The above isolated deficiencies pose no actual harm to the residents.
and telephone number of the agency responsible for the protection and advocacy of individuals with a mental
disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update
the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written
notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term
Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the
transfer and adequate relocation of the residents, as required at § 483.70(l).

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to provide written notification to the resident
representative and the ombudsman when a resident was transferred to the hospital. This was evident for 1 of 1
resident that was reviewed for hospitalizations (Resident #422).

Findings Included:

Resident #422 was admitted to the facility on 2/23/18 and diagnoses included congestive heart failure,
cerebral vascular accident, diabetes, dysphagia and aphasia.

An admission minimum data set for Resident #422 dated 3/2/18 identified the resident had moderately
impaired cognition.

Review of the medical record for Resident #422 revealed he was discharged to the hospital on 4/14/18 and
re-admitted to the facility on 4/16/18.

Review of the medical record for Resident #422 revealed he was discharged to the hospital on 5/25/18 and
re-admitted to the facility on 6/1/18.

An interview with the Social Worker (SW) on 6/15/18 at 4:06 pm revealed she had just been informed on
Monday, 6/11/18 that it was her responsibility to provide the written notification of a resident’s discharge to
the resident, resident representative and ombudsman. She stated there had been no written notification
provided to either the resident representative or ombudsman when Resident #422 was hospitalized.

An interview with the Director of Nursing (DON) on 6/15/18 at 5:06 pm revealed it was the SW’s
responsibility to provide written notification of a resident’s discharge to the resident representative and the
ombudsman. He stated that the SW was not aware of this and going forward the SW would complete the
notification per the regulation.
**STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs**

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**DATE SURVEY COMPLETE:** 6/15/2018

**NAME OF PROVIDER OR SUPPLIER:** UNIVERAL HEALTH CARE/NORTH RALEIGH

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 5201 CLARKS FORK DRIVE NW RALEIGH, NC

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<th>ID</th>
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**Event ID:** LK9N11