would be back to put her to bed. NA #4 also indicated that she had to wait to get help to put Resi

Facility ID: 20040007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345529	B. WING _			10/	26/2017
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LININ/EDO/		FIL DAL FIGU	5201 CLARKS FORK D		201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	IH RALEIGH		R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	Continued From page	e 18	F 2	242			
	was always short and or more to be put to I weekend.				Preference tool by the Director of Soci Services #1 or #2, and/or Activities Director. Any choices and preferences identified during assessment will be implemented as indicated.	al	
	(DON) on October 25 indicated that no resi hour and 45 minutes each resident's choice	vith Director of Nursing 5, 2017 at 4:30 PM he dent should have to wait an to be put to bed and that ee should be honored.			Director of Nursing, Assistant Director of Nursing, Staff Development Coordinate Unit Coordinators, and/or Director of Social Services #1 or #2, will complete 100% education for all current nursing	or,	
	2. Resident #162 was admitted on 11/10/16 and diagnoses included chronic obstructive pulmonary disease, cellulitus of the right lower limb, sepsis, muscle weakness and difficulty in walking.				staff to include licensed nurses and certified nurse aides, to include full time part time and as needed nursing employees about resident's rights to m choices. The emphasis of this educatio was on the importance of honoring each	ake n	
	identified that he requactivities of daily livin weakness and immo	bility. Interventions included hair and other ADL"s as	was on the importance of honoring each resident choices and preferences specifically about resident choices on when to get up in the morning, and whe to go back to bed. Any nursing staff not educated by 11/22/2017 will not be allowed to work until educated. This education will also be added on new him orientation process for all new nursing		en t		
	7/24/17 for Resident cognition was intact. person assist for tran	Data Set (MDS) dated #162 identified that his He required extensive two exfers and extensive one ssing and personal hygiene.			employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/2017 the Director of Nursing, Assistant Director of Nursing,		
	2:30 pm revealed that the main dining room once a week he was this. He stated he ha reasons why he could day so he could eat be	sident #162 on 10/25/17 at at the liked to eat breakfast in and that approximately not gotten up in time to do d been given different d not be up and ready every breakfast in the dining room were usually something to			Director of Social Services #1 and/or Director of Social Services #2 shall ensure compliance by completing the S Determination Audit form weekly and a needed for 30 days and monthly thereafter to ensure compliance with S Determination policy and procedure. A identified discrepancies shall be remediated.	s elf	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		С	
		345529	B. WING _			10/26/2017	
	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT	'H RALEIGH		52	TREET ADDRESS, CITY, STATE, ZIP CODE 201 CLARKS FORK DRIVE NW ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	shared this with the faccurring. A review of the grieval months, provided by tone grievance for Rewas dated 6/20/17 and voiced he was not go as he would like some resident stated that on himself ready after a everything he needed for someone to come. An interview on 10/26 Nursing Assistant (Nafamiliar with Resident care for him. She state preference to be up, and to the dining room for that Resident #162 has occasionally he wasn time to eat his breakfanded that the staff's preference for getting. An interview on 10/26 Administrator revealer resident. She stated the mentioned to her that him getting up and not breakfast in the dining added the staff was an up early and it was here.	dent #162 added that he had acility staff but it was still ance log for the past 6 the Administrator, identified sident #162. The grievance ad stated the resident had tten up and ready as early etimes in the mornings. The n 6/19/17 he had to get staff member brought him as he was tired of waiting and assist him. 6/17 at 10:53 am with A #1) revealed she was tired and provided the tit was the resident's fully dressed and ready to go breakfast. NA #1 stated and expressed to her that 't gotten up and dressed in ast in the dining room. She hould know that was his	F	242	Effective 11/22/2017, Executive Director of Nursing, Staff Development Coordinate Director of Social Services (#1 or #2), verview the completion, and follow through this monitoring process will be documented on a "Choices and Preferences completion audit form" maintained in the facility compliance binder." This monitoring process will talplace daily (Monday through Friday) for weeks then 3x/week for two more week then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Effective 11/22/2017, Executive Director of Nursing, Assistant Director of Nursing, Staff Development Coordinate Director of Social Services (#1 or #2), vereport findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly for three months, ountil the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Execu Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation in substantial	of or, vill gh gs ke 2 ss, or or, of or, vill ss for on	

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _				26/ 2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10//	20/2017	
				52	201 CLARKS FORK DRIVE NW			
UNIVERSA	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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 242	Continued From page	e 20	F 2	242	compliance.			
F 253 SS=D	HOUSEKEEPING & CFR(s): 483.10(i)(2)	MAINTENANCE SERVICES	F 2	253	Compliance Date: 11/22/2017		11/22/17	
	necessary to maintai comfortable interior; This REQUIREMENT by: Based on observation facility failed to maint cove molding, lighting. The facility failed to maint cove molding, lighting. The facility failed to maint cove molding, lighting. The facility failed to main 2 of 3 resident care. Findings included: A.1. Observation on revealed the wall behave 2. Observation on Room #414 the baths secured to the commascured to the com	inind 307 A was damaged. 10/24/17 at 4 PM revealed in room toilet seat was partially ode. :05 PM on 10/24/17 revealed on the back side of the 317. 0/24/17 at 3:45 PM revealed was an exposed piece of			F253D ROOT CAUSE This alleged noncompliance was result from the facility staff failed to communicate house keeping, laundry a maintenance needs in the facility. This was also resulted from facility failure to have a functional systemic process of communicating maintenance needs. IMMEDIATE ACTION TAKEN A1. On 10/27/2017, a wall behind room #307A was repaired by the facility Maintenance Director and/or Assistant Maintenance Director. A2. On 10/27/2017, the bathroom toiled seat in room #414 was re-secured to the commode by the facility Maintenance Director. A3. On 10/30/2017, a dried brown color on the back side of the toiled seat in row #317 was cleaned by the Housekeepin Supervisor. A4. On 10/30/2017, an exposed piece metal on the toilet seat in room #416 we removed and replaced by the facility	and d ne ored oom og		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 253	Continued From page	21	F 2	253			
	behind the head of the B 1. Observations on	e missing from the wall e bed in room 102 B. 10/23/17 at 12:11 PM s above the overbed light			Maintenance Director and/or Assistant Maintenance Director. A5. On 10/30/2017, un-finished plaster exposed wall that was rough with black colored marks in room #415B was		
	and the wall over the 2. Observation on 1 in Room #416 A there	bed in Room 318 A. 0/24/17 at 3:45 PM revealed was an accumulation of the			repaired and re-painted by the facility Maintenance Director and/or Assistant Maintenance Director.		
	There was an accumus substance in the floor	n the corners of the floor. ulation of a brown colored corners of the bathroom.			A6. On 10/31/2017, peeling paint on the walls in room #416 identified and repainted by the facility Maintenance	e	
		0/24/17 at 3:57 PM revealed vacy curtain had multiple tains.			Director and/or Assistant Maintenance Director. A6. On 10/31/2017, the missing cove		
	Room #414 there was	0/24/17 at 4 PM revealed in s an accumulation of a dried			molding on the wall behind the head of bed in room #102B was replaced by the		
	near the window.	nce in the corner of the wall 0/24/17 at 4:05 PM revealed			facility Maintenance Director and/or Assistant Maintenance Director. B1. On 10/27/2017, the spider webs		
	the bathroom wall in F approximate 3-inch-w	Room #317 had an			above the overbred light and the wall o the bed in room #318A was cleaned by		
		0/25/2017 4:53:31 PM of			the Housekeeping Supervisor. B2. On 10/27/2017, the accumulation of		
	brown colored particle	accumulation of dust and es in the corners of the floor			the dried brown colored substances in corners of the floor, and in the floor	the	
	and under the floor m				corners of the bathroom in room #416 were cleaned by the Housekeeping		
		at 10:42 AM with revealed she had not done light above the bed where			Supervisor. B3. On 10/27/2017, the privacy curtain with multiple dried brown colored stained		
	the cobwebs were no was always in the bed	ted because the resident d. HK #2 indicated she was			in room #415B was removed to be cleaned and replaced by the		
	floor tech working twice				Housekeeping Supervisor. B4. On 10/27/2017, the accumulation of		
	interview the floor tec Interview on 10/26/17	at 1:15 PM with the			the dried brown colored substance in the corners of the wall near the window in	ne	
		nundry. The Director of HK dexpectation of the staff ent rooms.			room #414 was cleaned by the Housekeeping Supervisor. B5. On 10/31/2017, the black colored li	ne	

Facility ID: 20040007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _		10	C 0/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		1/20/2017	
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NO	ORTH RALEIGH		RALEIGH, NC 27616			
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F 253	Administrator revelopments in Additionally, the acconducted a mock completion date whousekeeping and identified. Furthe	6/2017 at 4:54PM with the saled she expected her staff to good repair and clean. dministrator stated the facility a survey in July 2016 and the ras 8/11/17 to correct a maintenance problems r interview with the aled she expected privacy	F 2	across the width of the was inches-wide in room #31 by the facility Maintenance Assistant Maintenance Dis B6. On 10/27/2017, the act dust and brown colored pacorners of the floor and ur mat in room #305 was cle Housekeeping Supervisor IDENTIFICATION OF OTI 100% audits of all residen facility conducted by the Naupervisor, assistant main supervisor and/or House Supervisor to identify any room with the following ar Findings of this audit is do "Maintenance and Housek Supervisor, Maintenance Nasistant Maintenance Dis 11/22/2017. Any resident with concerns and not rec 11/22/2017 will be removed care usage until rectified. 1. Damaged walls; four of identified with damaged was maintenance supervisor a maintenance supervisor a maintenance supervisor a repair of the damaged was This repair will be completed 11/22/2017. 2. Bathroom toilet seat no other room identified with	17 was repainted the Director and/or rector. coumulation of articles in the originate of the floor reaned by the council of the floor reaned by the council of the floor reaned by the council of the floor reaned by the floor rector and floor resident reas of concerns; floor floor floor floor floor rector by area identified the floor rector by area identified by the floor resident floor floor rector by area identified the floor resident floor		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C
	ROVIDER OR SUPPLIER AL HEALTH CARE/NOR			STREET ADDRESS, CITY, STATE 5201 CLARKS FORK DRIVE N RALEIGH, NC 27616		10/26/2017
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PL (EACH CORRECTIV CROSS-REFERENCE DEF		
F 253	Continued From pag	e 23	F2	toiled seat being unseaction taken by Mainte and/or assistant mainfor this item. 3. Housekeeping need brown colored substate spider webs, and/or use curtain; five other room bathrooms identified with spider of privacy curtain needed Housekeeping Supercleaning of those idensubstances/particles acurtains. The cleaning by 11/22/2017. 4. Exposed piece of met taken by Maintenance assistant maintenance item. 5. Cove molding, peel unfinished plaster 2 or to be in need of cove identified with peeling room identified with peeling room identified with use Maintenance supervising identified to be repaired 10/30/2017 and to be 11/22/2017. Any room 11/22/2017 will be renuntil repaired.	ds, specifically nces/particles, ncleaned privacy ms and/or with brown colore no other room web, three other d to be cleaned. visor initiated utified brown colorand the privacy g will be complete netal; No other tified with an al. No further act a supervisor and/or e supervisor for the ling paints, and one offinished plaster. For and/or assistation schedule alled started on completed by a not repaired by	or o

