A. BUILDING ____________________________
B. WING ____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

UNIVERSAL HEALTH CARE/NORTH RALEIGH

STREET ADDRESS, CITY, STATE, ZIP CODE
5201 CLARKS FORK DRIVE NW
RALEIGH, NC  27616

SUMMARY STATEMENT OF DEFICIENCIES 
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

| ID | PREFIX | TAG | ID | PREFIX | TAG | PROVIDER'S PLAN OF CORRECTION 
|---|---|---|---|---|---|---|
| E 000 | | | | | | An unannounced COVID-19 Focused Survey and complaint was conducted on 07/14/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities.  
Event ID# VITR11.

2 of the 2 complaint allegations were unsubstantiated.

| F 000 | INITIAL COMMENTS | | | | | An unannounced COVID-19 Focused Infection Control Survey and complaint survey was conducted on 07/14/20. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.  
Event #VITR11.

2 of the 2 complaint allegations were unsubstantiated.

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

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