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345529	B. WING_			C 10/26/2017	
	ROVIDER OR SUPPLIER AL HEALTH CARE/NOR	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			
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F 253	Continued From pag	e 24	F2	Effective 11/22/20 book will be placed where any mainter recorded by any si Maintenance super maintenance super books daily (Mond maintenance need requires immediate maintenance super maintenance and the staff on duty. Effective 11/22/20 Keeping/Laundry staff will community on duty to aide more needed in order to the staff will be done with the staff will be done with the staff will community of the staff will be done with the staff will be deep cleaner. Housekeeping staff 100% of active factors and or expedit and or e	17 a maintenance wo d at each nursing stanance issue(s) can b taff member. ervisor or assistant ervisor will check these day to Friday). Any dis on the week-end the attention, a ervisor or assistant ervisor will be contact 17 House Supervisor leaning assignment for on duty to ensure m is cleaned and y basis. House Keep cate with licensed nursing the resident who clean resident's room while honoring reside 17, revised deep put forth by the house supervisor for each rod once monthly, By the fillity employees will be maintenance request to request any dis by Maintenance xecutive Director. This	ation e se se hat ted for ing irse en m. ent's	

Facility ID: 20040007

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH			01 CLARKS FORK DRIVE NW ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From pag	e 25	F	253	until educated. This education was als added to new hire process for all new employees effective 11/22/17 and will be provided annually. House Keeping Supervisor and/or Executive Director, will complete 100% education for all current housekeeping and laundry employees to include full time, part time and as needed employe about cleaning procedures. The emphase of this education was on cleaning of floand surfaces, corners, dusting, cleanin spider webs and cleaning of any dried substances. Likewise, housekeeping simere educated on inspecting privacy curtain for cleanliness and report to the supervisor immediately if a privacy curt is unclean. Any House Keeping and/or Laundry employee not educated by 11/22/2017 will not be allowed to work until educated. This education will also added on new hires orientation process for all new housekeeping and laundry employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/17, Executive Director and/or Maintenance Director will review maintenance work books to ensure compliance with work orders. This review mill be completed weekly x 4 weeks, the monthly x 3 months or until the pattern compliance is maintained. Findings of the monitoring process will be reported to facility quality assurance and performal improvement committee by the Execution Director and/or Maintenance Director monthly x 3 months or until pattern of	ees asis ors g taff e tain be s	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 10/26/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	10/20/2017
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F 253	Continued From page	26	F 25	compliance is achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee. Effective 11/22/17 Housekeeping supervisor will complete environmental cleanliness audits weekly x 4 weeks, the monthly x 3 months to assure floors, privacy curtain and surfaces are cleaned properly. Findings of this monitoring process will be reported to facility quality assurance and performance improvement committee by the Executive Director and/or Housekeeping Supervisor montity a months or until pattern of compliance is achieved. This plan will be modified according to outcomes as needed and determined by QAPI committee. RESPONSIBLE PARTY Effective 11/22/2017, the center Execut Director, Director of Nursing, Maintenat Director and/or House Keeping supervity will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance.	nen ed ty ent hly ce tive nce isor
F 278 SS=D		INATION/CERTIFIED ssments. The assessment of the resident's status.	F 27	Compliance Date: 11/22/2017	11/22/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345529	B. WING		C 10/26/2017	
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	10/20/2017	
(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 OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICE)	D BE COMPLETION	
F 278	each assessment w participation of health (i) Certification (1) A registered nurse the assessment is considered in the considered in the assessment must signed that portion of the assessment in the por	nust conduct or coordinate ith the appropriate th professionals. se must sign and certify that ompleted. who completes a portion of the gn and certify the accuracy of ssessment. cation and Medicaid, an individual owingly- all and false statement in a t is subject to a civil money than \$1,000 for each individual to certify a material in a resident assessment is ney penalty or not more than essment. ment does not constitute a	F 27	F278 ROOT CAUSE MDS nurse #1, MDS nurse #2, and facility Director of Social Services #		
	wandering behavior of assistance neede	· · ·		I	1 and n the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345529	B. WING _				26/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
LININGERO	AL LIEALTH CADE/MOD	TH BALEION		5	201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	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 PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 278	Continued From pag	e 28	F 2	278				
	Findings Included:	s admitted to the facility on			review this alleged noncompliance and identify the root cause. The root cause analysis concluded that, the MDS nurs #2 failed to assess and code resident #	e		
	7/24/17 and diagnos	es included cerebral vascular and cognitive deficit.			ADL assistance care needs correctly p RAI guidelines before coding section G MDS. The analysis further revealed that	er i of		
	A care plan for Resident revealed the resident			MDS nurse #2 solely coded section G resident #88 assessment using				
	resident in an area w was possible, alert s				documentation completed by facility certified nursing assistants and did not physically assess the resident before			
	wander away from under me, converse and ge	rersional activities for me. If I nit instruct staff to stay with ently persuade me to walk			coding. Likewise it was identified that Social worker #2 did not code the behaviors documented in Electronic			
	exits I favor for elope	rea with them. Note which ement from the facility and ear those areas. Monitor and for.			Medication Administration and/or in the nurses notes due to unawareness of he to pull such records and misunderstanding of the look back peri	ow		
	9/18/17 for Resident	data set (MDS) dated #198 identified her cognition			for section E of MDS. It is evident that resident #198 wandering behaviors an resident #88 assistance with eating we	d		
		aired and no behaviors of sent during the 7 day look			anticipated as the plan of care reflect appropriate intervention to address behaviors and ADL. This determinatio was made on 10/25/17.	n		
	pm for Resident #19	note dated 9/10/17 at 1:18 8 stated the resident was ne floor in room 202 by a NA.			IMMEDIATE ACTION TAKEN The MDS assessment for resident #19 ARD 9/18/2017 was modified on	8		
	pm stated resident d	note dated 9/15/17 at 6:19 oes ambulate around the nair going in and out of other			10/25/2017 to reflect documented behaviors for wandering on the look ba period per RAI guidelines in section E MDS by Social worker #2 the modified	of		
	pm for Resident #19	note dated 9/18/17 at 6:18 8 stated she had been found			MDS assessment was transmitted and accepted on 10/25/2017 by MDS nurse #1.			
		room at the side of the bed			The MDS assessment for resident #88			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C 10/26/2 0	117	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	10/26/20	<i>J17</i>	
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COM	(X5) MPLETION DATE	
F 278	Continued From pag	e 29	F 27	8			
	was doing she stated bed. An interview on 10/2 Nurse #1 and Social Social Worker #2 had (behaviors) for the M Resident #198. Social believed the look-bad 14 days. He added the nursing note entries section E should have for wandering behave that when she signed it was to confirm the accurate. She added MDS for Resident #1	If she was trying to get in the 6/17 at 1:03 pm with MDS Worker #2 revealed that discompleted section E DS dated 9/18/17 for al Worker #2 stated he ck period for section E was hat after reviewing the for 9/10, 9/15 and 9/18 e been coded to the positive for MDS Nurse #1 stated of the MDS as the coordinator MDS was not complete, not that section E of the 9/18/17 98 should have coded to behavior during the look		ARD 6/22/2017, section G assist daily living (ADL) was modified of 11/21/2017 to reflect the correct assistance needed by resident of meals specifically eating. The modification was done by MDS as was transmitted and accepted of 11/21/2017. The MDS assessment for reside ARD 9/21/2017, section G assist daily living (ADL) was modified of 11/21/2017 to reflect the correct assistance needed by resident of meals specifically eating. The modification was done by MDS as was transmitted and accepted of 11/21/2017.	on luring nurse #1. sessment n nt #88, tance of on luring nurse #1. sessment		
	Administrator revealed MDS's were coded at coordinator should resist was accurate befor 2. Resident # 88 was 6-15-2017. Resident Resident #88 was accurate before the sident was accurate before the sident was the resident was the resident was #88 was documented was sident was was documented was documented was was documented was was documented was doc	admitted to the facility on remains in the facility.		IDENTIFICATION OF OTHERS 100% audit for current residents recent MDS assessment was comby the Social Worker #1 and #2, Coordinator, MDS Coordinator #3 to determine other resident with documented wandering behaviors in the look period was coded appropriately guidelines in section E of MDS didentify if any other resident has in-accurate coding of eating in section of MDS 3.0. The results of the actindicated no other residents with documented wandering behavior identified to be coded inaccurate guidelines in section E of MDS 3.0. The results of the actindicated no other residents with documented wandering behavior identified to be coded inaccurate guidelines in section E of MDS 3.0. The resident coded inaccurate guidelines in section E of MDS 3.0.	mpleted MDS 2 and/or e if any back per RAI 5.0, and to ection G audit rs ely per RAI 6.0, and,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			71. 501251	_		(
		345529	B. WING			10/:	26/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
IINIVERS	AL HEALTH CARE/NOR	TH RAI FIGH		52	201 CLARKS FORK DRIVE NW		
ONIVERSA	AL HEALTH CARE/NOR	MALLIGH		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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	Continued From page	e 30	F	278			
	extensive assistance extensive assistance locomotion, dressing toileting. Resident #8	with 2 people for transfers,			RAI guidelines in section E and G of M 3.0 respectively. Findings of this audit i documented on "MDS accuracy audit to located in the facility compliance binder This audit was completed on 10/29/17.	s ool"	
	A review of the MDS dated 9-21-17 revealed that the resident was not cognitively intact. Resident #88 was documented as needing limited assistance with one person for bed mobility, extensive assistance with 2 people for transfers, independent with locomotion, extensive assistance with one person for dressing and toileting, limited assistance with one person for personal hygiene and eating. A review of the care plan dated 9-22-17 revealed the following goal; the resident will continue to				SYSTEMIC CHANGES Effective 11/22/2017, social workers (# and/or #2) will review behaviors documented in Clinical documentation and electronic Medication Administratic Records (eMARs) through "clinical note report" and "behavior types" report loca in the facility used licensed Electronic Health records software to ensure all documented behaviors from eMAR on look back period are coded accurately RAI guidelines.	on es uted	
	(ADL) care and assis interventions for resid assisting with bathing assist with grooming toileting and transfers with wheelchair mobil	dent #88 included staff g and dressing routinely, and oral care, assist with s using 2 people and assist lity.			On 10/25/17, MDS consultant conducter re-education to MDS nurse #1, MDS nurse #2, Director of Social Services # and #2, on accurate coding of MDS using Resident Assessment Instruments (RA guidelines. This education covers coding requirements and supportive documentation for each item coded in	1 ng I) ng	
	revealed that physica treat for range of mot and therapeutic exerc				MDS, specifically related to section E a Section G of MDS 3.0 assessment. Effective 11/22/2017, Education on the Accurate coding of MDS will be added new hires orientation education for MD	to	
	revealed that residen required one person ADL's.	ng notes dated 6-16-17 t #88 could feed himself and assist with toileting and			nurses, Director of Social Services, Activities Director, and the C Dietary Manager (DM). This education will also provided annually for MDS nurses, Director of Social Services, Activities		
		ng notes dated 6-17-17 t #88 could feed himself and			Director, and the Dietary Manager (CD	M).	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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		345529	B. WING _	· · · · · · · · · · · · · · · · · · ·	10/	26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	DΕ		
LIMIVEDS	AL HEALTH CARE/NO	ARTH RAI EICH		5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NO	OKIH KALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
				DEFICIENCY)			
E 070		•4					
F 278	Continued From pa	-	F 2	78			
		on assist with ADL's and		MONITORING PROCESS			
	transfers.			Effective 11/22/2017, prior to			
				MDS Nurse #1 and/or MDS			
		sing notes dated 6-20-17		review section E of MDS asso			
		ent #88 was independent with		completed by the social work			
		d wheelchair mobility but		ensure that all documented b			
	required a one per	son assist with ADL's.		clinical records and eMARs a			
				accurately per RAI guideline			
		cumentation in resident #88's		reviews will take place Monda			
		m 6-21-17 to 10-26-17		Friday, prior to submission for			
	revealed there was no more documentation			on all completed MDS asses	•		
		e of assistance the resident		50% of all completed MDS as			
	l -	gards to his ADL's, feeding and		weekly for 2 weeks, then 25%			
	mobility.			completed MDS assessments	•		
		: 1 ///00		3 months or until the pattern			
		resident #88 occurred on		compliance is achieved. Any			
		m. Resident #88 was observed		coding identifies will be noted			
		o the dining room to eat supper.		corrected before submission			
		also observed being able to ass from the table and take a		nurse #1 or #2. Findings of the process will be documented or			
		tance. Once supper arrived the		accuracy monitoring tool loca			
		to eat his meal on his own		facility compliance binder.	ited iii tiie		
	without assistance			lacility compliance binder.			
	Williout assistance	nom stan.		Effective 11/22/2017, prior to	euhmission		
	An interview with the	he nurse occurred on 10-26-17		MDS Nurse #1 will review se			
		rse stated that resident #88		MDS 3.0 completed by MDS			
		e dining room to eat but the		(and vice versa) to ensure that			
		any reports of resident #88 not		appropriate self-care perform			
	being able to feed	* · · ·		and assistance needed for ea			
	2011.9 0.210 10 1000			component of ADL is codded	•		
	An interview with the	he MDS coordinator occurred		per RAI guideline. These revi	•		
		0pm. The MDS coordinator		place Monday through Friday			
		know why resident #88 was		submission for 2 weeks on a	•		
		ving a decline in eating		MDS assessments, 50% of a	•		
		ot have any notes. The MDS		MDS assessments weekly for			
		oked at the nursing notes and		then 25% of all completed MI			
		because he had a room		assessments monthly for 3 m			
	_	iagnosed with a urinary tract		until the pattern of compliance			
	infection."	-		achieved. Any inaccurate cod			

Facility ID: 20040007

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
							С
		345529	B. WING _			10/	/26/2017
	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT	H RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	stated he has not need any of his meals. The same. The wife stated with him during meal had to help him with he had to help him with the 10-26-17 at 1:15pm. It that her expectation would correctly and the same and the state of the same and	dent #88 and his wife at 4:00pm. Resident #88 ded help from staff to eat resident's wife agreed with d sometimes she will stay time but that she has not his meal. Administrator occurred on The Administrator stated would be that the MDS be hat the MDS coordinator I staff's documentation to	F2	278	will be noted and corrected before submission by MDS nurse #1 or #2 (whoever is completing the audit). Findings of this monitoring process will documented on MDS accuracy monitor tool located in the facility compliance binder. Effective 11/22/2017, MDS nurse #1 or #2, Director of Social Services #1, and Director of Social services #2 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee any additional monitoring or modification of this plan monthly X3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this pattern to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Execu Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure implementation in substantial compliance.	ring /or t for on I d. lan tive II	
F 353 SS=E	SUFFICIENT 24-HR CARE PLANS CFR(s): 483.35(a)(1)-	NURSING STAFF PER -(4)	F3	353	Compliance Date: 11/22/2017.		11/22/17
	483.35 Nursing Servi	ces					
	The facility must have	sufficient nursing staff with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING		C 10/26/2017	
	ROVIDER OR SUPPLIER AL HEALTH CARE/NOR	TH RALEIGH	,	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	1 10/20/2011	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 353	provide nursing and resident safety and a practicable physical, well-being of each reresident assessment and considering the diagnoses of the faci accordance with the at §483.70(e). [As linked to Facility be implemented beg (Phase 2)] (a) Sufficient Staff. (a)(1) The facility musufficient numbers of of personnel on a 24 nursing care to all reresident care plans: (i) Except when waive this section, licensed (ii) Other nursing per limited to nurse aides (a)(2) Except when we this section, the facil nurse to serve as a coduty. (a)(3) The facility musurses have the spesets necessary to care	cetencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial esident, as determined by its and individual plans of care number, acuity and flitry's resident population in facility assessment required. Assessment, §483.70(e), will inning November 28, 2017 ast provide services by a feach of the following types hour basis to provide sidents in accordance with a fed under paragraph (e) of a furses; and a fesonnel, including but not a fesonnel, including but not a feach of the services on each tour of a fest ensure that licensed control of the following types on each tour of a fest ensure that licensed control of the following types on each tour of a fest ensure that licensed control of the following types on each tour of a fest ensure that licensed control of the following types on each tour of a fest ensure that licensed control of the following types of the first ensure that licensed control of the following types of the first ensure that licensed control of the following types of the first ensure that licensed control of the first ensure that licensed control of the following types of the first ensure that licensed control of the first	F 35	3		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345529	B. WING _		C 10/26/2017
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	•
				5201 CLARKS FORK DRIVE NW	
UNIVERSA	AL HEALTH CARE/N	ORTH RALEIGH		RALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE A	SHOULD BE COMPLETION
				DEFICIENCY)	
F 353	Continued From p	page 34	F 3	53	
		are includes but is not limited to atting, planning and implementing			
	_	ns and responding to resident's			
	This REQUIREMI	ENT is not met as evidenced			
	'	ations, resident interviews,		ROOT CAUSE	
	family interviews,	staff interviews and record		F241-This alleged noncomplia	nce was
	review the facility	failed to provide nursing staffing		resulted from the facility staff fa	ailed to
		ity and quality to provide the		answer call bell in a timely ma	
	· ·	ce with putting a resident to bed		attend to the resident's need.	
	•	to get a resident up when		also resulted from facility failur	
	1 -	provide care in a manner to		assignments according to acui	
		y not answering call bells timely		meet residents' need, which m	
		ding assistance with activities of		facility appeared to have insuff	ficient
		was evident for 2 of 3 residents ces (Resident #133 and		number of staff.	
	Resident #198) ar	nd 3 of 3 residents reviewed for		F252-This alleged noncomplia	ince was
		#126 Resident #133, and		resulted from the facility staff fa	
	Resident # 162).			honor resident's choices to go waking up in the morning. This	
	Findings included	:		resulted from facility failure to assignments according to acui	
	This tag is cross r	referenced to:		meet residents' need, which m facility appeared to have insuff	
	F-241 Based on o	bservations, resident, family		number of staff.	
		the facility failed to provide			
		to maintain the resident's dignity		IMMEDIATE ACTION TAKEN	
	-	call bells timely for resident		Resident #133 is no longer in t	
	_	ce with activities of daily living		resident was discharged on 11	
		nd Resident # 198) and by		No other actions taken for this	
	1 -	nt to set in a wet brief for 5 hour		Resident #126 is no longer in t	-
		This was evident by 3 of 3		resident was discharged on 10	
	residents reviewe	d for dignity.		No other actions taken for this On 10/25/2017 Resident #198	
	F-242 Based on o	bservation, staff and resident		care was provided by Nurse A	ide #6 and
		ility failed to honor a resident's		Nurse Aide #7.	
		to bed (Resident #133) and		Resident #162 is getting out of	
	failed to honor a r	esident's choice to get out of		morning per choice effective 1	0/22/2017.

Facility ID: 20040007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						С	
		345529	B. WING		10	/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
LINIVEDO	AL LIEALTH CARE/AL	ODTU DAL FIGU		5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/N	ORTH RALEIGH		RALEIGH, NC 27616			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETION DATE	
F 353	Continued From p	page 35	F 3	53			
	bed early (Reside	nt #162) for 2 of 3 residents					
	reviewed for choice			IDENTIFICATION OF OTH	ERS		
				On 11/20/2017, 100% of all	current alert		
	During an intervie	w with Nursing Assistant (NA)		and oriented residents in th			
	_	2, 2017 at 8 PM she revealed		interviewed by the Center E	•		
	that she cut off Re	esident #133 call bell off around		Director, Director of Social	services (#1 or		
	7 PM and told her	she would be back to put her to		#2), Director of Nursing, As	sistant Director		
	bed. NA #4 also ir	ndicated that she had to wait to		of Nursing and/or Staff Dev			
		esident #133 to bed because		Coordinator to determine if	,		
	· ·	on assist. NA #4 indicated that		resident voiced concerns al			
	she was still waitii	ng on help to for Resident #133.		responses. Six other reside			
				complained of call bell not be	-		
		ievance log for the past 6		answered in a timely manne			
		by the Administrator, identified		100% choices and preferen			
	_	Resident #162. The grievance		completed by the Director of			
		0, 20177 and stated the ed he was not gotten up and		Services #1 and/or Director Services #2 on 11/15/2017,			
		he would like sometimes in the		11/17/2017 to determine ea			
		sident stated that on June 19,		choices and preferences, s			
	_	et himself ready after a staff		relation to waking up in the			
	_	nim everything he needed as he		going to bed at night. This	-		
		ig for someone to come and		completed by interviewing t			
	assist him.			current alert and oriented re	•		
				resident's voiced choices a	nd preferences		
	An interview on O	ctober 26, 2017 at 10:53 AM		related to preferences on w	aking up in the		
	with Nursing Assis	stant (NA #1) revealed she was		morning and going to bed a	it night was		
	familiar with Resid	dent #162 and had provided		added in each resident's ca	•		
		stated that it was the resident's		anticipated effective 11/17/2	•		
	•	up, fully dressed and ready to go		of this audit are documente			
		for breakfast. NA #1 stated		Choices Audit tool" located	in the facility		
		2 had expressed to her that		compliance binder.	<i></i>		
	· ·	asn't gotten up and dressed in		100% audit of all grievance	•		
		eakfast in the dining room. She		residents or family member			
		aff should know that was his		last 30 days completed by t			
	preference for get	ung up.		director, Director of Social S			
	During on intendi-	wwith Director of Nursian		and/or Director of Social Se			
	_	w with Director of Nursing		determine any grievance th			
		r 26, 2017 at 4:30 PM he expectation were for all staff to		resident being wet for exter time and determine whethe			
	mulcaled that ills	EXPECTATION MELE TO All STAIL TO	1	unie and determine whethe	i oi not such		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING _	B. WING		C 10/26/2017	
	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT	H RALEIGH		520	REET ADDRESS, CITY, STATE, ZIP CODE 1 CLARKS FORK DRIVE NW LEIGH, NC 27616	1 10/	20/2017
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION			(X5) COMPLETION DATE
F 353	answer call bell withir indicated no residents for care and treatmer. His expectation would residents with respect that resident's choice. On October 26, 2017 interview with the Adrithe facility was currer staffing, call bell respexperience. She state recruit new staff and with training that focu voice and a choice".	an 3-5 minutes. DON also as sure had to wait 5 hours at. Zero tolerated for this. It is be that all staff treat and dignity all at times and needs to be honored. at 4:29 PM during an ministrator. She stated that atly addressing sufficient onse and the dining and that they are trying to provide all of the new staff ses on "Residents have a Stated that the department is in their daily Ambassador	F		grievances were investigated and/or resolved per center's grievance policy a procedures. The audit revealed that all other grievances related to incontinent care a call bell responses filed within the last 3 days were investigated and resolved per facility grievance policy and procedure. This audit will be completed by 11/22/1 Findings of this audit will be documented on grievance audit tool located at the facility compliance binder. On 11/20/2017, the Center Executive Director, Director of Social services (#1 #2), Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator conducted the 100% observation of all current residents in the facility to determine if any other resider has any sign or indication of being soiled (with urine). The observation revealed no other resident identified to be soiled (with urine). Findings of this audit will be documented on "resident observation to located at the facility compliance binde SYSTEMIC CHANGES Effective 11/22/2017, Resident #198 is being toileted per plan of care and has evidenced unmet needs related to call light response. On 11/20/2017, the Regional Clinical Consultant revised facility nursing assistant assignment to ensure that the staffing pattern corresponds with the acuity level Effective 11/22/2017, the facility will util the revised assignment sheet and ensuthat each assignment's acuity level is	and 30 er 7. ed or ctor ne nt ed that e ool" r.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING		C	
	345529	B. WING		10/26/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/20/2017	
			5201 CLARKS FORK DRIVE NW		
UNIVERSAL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616		
(X4) ID SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 353 Continued From pag	e 37	F 35	3		
F 353 Continued From pag	e 37	F 35	maintained. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and/or Unit Coordinators will adjust the assignmen sheets whenever necessary to ensure the acuity level is maintained effective 11/22/2017. Effective 11/22/2017, moving forward current nursing assistants will be responsible to honor resident's choice waking up in the morning and going to bed at night during their shift and as appropriate. Effective 11/22/17, Resident choices a preferences to include choices of waki up in the morning and going to bed at night will be assessed on admission/readmission, quarterly and significant changes. This assessment be documented in Choices and Preference tool by the Director of Soc Services #1 or #2, and/or Activities Director. Any choices and preferences identified during assessment will be implemented as indicated. Director of Nursing, Assistant Director Nursing, Staff Development Coordinat and/or Unit Coordinators will complete 100% education for all current facility employees, to include full time, part tir and as needed employees about call to responses. The emphasis of this education was on the importance of responding to resident's call bell when activated and ensure resident's needs anticipated. Any employee not educate by 11/22/2017 will not be allowed to w	all s of of or ene pell are ed	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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		345529	B. WING _			10/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
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F 353	Continued From pag	e 38	F3	for all new employ 11/22/2017. Director of Nursing, Staff De and/or Unit Coord 100% education of staff to include lick certified nurse aid part time and as a employees about emphasis of this of importance of profor each resident ensure resident's Any nursing staff 11/22/2017 will not until educated. The added on new hir for all new nursing 11/22/2017. Director of Nursing, Staff De Unit Coordinators Social Services # 100% education of staff to include lick certified nurse aid part time and as a employees about choices. The emp was on the import resident choices a specifically about when to get up in to go back to bed educated by 11/2 allowed to work up education will also	ing, Assistant Director of evelopment Coordinate dinators will complete for all current nursing tensed nurses and des, to include full time needed nursing a incontinent care. The education was on the eviding incontinent care in a timely fashion and needs are anticipated not educated by on the allowed to work his education will also resorientation process g employees effective evelopment Coordinators, and/or Director of all current nursing tensed nurses and des, to include full time needed nursing a resident's rights to mothasis of this education tance of honoring each	e, ee, ee d d d be s e of or, ee, ake on ch	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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UNIVERSA	AL HEALTH CARE/NOR	IN KALEIGN		R/	ALEIGH, NC 27616		
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F 353	Continued From page	e 39	F3	853	employees effective 11/22/2017. MONITORING PROCESS Effective 11/22/2017, Executive Director of Director of Nursing, Assistant Director of Nursing, Staff Development Coordinate Director of Social Services (#1 or #2), was complete the random audit of call light response for five rooms to determine the call light response time. Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Director of Social Services (#1 or #2), will activate the call bell in resident's room/bathroom and observe and document response time. Findings from this monitoring process will be documented on a "Call light response audit form" maintained in the facility compliance binder." This monitoring process will take place daily (Monday through Friday) for 2 weeks then 3x/we for two more weeks, then weekly for 2 weeks then monthly for 3 months or un the pattern of compliance is maintained Effective 11/22/2017 the Director of Nursing, Assistant Director of Nursing, Director of Social Services #1 and/or Director of Social Services #2 shall ensure compliance by completing the Significant Determination Audit form weekly and an needed for 30 days and monthly thereafter to ensure compliance with Science of Nursing, Assistant Director of Nursing, Staff Development Coordinator Nursing Staff Development Coordinator Nursing Staff Development Coordi	of or, will ne s eek til d. Self s elf any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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OHIV EIKO	ALTIEAETH GAREN	OKT TALLION		RALEIGH, NC 27616			
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F 353	Continued From p	page 40	F 3	Director of Social Services review the completion, and of Choices and Preference from this monitoring process documented on a "Choices Preferences completion aud maintained in the facility cobinder." This monitoring proplace daily (Monday throug weeks then 3x/week for two then weekly for 2 weeks the 3 months or until the pattern compliance is maintained. Effective 11/22/2017, Exect Director of Nursing, Assista Nursing, Staff Development Director of Social Services report findings of this monit to the facility Quality Assura Performance Improvement any additional monitoring of this plan monthly for thre until the pattern of compliar maintained. The QAPI commodify this plan to ensure the remains in substantial complication of Social Services report findings of this monit to the facility Quality Assuration of Social Services report findings of this monit to the facility Quality Assuration of Social Services report findings of this monit to the facility Quality Assuration of this plan monthly for thre until the pattern of compliar maintained. The QAPI commodify this plan to ensure the until the pattern of compliar maintained. The QAPI commodify this plan to ensure the until the pattern of compliar maintained. The QAPI commodify this plan to ensure the remains in substantial complete the pattern of compliar maintained. The QAPI commodify this plan to ensure the remains in substantial complete them in substantial complete them in substantial complete them is substantial complete.	follow through tool. Findings s will be and dit form" mpliance ocess will take h Friday) for 2 o more weeks, en monthly for n of utive Director, nt Director of t Coordinator, (#1 or #2), will oring process ance and Committee for modification e months, or nce is mittee can he facility oliance. utive Director, nt Director of t Coordinator, (#1 or #2), will oring process ance and Committee for modification e months, or nce is mittee to months, or nce is mittee can he facility or modification e months, or nce is mittee can he facility		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT	'H RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			
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F 353 F 356 SS=B	POSTED NURSE ST. CFR(s): 483.35(g)(1)-	AFFING INFORMATION	F 3	RESPONSIBLE PARTY Effective 11/22/2017, the center E Director and the Director of Nursir be ultimately responsible to ensur- implementation of this plan of corr for this alleged noncompliance to the facility remains in substantial compliance and has sufficient nurs staff to meet each resident's need accordance with the facility assess Compliance Date: 11/22/2017	ng will e ection ensure sing and in	11/22/17	
22=R	483.35 (g) Nurse Staffing Info (1) Data requirement the following informat (i) Facility name. (ii) The current date. (iii) The total number by the following categ unlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practica	and the actual hours worked gories of licensed and the city responsible for t: I nurses or licensed defined under State law)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345529	B. WING_		C 10/26/2017	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	10/20/2017	
(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 CORRECT ((EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION	
F 356	specified in paragraphically basis at the best daily basis at the best (ii) Data must be post (A) Clear and readal (B) In a prominent puresidents and visitor (3) Public access to The facility must, up make nurse staffing for review at a cost restandard. (4) Facility data reter facility must maintain staffing data for a mirequired by State law This REQUIREMEN by: Based on observation interviews, the facility staffing information of and the facility failed census on the daily	ents. post the nurse staffing data oh (g)(1) of this section on a ginning of each shift. sted as follows: ple format. ace readily accessible to	F3		essary d with	
	Finding included:			reveal that this alleged noncomplia resulted from the Center's Directo Nursing misinterpretation of regula	r of tory	
	revealed the daily nu 10/20/2017 was pos	0/22/2017 at 7:30 PM urse staffing information for ted in a plastic see-through top of a desk in the facility's		requirements related to posting of hours, specifically of whether or no residents on bed hold should be confirmed the Director of Nursing thought residents.	ot ounted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	•	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
				52	201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	IH 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 356	Continued From page	e 43	F3	356				
F 356	front lobby. The staffi posted for 10/22/201 An observation on 10 daily nurse staffing in plastic see-through codesk in the facility's fi 10/23/2017. The facilithere were 115 census staff posted included including the 3 bed h An observation on 10 the daily nurse staffir a plastic see-through desk in the facility's fi 10/24/2017. The facil revealed there were number on the postin holds census with the correct census was 1 An interview with the 10/24/2017 at 11:30.4 was 116 on 10/24/20	ing information was not 7. 2/23/2017 at 10 AM revealed information was posted in a over on a stand on top of a ront lobby and was dated lity's census sheet revealed us on 10/23/17. The nursing all census in the facility, and olds. 2/24/2017 at 11 AM revealed in a cover on a stand on top of a ront lobby and was dated lity's resident census sheet 118 census. The census in g continued to combine bed in a skilled nursing census. The life. Director of Nursing on AM revealed that the census 17. He stated that it was his ed nurse staffing be correct	F3	356	on bed hold can be counted on nursing hours since they are counted on daily census of the facility. Regional Clinical Consultant re-educated the Center Director of Nursing on 10/26/2017 corninformation that should be posted per regulatory requirements and procedure and the importance of completing thorough investigation. This analysis w completed on 10/26/2017 IMMEDIATE ACTION TAKEN No residents were affected by this alleg deficient practice On 10/23/2017, and 10/24/2017 posted daily nurse staffing information retrieve by the Director of Nursing, Corrected a re-posted with the correct census information. SYSTEMIC CHANGES Effective 11/22/2017, Staffing Coordination Director of Nursing, Assistant Director of Nursing and/or Staff Development coordinator will complete daily posting nursing hours, and post such information the day before it's due, Monday through Friday. Receptionist on duty, Nurse Managers and or 100 hall nurse modify posting at the beginning of each shift to reflect the correct information to include correct census, number of full time equivalents and total hours scheduled to work per shift for Register Nurses (RNs), Licensed Practical Nurse (LPNs) and Certified Nurse Aides, as we constitute the correct information of the correct information to include the correct information to include correct census, number of full time equivalents and total hours scheduled to work per shift for Register Nurses (RNs), Licensed Practical Nurse (LPNs) and Certified Nurse Aides, as we constitute the correct information to the correct information to the correct information to the correct census, number of full time equivalents and total hours scheduled to work per shift for Register Nurses (RNs), Licensed Practical Nurse (LPNs) and Certified Nurse Aides, as we constitute the correct information to the c	ect es as ged d d d nd will n o red es		
					as removing the previous day posting from the board. The posted hours will be located on the facility front lobby for ea			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 10/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u>I</u>)E	10/20/2017	
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	'H 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	DATE	
F 356	Continued From page	÷ 44	F3	Effective 11/22/2017, Staffing Director of Nursing, Assistant Nursing and/or Staff Develop coordinator will complete dail nursing hours, for Saturdays, and Mondays and post such by the close of business on F Receptionist on duty, Weekesupervisor and or 100 hall nursift on Saturday and Sunday the correct information to includensus, number of full time earned total hours scheduled to shift for Registered Nurses (F Licensed Practical Nurses (LI Certified Nurse Aides, as well the previous day posting from The posted hours will be local facility front lobby for easy act and visibility. Executive Director, Director of (ADON), Assistant Director of (ADON) and/or Staff Develop Coordinator (SDC) will compleducation for all current facility nurses, receptionist and Staff coordinator, to include full time and as needed employees at process of posting nursing he ensure compliance. The empleducation was on the importational current including only residents in the the beginning of each shift and staffing responsible for direct at the beginning of each shift.	t Director of ment by posting of Sundays information ridays. End urse will ng of each ys to reflect ude correct quivalents work per RNs), PNs) and I as removing the board ated on the excessibility of Nursing Nursing oment lette 100% ty Licensed fing the part time cour revised on the excession of this ance of the facility at and nursing care present the sure of the facility at and nursing care present the sure of the facility at and nursing care present the sure of the facility at and nursing care present the sure of the facility at and nursing care present the sure of the facility at and nursing care present the sure of the facility at and nursing care present the sure of the facility at and nursing care present the sure of the facility at and nursing care present the sure of the facility at and nursing care present the sure of the su	of of t t tet d e d d is	

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NAME OF PI	ROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FOR RALEIGH, NC 27				
(V4) ID	SUMMADV ST	TATEMENT OF DEFICIENCIES	ID	•	OVIDER'S PLAN OF CORRECTION		(X5)	
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F 356	Continued From page	e 45	FS		rse, Receptionist and/or			
				11/22/2017 v	rdinator not educated by will not be allowed to work ed. This education will also	be		
				added on ne	ew hires orientation process mployees effective			
				Effective 11/2 Assistant Dir Developmen audit posted daily (Monda completion a process will through Frida for two more weeks then a the pattern of Any issues ic monitoring p promptly. Fir process will staffing audit	NG PROCESS 122/2017, Director of Nursing rector of Nursing, and/or Soft Coordinator will review a lanursing staffing information ay through Friday) to ensurand accuracy. This monitor take place daily (Monday ay) for 2 weeks then 3x/weeks, then weekly for 2 monthly for 3 months or un of compliance is maintained dentified during this process will be addressed andings from this monitoring be documented on a "Daily tr" form and filed in the facili binder effective 11/22/2017	taff nd on re ring eek ntil d.		
				Assistant Dir Developmen findings of th facility Qualit Performance any additions of this plan n until the patt maintained. modify this p	22/2017, Director of Nursing rector of Nursing, and/or Sout Coordinator will report his monitoring process to the ty Assurance and the Improvement Committee all monitoring or modification monthly for three months, othern of compliance is The QAPI committee can olian to ensure the facility ubstantial compliance.	taff ne for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 201 CLARKS FORK DRIVE NW	10//	20/2017
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH		R	ALEIGH, NC 27616		
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F 356 F 431 SS=D	Continued From page DRUG RECORDS, L. BIOLOGICALS	ABEL/STORE DRUGS &		356 431	RESPONSIBLE PARTY Effective 11/22/2017, the center Executive 21/22/2017, the center Executive Director and the Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 11/22/2017.	n re	11/22/17
	drugs and biologicals them under an agreet §483.70(g) of this par unlicensed personnel law permits, but only supervision of a licens: (a) Procedures. A fact pharmaceutical service that assure the accuratispensing, and admit biologicals) to meet the pharmacist who (2) Establishes a syst disposition of all contridetail to enable an accurate service.	ide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general sed nurse. cility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and ne needs of each resident.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER AL HEALTH CARE/NOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		3/26/2017	
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F 431	labeled in accordance professional principle appropriate accesso instructions, and the applicable. (h) Storage of Drugs (1) In accordance withe facility must store locked compartment controls, and permit have access to the k (2) The facility must permanently affixed controlled drugs listed Comprehensive Drug Control Act of 1976 abuse, except when package drug distrib quantity stored is mit be readily detected. This REQUIREMEN by: Based on observations	I controlled drugs is odically reconciled. Is and Biologicals. Is used in the facility must be see with currently accepted ses, and include the ry and cautionary expiration date when I and Biologicals. Ith State and Federal laws, see all drugs and biologicals in sounder proper temperature only authorized personnel to seys. I provide separately locked, compartments for storage of sed in Schedule II of the graph and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can I is not met as evidenced on, record reviews and staff of failed to store medications in	F 4	F431 ROOT CAUSE This alleged non compliance in	resulted		
	Findings included: Review of the manuf storage of Prednisol	medication carts observed. facturer's instructions for one eye drop container nust be stored upright.		from the facility failure to have ensuring medication that shou upright remains upright when moved. This is concluded as a medication to include eye drop stored in the plastic back with base to support upright placer	ald be stored the cart is such ps were out a wide		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 10	720/2017
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UNIVERS	AL HEALTH CARE/NO	RTH RALEIGH			LEIGH, NC 27616		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 431	Continued From pa	ge 48	F 4	131			
	Review of the manu	ufacturer's instructions for			Likewise, the facility failed to date an		
	storage of Calcitoni			insulin placed in the refrigerator when a	an		
	revealed the bottle			orange top fell off.			
	A.Observation of th			IMMEDIATE ACTION TAKEN	ad		
		olone eye drop containers were			No Residents were named in this alleg non compliance	eu	
		The label on the bottles			A1. Two identified Prednisolone eye dr	op	
	indicated to store u				in a container not stored upright in	9	
		on spray was not stored			100-medication cart were discarded an	ıd	
		on the medication indicated to			re-ordered by the Pharmacy Clinical		
	stand the medication	. •			Director on 10/25/2017.		
		2017 at 1:45 PM with the			A0.0 :1 ('5 10.1') : 0.1		
	1	cist revealed that medications			A2. One identified Calcitonin Salmon	tion	
	should be stored up	ongnt.			spray not stored upright in 100-medica cart were discarded and re-ordered by		
	B.1. Observation of	of the 100-medication cart on			Pharmacy Clinical Director on 10/25/20		
		PM with the Director of					
	Nurses (DON)and	consultant pharmacist			B2. The opened Novolog regular insuli	n	
	revealed the Predn	isolone eye drop containers			bottle observed in the Unit 1 medication	n	
		non nasal spray still were not			refrigerator was discarded and re-order		
	stored upright.				Pharmacy Clinical Director on 10/25/20)17.	
	2. Continued obse	rvation with the DON revealed			IDENTIFICATION OF OTHERS		
	in the Unit 1 medica	ation refrigerator was a stored			All residents who receives medication		
		ular insulin in which the orange			have the potential to be affected by this	3	
	1	oved and was not dated when			alleged non- compliance.		
	opened. Expectation	ons should be stored upright.			On 10/25/17 and 10/26/2917, the		
	Interview on 10/05/	2047-t 4:40 DM with			Pharmacy Clinical Director, Pharmacy		
		2017at 4:19 PM with aled her expectation would be			Consultant and/or Director of Nursing, inspected all medication storage rooms		
		e label instructions on how to			and medication carts to ensure all	•	
	store and follow the				medication are stored per manufacture	r	
					guidelines. The audit revealed that all		
					other medication were stored per		
				- 1	manufacturer guidelines and all insulin		
					were dated per manufacturer guideline		
					Findings of this audit is documented or		
					"Medication storage audit tool" located	at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	_	(X3) DATE SURVEY COMPLETED			
		345529	B. WING			C 10/26/2017		
	ROVIDER OR SUPPLIER AL HEALTH CARE/NOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616				
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F 431	Continued From page	e 49	F 4	the facility compliance of the facility compliance of the facility compliance of the facility compliance of the facility completed by 11/2 allowed to work upright will nurse, and/or Meeducation will also deducted by 11/2 allowed to work up education will also deducted in the facility completed by 11/2 allowed to work up education will also deducted by 11/2 allowed to work up education will also deducted by 11/2 allowed to work up education will also such processing the facility completed by 11/2 allowed to work up education will also such prescription bottle education will also deducated by 11/2 allowed to work up education will also such prescription bottle education will also deducated by 11/2 allowed to work up education will also such prescription bottle education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducation will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up education will also deducated by 11/2 allowed to work up educated by 11/2 allowed to w	NGES 017, all medication that ad upright will be place of upright will be place of the stock of the stock of the stored upright. Any on will be corrected 017, any open insuling the stored upright. Any on will be corrected 017, any open insuling the stored upright. Any on will be corrected 017, any open insuling the stored upright. Any on will be corrected 017, any open insuling the stored in	ed ng on see ee in will ff nt n as esss		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	C	(X3) DATE SURVEY COMPLETED			
		345529	B. WING _			C 10/26/2017		
	ROVIDER OR SUPPLIER AL HEALTH CARE/NOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616				
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F 431	Continued From pag	e 50	F 4	MONITORING PROCES The Director of Nursing, and/ Supervisor will be respor checking medication card to ensure medication are labelled appropriately pe guidelines. This monitoritake place daily (Monday for 2 weeks then, then we then monthly for 3 month pattern of compliance is issues identified during the process will be addressed. Findings from this monitoring tools and file compliance binder effect. Effective 11/22/2017, Director of Nurn Development Coordinate findings of this monitoring facility Quality Assurance Performance Improveme any additional monitoring of this plan monthly for the until the pattern of complimation of this plan to ensurn remains in substantial control of the Ultimately responsible implementation of this plan for this alleged noncompliance in salleged noncompliance in salleged noncompliance of this plan to this plan to the Director and	Assistant /or Nursing nsible for ts and medication e stored and er manufacturer ing process will y through Friday reekly for 2 week ns or until the maintained. Any his monitoring ed promptly. oring process wi edication Storage ed in the facility tive 11/22/2017. rector of Nursing rsing, and/or Sta or will report g process to the e and ent Committee for g or modification hree months, or liance is ommittee can re the facility ompliance. e center Executiv or of Nursing will e to ensure lan of correction	c) ks v iiii ee j, aff cor n		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 1 0/26/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		10/20/2017	
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH		RALEIGH, NC 27616			
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F 431	Continued From page	e 51	F 4	the facility remains in sub compliance.	ostantial		
F 469 SS=D	MAINTAINS EFFECT PROGRAM CFR(s): 483.90(i)(4)	IVE PEST CONTROL	F 4	Compliance Date: 11/22/	2017.	11/22/17	
	(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews the facility failed to have an effective pest control program. This was evident in 1 of 3 resident care units. Findings included: Observation on 10/26/17 at 10:27 AM revealed a dead insect on the bathroom floor in Room #201. Observation on 10/26/17 at 10:30 AM revealed a dead black colored insect laying on the floor in the hallway near unit 200. Interview on 10/26/17 at 10:35 AM with Housekeeper (HK) #1 revealed she was a new employee and has never seen any pest in the facility. Observation on 10/26/17 at 10:40 AM revealed 3 black colored insect crawling in the hallway off the 200-resident unit. Interview on 10/26/17 at 10:42 AM with HK #3 indicated that she had seen 2 (two) or 3 (three) crawling insects in the hallway but never reported. Interview on 10/26/2017 at 3:58 PM with the Maintenance Director who stated that the pest control company provided routine service to the facility every 3rd Tuesday of each month. He stated that a concern log is kept at the front desk should a resident, staff or family member had a			F469 ROOT CAUSE Based on root cause and administrative staff, facilit report the sighting of insedirected/expected. Howe does have a Pest Control required by regulation. IMMEDIATE ACTION Room 201 and the entire inspected on 11/15/2017 activity by Contracted lice control company, no furth identified. On November Licensed Pest Control comprovides services at the complete pest audit, inclutreatment inside and outs perimeter of facility. IDENTIFICATION OF OT On November 15, 2017 L Control company that pro-	ty staff failed to ects as ever the facility I Program as 200 hall were for any pest ensed Pest her issues 15, 2017 ampany that center did a uding full facility side around THERS Licensed Pest		

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		345529	B. WING _				C 26/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				52	01 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH	RALEIGH, NC 27616		ALEIGH, NC 27616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 469	revealed his expectat would report any pest so these areas would monthly visit. Interview on 10/26/20	gs. Continued interview ion was that staff members t concerns to the receptionist be treated during the 117 at 4:54 PM with the d she expected staff to	F 4	169	the center did a complete pest audit, including full facility treatment inside an outside around perimeter of facility. No other issues related to pest control identified. SYSTEMIC CHANGES Effective 11/22/2017, the center Director of Maintenance, Director of Housekeep and/or Executive Director, initiated a process for communication by facility employees by creating Maintenance Books at each nurse station, and revise the pest control book at receptionist de Those books will be utilized by facility sto communicate all maintenance reque and/or any pest noted in the facility than need attention. The center Director of Housekeeping, and/or Maintenance Director will review the maintenance are pest control books daily (Monday throut Friday) and address any identified maintenance and/or pest control related issue promptly effective 11/22/2017. A negative findings will be documented of the pest control audit forms and maintained in the "Daily meeting binder. This systemic process will take place of (Monday through Friday). Any identified issues will be addressed promptly and appropriate actions will be implemented by the center Director of Social services #1, Director of Social services #2 and/of Executive Director. This process will be incorporated in a daily Stand up meeting binder.	or pring ed sk. staff sts t ad gh d ny n eily d sore	
					Director of Maintenance, Director of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			1	0
NAME OF P	ROVIDER OR SUPPLIER	343323		STREE	ET ADDRESS, CITY, STATE, ZIP CODE	10/	26/2017
TO THIS COLUMN	NOVIDEN ON CONTENEN				CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NOR	ΓΗ RALEIGH			EIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 469	Continued From page	e 53	F4	H D D D CC far far ree cc far	ousekeeping and/or Executive Directoricector of Nursing (DON), Assistant irector of Nursing (ADON) and/or Statevelopment Coordinator (SDC) will omplete 100% education for all current icility employees, to include full time, presenting any noted pests in the facility omptly in Maintenance Book at nurse action, and/or pest control book at acceptionist desk. The emphasis of this ducation was on the importance of ommunicating any noted pest in the acility. This education will be complete by 11/22/2017, any employee not ducated by 11/22/2017 will not be lowed to work until educated. This ducation will also be added on new him intentation process for all new employer fective 11/22/2017. CONITORING PROCESS Iffective 11/22/2017, Executive director and/or Director of Nursing will monitor ompliance by reviewing maintenance anders and Pest Control book to ensure that the Maintenance in the Director of House eeping review the books daily (Monda arough Friday). This monitoring process ill take place weekly for four weeks, the onthly for three more months or until attern of compliance is maintained. An sues identified during this monitoring process will be addressed promptly. Indings from this monitoring process we documented on a "pest Control eview" form and filed in the facility eview" form and filed in the facility	ff nt part e s ed res ees or, ure aff ay ss hen the ny	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		7/20/2017
				5201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		JLD BE	(X5) COMPLETION DATE		
F 469	Continued From page	÷ 54	F 4	Effective 11/22/2017, Maintenance Director, Housekeeping Director, at the Center Executive director, will compliance by completing Pest Coaudit by inspecting the facility for evidence of any pests. This monitor process will take place three times for four weeks, then weekly for eigmore weeks, then monthly for 3 muntil the pattern of compliance is maintained. Any issues identified this monitoring process will be adopromptly. Findings from this monitor process will be documented on a "Control Audit" form and filed in the compliance binder effective 11/22/Effective 11/22/2017, Maintenance Director, Housekeeping Director, at the Center Executive director will refindings of this monitoring process facility Quality Assurance and Performance Improvement Commany additional monitoring or modific of this plan monthly for three mont until the pattern of compliance is maintained. The QAPI committee modify this plan to ensure the facil attain and maintain substantial compliance. RESPONSIBLE PARTY Effective 11/22/2017, the center Experience of Maintenand/or Housekeeping Supervisor wultimately responsible to ensure	e and/or monitor ontrol cany oring a week ht onths or during lressed oring pest facility 2017. e and/or eport to the dittee for cation hs, or will eity	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER AL HEALTH CARE/NORT	ΓΗ RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	10/20/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		OULD BE COMPLETION
F 469	Continued From page	e 55	F 46	implementation of this plan of corr for this alleged noncompliance to the facility remains in substantial compliance.	
F 520 SS=D	QAA COMMITTEE-M QUARTERLY/PLANS CFR(s): 483.75(g)(1)	3	F 52	Compliance Date: 11/22/2017	11/22/17
	(g) Quality assessme	ent and assurance.			
	(1) A facility must ma and assurance comm minimum of:	intain a quality assessment nittee consisting at a			
	(i) The director of nur	rsing services;			
	(ii) The Medical Direc	ctor or his/her designee;			
	staff, at least one of v	a board member or other			
	(g)(2) The quality ass committee must :	sessment and assurance			
	coordinate and evalu	h respect to which quality			
		ement appropriate plans of tified quality deficiencies;			
	(h) Disclosure of info	rmation. A State or the			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 10/26/2017	
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW 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 OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 520	Continued From page	ge 56	F 5	20			
	records of such com such disclosure is re such committee with section.	equire disclosure of the amittee except in so far as elated to the compliance of a the requirements of this					
	committee to identify deficiencies will not sanctions. This REQUIREMEN by:	faith attempts by the y and correct quality be used as a basis for IT is not met as evidenced view, resident and staff		F520			
	Assurance Committed procedures and more committee put into procedures and more committee put into procedures are deficiency quality of care on a survey on August 25 recite deficiencies in Respect F241, Choi (MDS coding F 278, Staff F 353 and Dati Medication F 431. Tragain on October 26 and a complaint surfacility during two the facility's inability	nitor the interventions that the place in August 2016. This that was originally cited in recertification and complaint 5, 2016. This was for five in the area: Dignity and ces F242, Minimum Date Set Provide Sufficient Nursing and Opened Biological his deficiencies was cited 6, 2017 during recertification vey. The continued failure of to surveys showed a pattern of to sustain an effective Quality		ROOT CAUSE Repeated citation caused by the failure to follow through with plaset forth on the previous two support of the facility staff facility answer call bell in a timely mare attend to the resident's need. The also resulted from facility failure assignments according to acuit meet residents' need, which makes facility appeared to have insuffinumber of staff. F242 -This alleged noncompliant resulted from the facility staff facility and the facility and th	an of action urveys. Ince was ailed to inner and This was a to divide by level to ake a icient ince was ailed to to bed and		
	interview, the facility wait to be fed in the			waking up in the morning. This resulted from facility failure to cassignments according to acuit meet residents' need, which make facility appeared to have insuffinumber of staff. F278 - MDS nurse #1, MDS nut the facility Director of Social Seand #2 met with the MDS cons the contracted facility manager	divide ty level to ake a icient urse #2, and ervices #1 ultant from		

Facility ID: 20040007

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI	_		، ا	C
		345529	B. WING				26/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	20/2017
					201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		R	RALEIGH, NC 27616		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION			(X5)
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F 520	Continued From page	e 57	F	520			
		sampled residents observed			consulting company on 10/25/2017 to		
	during a lunch meal.	campion recidente escerven			review this alleged noncompliance and	to	
					identify the root cause. The root cause		
	During the recertifica	tion and complaint survey of			analysis concluded that, the MDS nurs		
	October 26, 2017 the	facility was cited for F241			#2 failed to assess and code resident #	‡ 88	
		e in a manner to maintain the			ADL assistance care needs correctly p		
		not answering call bells			RAI guidelines before coding section G		
		eding assistance with			MDS. The analysis further revealed that		
	activities of daily livin			MDS nurse #2 solely coded section G	of		
	Resident # 198) and			resident #88 assessment using			
	in a wet brief for 5 ho was evident by 3 of 3			documentation completed by facility certified nursing assistants and did not			
	dignity.	residents reviewed for			physically assess the resident before		
	digility.				coding. Likewise it was identified that		
	F242 Based on staff	interview, resident interview			Social worker #2 did not code the		
		e facility failed to honor a			behaviors documented in Electronic		
		ambulate daily for 1 of 1			Medication Administration and/or in the	,	
	sampled residents at	ole to ambulate with			nurses notes due to unawareness of he	ow	
	assistance (Resident	: # 22).			to pull such records and		
					misunderstanding of the look back peri		
	_	tion and complaint survey of			for section E of MDS. It is evident that		
		facility was cited for F242			resident #198 wandering behaviors and		
		sident's choice to go back to			resident #88 assistance with eating we	ere	
	bed (Resident #133)				anticipated as the plan of care reflect		
	l	et out of bed early (Resident			appropriate intervention to address	<u>_</u>	
	#102) 101 2 01 3 Tesiu	ents reviewed for choices.			behaviors and ADL. This determination was made on 10/25/17.	i 1	
	F 278 Based on resid	dent interview, staff interview,			Was made on 10/20/17.	ĺ	
		dical record review, the			IMMEDIATE ACTION TAKEN		
		the Minimum Data Set			Resident #133 is no longer in the facilit	ıy,	
	_	occurately in the areas of life			resident was discharged on 11/10/2017	•	
	expectancy (Residen				No other actions taken for this resident		
		e care (Resident #1), active			Resident #126 is no longer in the facilit	•	
	,	s #1 and #11), medications			resident was discharged on 10/29/2013		
	I -	‡72), behaviors (Resident			No other actions taken for this resident		
	#103), dental status (On 10/25/2017 Resident #198 incontin		
	·	omary and routine activities			care was provided by Nurse Aide #6 at	nd	
	(Resident #96) for 5 (of 26 sampled residents.			Nurse Aide #7. Resident #162 is getting out of bed in t	ho	
	İ		1		The side in the roads are till a control of the area.	ue: '	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		l' /	(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C (26/2047	
NAME OF D	ROVIDER OR SUPPLIER	0.70020	1	STREET ADDRESS, CITY, STATE, ZIP COD		/26/2017	
NAME OF P	ROVIDER OR SUPPLIER				JE		
UNIVERS	AL HEALTH CARE/N	ORTH RALEIGH		5201 CLARKS FORK DRIVE NW			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From p	age 58	F 5	20			
	During the recertife October 26, 217 the falling to accurate (MDS) for wander and for level of as (Resident #88) for Activities of Daily F 353 Based on restaff, family and refailed to provide some surrousing staff to me evidenced by allow be fed in the assist residents were be 94 & #81) of 3 safailing to honor and aily for 1 of 1 sarambulate with assist resolving grievand help in a timely manale resident whill living care to 1 of reviewed for activiting to provide requantity and quality and quality and quality and quality and to provide cardignity by not ansinesidents needing daily living. This was reviewed for choice reviewed for choice and to provide cardignity for choice and to provide cardignity by not ansinesidents needing daily living. This was reviewed for choice and to provide cardignity for choice and to provide cardignity by not ansinesidents needing daily living. This was reviewed for choice and to provide cardignity by not ansinesidents needing daily living. This was reviewed for choice and to provide cardignity by not ansinesidents needing daily living. This was reviewed for choice and to provide cardignity by not ansinesidents needing daily living. This was reviewed for choice and to provide cardignity by not ansinesidents needing daily living. This was reviewed for choice and the provide cardignity by not ansinesidents needing daily living. This was reviewed for choice and the provide cardignity by not ansinesidents needing daily living.	rication and complaint survey of the facility was cited for F278 by code the Minimum Data Set ing behavior (Resident #198) sistance needed with eating to 2 of 4 residents reviewed for		morning per choice effective The MDS assessment for res ARD 9/18/2017 was modified 10/25/2017 to reflect docume behaviors for wandering on the period per RAI guidelines in s MDS by Social worker #2 the MDS assessment was transmaccepted on 10/25/2017 by M #1. The MDS assessment for res ARD 6/22/2017, section G as daily living (ADL) was modified 11/21/2017 to reflect the corr assistance needed by reside meals specifically eating. The modification was done by ME The modified/corrected MDS was transmitted and accepte 11/21/2017. The MDS assessment for res ARD 9/21/2017, section G as daily living (ADL) was modified 11/21/2017 to reflect the corr assistance needed by reside meals specifically eating. The modification was done by ME The modified/corrected MDS was transmitted and accepte 11/21/2017. A1. Two identified Prednisold in a container not stored uprin 100-medication cart were dis re-ordered by the Pharmacy Director on 11/25/2017. A2. One identified Calcitonin spray not stored upright in 10 cart were discarded and re-o	sident #198 d on ented he look back section E of e modified mitted and MDS nurse sident #88, ssistance of ed on ect nt during e DS nurse #1. assessment d on sident #88, ssistance of ed on ect on during e DS nurse #1. assessment d on sident #88, ssistance of ed on ect nt during e DS nurse #1. assessment d on some eve drop ght in carded and Clinical Salmon D0-medication		

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345529	B. WING		1	0/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
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UNIVERSA	AL HEALTH CARE/NOR	IH RALEIGH		RALEIGH, NC 27616			
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F 520	Continued From page	e 59	F 52	20			
	Resident # 162).			B2. The opened Novolog regula	ar insulin		
	,			bottle observed in the Unit 1 me			
	F431 Based on recor	d review, observation and		refrigerator was discarded and			
		failed to discard expired		Pharmacy Clinical Director on 1			
	medications in 1 (400	0/500 medication room) of 2		Corrective action will be accom			
	medication rooms an	d to date a medication in 1		those residents having potentia	I to be		
	(400 medication cart)	of 4 medication carts.		affected by the same deficient p	oractice:		
	During the recertifica	tion and complaint survey of					
		facility was cited for F 431		IDENTIFICATION OF OTHERS			
	_	ations in an upright position		On 11/20/2017, 100% of all cur			
	•	s instructions for 1of 2		and oriented residents in the fa	,		
medication carts observed.		erved.		interviewed by the Center Exec			
	E 500 D	:!d::		Director, Director of Social serv			
	F 520 Based on med			#2), Director of Nursing, Assista			
		sident and family interview,		of Nursing and/or Staff Develop			
		Assessment and Assurance led to maintain implemented		Coordinator to determine if any other resident voiced concerns about call bell			
		itor the interventions the		responses. Six other residents	Call Dell		
	•	ace following the 9/25/14		complained of call bell not being	n		
		ation surveys. This was for		answered in a timely manner.	3		
		es in the areas of Dignity		100% choices and preferences	audit		
		of Daily Living (F312) cited		completed by the Director of So			
	9/25/14 and 9/17/15			Services #1 and/or Director of S			
	Assessment Accurac	y (F278), Comprehensive		Services #2 on 11/15/2017, 11/	16/2017, &		
	Care Plans (F280), S	Sufficient Staffing (F353) and		11/17/2017 to determine each r	esidents		
	Sanitary Conditions (F371) cited 9/17/15. These		choices and preferences, speci	fically in		
		ed again on the recertification		relation to waking up in the mor	-		
	•	he continued failure of the		going to bed at night. This aud			
		onsecutive federal surveys of		completed by interviewing the f	-		
	, , , , , , , , , , , , , , , , , , , ,	and two consecutive federal		current alert and oriented reside			
		278, F280, F353 and F371)		resident's voiced choices and p			
		e facility's inability to sustain		related to preferences on wakin			
	•	ssessment and Assurance		morning and going to bed at nig	•		
	program.	tion and complaint access		added in each resident's care p			
	_	tion and complaint survey of		anticipated effective 11/17/2017	•		
		e facility was cited for F520		of this audit are documented or			
	for falling to follow the	urance Committee failed to		Choices Audit tool" located in the compliance binder.	ie lacility		
	maintain procedures			100% audit of all grievances file	ed by		
	mamam procedures	and monitor the	1	100 /0 addit of all grievarioes file	.⊶ ⊳y	_ I	

Facility ID: 20040007

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	I` '		TE SURVEY MPLETED
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F 520	August 2016. This woriginally cited in quarecertification and complete 2016. This was for finarea: Dignity and Resulting Minimum Date Set (I Sufficient Nursing State Biological Medication was cited again on Continued failure of the showed a pattern of sustain an effective of Program. On October 26, 2017 interview with the Active with the Active with the Active facility was currestaffing, call bell respectively experience. She state recruit new staff and with training that focusive and a choice." managers include the rounds they do on the that they are working and they are conducted that she received the state of that the received that she received the state of the state o	e committee put into place in ras for a deficiency that was ality of care on a complaint survey on August 25, we recite deficiencies in the respect F241, Choices F242, MDS coding F 278, Provide aff F 353 and Dating Opened in F 431. This deficiencies October 26, 2017 during complaint survey. The he facility during two surveys the facility's inability to Quality Assurance (QAA) 7 at 4:29 PM during an alministrator. She stated that ently addressing sufficient conse and the dining ted that they are trying to provide all of the new staff uses on "Residents have a Stated that the department is in their daily Ambassador peir assigned units. Stated the ation and MDS accuracy, ting informal audits of the ation and MDS accuracy, ives monthly audits from the tregarding the med carts and	F 5	residents or family members of last 30 days completed by the director, Director of Social Serv determine any grievance that resident being wet for extended time and determine whether of grievances were investigated resolved per center's grievance procedures. The audit revealed that all othe grievances related to incontinucall bell responses filed within days were investigated and refacility grievance policy and portion of this audit will be completed bore facility compliance binder. On 11/20/2017, the Center Endirector, Director of Social sees #2), Director of Nursing, Assis of Nursing and/or Staff Develor Coordinator conducted the 10 observation of all current residence facility to determine if any other has any sign or indication of bore (with urine). The observation of other resident identified to (with urine). Findings of this and documented on "resident observated at the facility compliar 100% audit for current resider recent MDS assessment was by the Social Worker #1 and #4.	e Executive rvices #1 rices #2 to involve ed period of or not such and/or ce policy and her ent care and in the last 30 esolved per rocedure. by 11/22/17. locumented d at the executive rvices (#1 or estant Director opment 00% dents in the er resident being soiled revealed that be soiled ludit will be ervation tool" nce binder. ints' most completed #2, MDS	
					#2, MDS or #2 and/or nine if any ed	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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F 520	Continued From pag	e 61	F	period was coded app guidelines in section E identify if any other resin-accurate coding of of MDS 3.0. The resu indicated no other residocumented wanderin identified to be coded guidelines in section E no other resident code RAI guidelines in section E no other resident code RAI guidelines in section 5.0 respectively. Finding documented on "MDS located in the facility of This audit was comple On 10/25/17 and 10/20 Pharmacy Clinical Director Consultant and/or Director inspected all medication and medication carts to medication are stored guidelines. The audit rother medication were manufacturer guideline were dated per manuform Findings of this audit is "Medication storage at the facility compliance SYSTEMIC CHANGE On 11/20/2017, the Reconsultant will complete facility Administration for Nursing, regarding the facility Administration of Nursing, regarding the facility assurance performance program (QAPI) procesuil include how to identifications as well as system that will ensure	ed of MDS 3.0, and sident has eating in section of alts of the audit idents with a behaviors inaccurately per Fe of MDS 3.0, and ed inaccurately per fine E of MDS 3.0, and ed inaccurately per fine E of MDS 3.0, and ed inaccurately per fine E of MDS 3.0, and ed inaccurately per ion E and G of MI and G of M	RAI I, er DS s sool" :

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F 520	Continued From pag	e 62	F 52	measurable outcomes. The education also cover methods on how to track trend data, as well as best practices root cause analysis. Effective 11/22/2017, this plan of correction will be incorporated and discussed in the QAPI committees meeting by the Executive Director runtil the next annual inspection. An repeated citation in the following yenecessitate modification of this plar extension of discussion during mon QAPI meetings. Effective 11/22/2017, Resident #19 being toileted per plan of care and levidenced unmet needs related to dight response. On 11/20/2017, the Regional Clinic Consultant revised facility nursing assistant assignment to ensure tha staffing pattern corresponds with thacuity level Effective 11/22/2017, the facility will the revised assignment sheet and ethat each assignment's acuity level maintained. The Director of Nursing Assistant Director of Nursing, Staff Development Coordinator and/or U Coordinators will adjust the assign sheets whenever necessary to ensithe acuity level is maintained effect 11/22/2017. Effective 11/22/2017, moving forwa current nursing assistants will be responsible to honor resident's cho waking up in the morning and going bed at night during their shift and as appropriate. Effective 11/22/17, Resident choice	monthly by ear will n and othly al s is has not call al t the le ll utilize ensure is g, init ment ure that cive ard all lices of g to s

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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F 520	Continued From pag	e 63	F	preferences to include up in the morning and night will be assessed admission/readmission significant changes. The documented in Chopreference tool by the Services #1 or #2, and Director. Any choices a identified during asses implemented as indicateffective 11/22/2017, and/or #2) will review the documented in Clinical and electronic Medicatefective 11/22/2017, and "behavior to in the facility used licer Health records softward documented behaviors look back period are concept and "behaviors look back period are concept and to be stored uprin prescription bottles to such upright especially carts are moved. Effective 11/22/2017, a will review the medicate Prednisolone eye drop Salmon spray are store identified deviation will promptly. Effective 11/22/2017, a be dated and stored perecommendation Director of Nursing, As Nursing, Staff Develop and/or Unit Coordinator.	going to bed at on and quarterly and was assessment workers and Director of Social Cornects and preferences and preferences and preferences and preferences and preferences and preferences are to administration and administration and administration and accurately all medication that ight will be placed to help maintaining when medication and incoming nurse and/or Calcitonic and and/or Calcitonic and preferences and/or Calcitonic and and/or Calcitonic and and/or Calcitonic and and/or Calcitonic and and/or Calcitonic and/or Calc	with will fal 1 on es ated a per at ed ng on ee ee in will will

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F 520	Continued From page	e 64	F		100% education for all current facility employees, to include full time, part tim and as needed employees about call be responses. The emphasis of this education was on the importance of responding to resident's call bell when activated and ensure resident's needs anticipated. Any employee not educate by 11/22/2017 will not be allowed to wo until educated. This education will also added on new hires orientation process for all new employees effective 11/22/2017. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinate and/or Unit Coordinators will complete 100% education for all current nursing staff to include licensed nurses and certified nurse aides, to include full time part time and as needed nursing employees about incontinent care. The emphasis of this education was on the importance of providing incontinent car for each resident in a timely fashion an ensure resident's needs are anticipated Any nursing staff not educated by 11/22/2017 will not be allowed to work until educated. This education will also added on new hires orientation process for all new nursing employees effective 11/22/2017. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator Unit Coordinators, and/or Director of Social Services #1 or #2, will complete 100% education for all current nursing staff to include licensed nurses and certified nurse aides, to include full time part time and as needed nursing	ell are d brk be f or e, e d d f. be s	

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F 520	Continued From page	e 65	F 5	520	employees about resident's rights to m choices. The emphasis of this education		
					was on the importance of honoring each resident choices and preferences		
					specifically about resident choices on		
					when to get up in the morning, and who	en	
					to go back to bed. Any nursing staff no		
					educated by 11/22/2017 will not be		
					allowed to work until educated. This		
					education will also be added on new hi	res	
					orientation process for all new nursing		
					employees effective 11/22/2017.	- d	
					On 10/25/17, MDS consultant conductor re-education to MDS nurse #1, MDS	J u	
					nurse #2, Director of Social Services #	1	
					and #2, on accurate coding of MDS us		
					Resident Assessment Instruments (RA	•	
					guidelines. This education covers codi		
					requirements and supportive	Ū	
					documentation for each item coded in		
					MDS, specifically related to section E a	and	
					Section G of MDS 3.0 assessment.		
					Effective 11/22/2017, Education on the		
					Accurate coding of MDS will be added		
					new hires orientation education for MD	S	
					nurses, Director of Social Services,		
					Activities Director, and the C Dietary Manager (DM). This education will also	, ho	
					provided annually for MDS nurses,) De	
					Director of Social Services, Activities		
					Director, and the Dietary Manager (CD	M)	
					Director of Nursing (DON), Assistant	,.	
					Director of Nursing (ADON) and/or Sta	ff	
					Development Coordinator (SDC) will		
					complete 100% education for all currer	nt	
					facility Licensed nurses, and Medicatio		
					aide, to include full time, part time and		
					needed employees about revised proce	ess	
					of medication storage and dating of		

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F 520	Continued From page	e 66	F	insulin. The ed was on the immedication the kept upright was prescription be medication can completed by nurse, and/or educated by allowed to wo education will orientation premployees eff. MONITORING Effective 11/2 Director of Noursing, Staff Director of Noursing, Staff Director of Noursing, Staff Director, Director, Director, Director, Director, Director, Director of Noursing, Staff Director, Director, Director, Director, Director, Director, Director, Director, Was and document from this more documented audit form" money compliance be process will to through Fridated for two more weeks then more weeks then more weeks then more weeks then more weeks the mor	emphasis of this education inportance of ensuring that hat is recommended to be will need to be placed in the pottles while stored in arts. This education will be a 11/22/2017, Any License of Medication aide not 11/22/2017 will not be ork until educated. This I also be added on new his rocess for all new License of the process will be on a "Call light response on a "Call li	t ne e e d or, of or, will he t s e e	

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F 520	Continued From page	e 67	F	520	Nursing, Assistant Director of Nursing, Director of Social Services #1 and/or Director of Social Services #2 shall ensure compliance by completing the Sequence of Determination Audit form weekly and a needed for 30 days and monthly thereafter to ensure compliance with Sequence of Determination policy and procedure. A identified discrepancies shall be remediated. Effective 11/22/2017, Executive Director Director of Nursing, Assistant Director Of Nursing, Assistant Director Of Social Services (#1 or #2), and follow through the completion, and follow through the completion, and follow through the documented on a "Choices and Preference tool. Finding from this monitoring process will be documented on a "Choices and Preferences completion audit form" maintained in the facility compliance binder." This monitoring process will taplace daily (Monday through Friday) for weeks then 3x/week for two more week then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. The Director of Nursing, Assistant Director of Nursing, and/or Nursing Supervisor will be responsible for checking medication carts and medicate to ensure medication are stored and labelled appropriately per manufacture guidelines. This monitoring process will take place daily (Monday through Fridation 2 weeks then, then weekly for 2 weeks then monthly for 3 months or until the pattern of compliance is maintained. Ar issues identified during this monitoring process will be addressed promptly.	elf Iny or, of or, vill igh gs ke 2 ks, or ion f y) eks	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION		(X3) DATE SURVEY COMPLETED
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F 520	Continued From page	e 68	F	be Mo con Effe Dire Number 1	dings from this monitoring documented on a "Medica nitoring tools" and filed in impliance binder effective 1 ective 11/22/2017, Execute ector of Nursing, Assistantsing, Staff Development (ector of Social Services (# fort findings of this monitorine facility Quality Assurant formance Improvement Or additional monitoring or this plan monthly for three ill the pattern of compliance intained. The QAPI commidify this plan to ensure the nains in substantial compliective 11/22/2017, prior to 0S Nurse #1 and/or MDS riew section E of MDS assimpleted by the social work sure that all documented be considered in the pattern of the pattern of the pattern of all completed MDS assess of all completed MDS ass	ation Stora the facility 11/22/2017 ive Director of Coordinate to rector of committee modificatio months, of the facility tiance. submission nurse #2 v tessment to respect to the rector to r	ge y.
ORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: BZC3*	<u> </u>		ective 11/22/2017, prior to		ation sheet Page 69 of 71

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From pag	e 69	F 52	MDS Nurse #1 will review section G MDS 3.0 completed by MDS nurse (and vice versa) to ensure that an appropriate self-care performance let and assistance needed for eating component of ADL is codded accurat per RAI guideline. These reviews will place Monday through Friday, prior to submission for 2 weeks on all compl MDS assessments, 50% of all compl MDS assessments weekly for 2 weel then 25% of all completed MDS assessments monthly for 3 months of until the pattern of compliance is achieved. Any inaccurate coding ider will be noted and corrected before submission by MDS nurse #1 or #2 (whoever is completing the audit). Findings of this monitoring process we documented on MDS accuracy monit tool located in the facility compliance binder. Effective 11/22/2017, Executive Director of Nursing, Assistant Director Of Social Services (#1 or #2) report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committed any additional monitoring or modificated of this plan monthly for three months until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Effective 11/22/2017, MDS nurse #1 #2, Director of Social Services #2 will rep findings of this monitoring process to	#2 /el ely take o eted eted eted eted ss, r htifies stor, r of ator, ,, will eess e for tion or or d/or ort

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F 520	Continued From page	÷70	F	facility Quality Assurance at Performance Improvement any additional monitoring of this plan monthly X3 more the pattern of compliance is The QAPI committee can move to ensure the facility remains substantial compliance. Effective 11/22/2017, Direct Assistant Director of Nursin Development Coordinator would findings of this monitoring particularly Quality Assurance at Performance Improvement any additional monitoring of this plan monthly for thre until the pattern of compliar maintained. The QAPI commodify this plan to ensure the remains in substantial compliance and the Director of be ultimately responsible to implementation of this plan for this alleged noncompliant the facility remains in substantial compliance and has sufficient staff to meet each resident accordance with the facility Compliance Date: 11/22/20	Committee r modification the, or until s maintained nodify this plas in tor of Nursing, and/or Si will report process to the Committee r modification e months, once is mittee can the facility pliance. The Nursing will be ensure of correction ce to ensure antial ent nursing s need and assessment.	on d. d. dan ng, taff ne for on or	