STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The surveyor entered the facility for a complaint investigation on 5/30/24 and exited on 5/31/24. Additional information was obtained through 6/6/24. Therefore the exit date was changed to 6/6/24. The following intakes were investigated. NC 215420; NC 216835; NC 216770; NC216834; and NC217156. Two of twelve allegations resulted in deficiencies.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, family, Nurse Practitioners, and physicians, for a resident with multiple wounds caused by shearing and pressure, the facility failed to have a system in place to accurately evaluate the extent nutrition was contributing to the development and non-healing of the wounds and develop a plan to address any nutritional deficit. This was for one (Resident # 4) out of three sampled residents with	F 686	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated.	7/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 1 pressure sores. The findings included: Resident # 4 was initially admitted to the facility on 8/19/22 with a most recent readmission date on 8/29/23 following hospitalization. The resident had diagnoses which included chronic encephalopathy, hypertension, history of remote infarcts to the basal ganglia and thalami, gastrostomy placement, and history of ileus. Review of Resident # 4's quarterly Minimum Data Set assessment, dated 12/1/23, revealed the resident was severely cognitively impaired. Additionally, the resident was assessed to be totally dependent on staff for her bathing, eating, and hygiene needs. The resident was incontinent of both bowel and bladder. She received both a mechanical soft diet and nutritional support from a feeding tube which provided 26 to 50 % of her caloric intake. She was 63 inches tall and weighed 179 pounds according to the 12/1/23 assessment and had a stage 4 pressure sore. According to the resident's care plan, dated 2/28/24, the resident had pressure sores and was at risk for future development of pressure sores. One of the interventions included on the care plan was to refer the resident to the dietician for evaluation of nutritional status. Review of physician orders revealed Resident # 4 was prescribed to receive a mechanical soft diet. This order was in effect from 8/31/23 to 5/15/24. Additionally, Resident # 4 was prescribed to receive Nutren 1.5 250 ml (milliliters) four times per day via gastrostomy tube between her meals. (Nutren is a formula used for enteral feedings).	F 686	F686- Treatment Services to Prevent /Heal Pressure Ulcer 1. Resident #4 has been discharged from the facility 2. The facility RD will assess current residents with wounds for weight loss and make recommendations as necessary. 3. The Administrator will educate the Registered Dietician on the requirement of completing nutritional assessments on residents with wounds and the need to collaborate with the IDT any weight changes during weekly risk meetings. Education began on 6/17/24. 4. The DON or designee will monitor RD recommendations weekly x 4 weeks beginning 6/17/24 for current residents with wounds that have had significant weight losses to ensure appropriate interventions have been implemented. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis. 6. Date of compliance: July 1, 2024 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 2	F 686		

This order was in effect from 9/1/23 to 4/16/24. The resident was also ordered to receive Prostat 30 ml (milliliters) twice per day via gastrostomy tube. This order originated on 9/12/23 and was in effect until 2/24/24. On 2/24/24 the resident's Prostat was decreased to 30 ml once per day without explanation in the record. (Prostat is a concentrated protein liquid supplement).

Review of wound physician notes revealed Resident # 4 was seen weekly by the wound physician for care. The Wound Physician's documentation included the following information about the resident's wounds.

On 12/7/23 the resident had a Stage 4 sacral pressure sore which measured 5.7 X 4.5 X 1.6 cm (centimeters) with 20% necrotic tissue (dead tissue), 20% slough (devitalized tissue that needs to be removed for healing), 50% granulation tissue (healthy tissue), and 10% fascia/bone. (Fascia is the connective tissue that holds bone, organs, and blood vessels in place). The pressure sore had undermining. (Undermining is skin erosion under the skin which is not always visible from looking at a wound).

On 12/7/23 the resident had a wound attributed to trauma/injury to the left medial knee which measured 1.1 X 0.6 X 0.3 cm and which had 40% slough and 60% granulation tissue.

During an interview with the Wound Physician on 6/4/24 at 12:37 PM, the wound physician reported that the resident was very contracted and the medial knee wound was due to shearing as her knees would rub together.

On 12/14/23 the sacral pressure sore measured

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 3	F 686		

4.8 X 6.0 X 2.0 cm with 20% necrotic tissue, 20% slough, 50% granulation tissue, and 10% fascia/bone. The undermining continued.

On 12/14/23 the resident's left medial knee wound measured 0.8 cm X1.0 X 0.2 cm with 30% slough and 70 % granulation.

On 12/21/23 the sacral pressure sore measured 3.3 X 6.6 cm X 1.7 cm with 30 % slough, 60 % granulation tissue, and 10% fascia. The undermining continued.

On 12/21/23 the resident's left medial knee wound measured 0.9 X 0.9 X 0.2 cm with 30% slough and 70% granulation tissue.

On 12/28/23 the sacral pressure sore measured 4.0 X 5.0 X 1.4 with 40% slough, 50% granulation, and 10% fascia.

On 12/28/23 the resident's left medial knee wound measured 1.0 X 1.5 X 0.2 cm with 30% slough and 70% granulation tissue.

On 1/4/24 the sacral pressure sore measured 5.0 x 4.8 X 1.0 cm with 40% slough, 55% granulation, and 5% fascia. The undermining continued.

On 1/4/24 the resident's left medial knee wound measured 1.1 X 0.9 X 0.1 cm with 50 % slough and 50 % granulation tissue.
Additionally, on 1/4/24, the wound physician noted two new wounds. One was on the left medial ankle and attributed to "trauma/injury" measuring 4.7 X 1.5 X 0.2 cm with 20% slough and 40 % granulation tissue. The other wound was documented as a "skin tear" to the right lateral ankle measuring 0.7 X 0.5 X 0.1 cm with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 4	F 686		

100 % granulation tissue.

During the interview with the Wound Physician on 6/4/24 at 12:37 PM, the Wound Physician reported that the resident's wounds on her ankles also came about from shearing when her ankles rubbed against each other or against the sheets due to her contractures.
When the right lateral ankle started it appeared as a skin tear from the rubbing on the sheets and the skin had folded back. Therefore, she placed under etiology "skin tear" for the right ankle and "trauma/injury" for the left ankle.

On 1/11/24 the sacral pressure sore measured 4.2 X 5.5 X 1.4 cm with 20% slough, 75% granulation, and 5 % fascia. The undermining continued.

On 1/11/24 the left medial knee wound measured 0.7 X 1.1 X 0.1 cm with 10% slough and 90 % granulation tissue.

On 1/11/24 the left medial ankle wound measured 4.0 X 1.1 X 0.2 cm with 10% slough and 40 % granulation tissue.

On 1/11/24 the right lateral ankle wound measured 1.0 X 0.8 X 0.1 cm with 100% slough.

On 1/18/24 the sacral pressure sore measured 4.0 X 4.0 X 1.0 cm with 5 % slough, 90 % granulation, and 5 % fascia. The undermining continued.

On 1/18/24 the left medial knee wound measured 0.7 X 0.7 and was considered a scab.

On 1/18/24 the left medial ankle wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 5	F 686		

measured 3.3 x 1.8 X non-measureable cm and was 60% necrotic tissue and 40% skin.

On 1/18/24 the right lateral ankle wound measured 1.8 X 1.7 X 0.5 cm and was 100 % granulation tissue.

On 1/25/24 the sacral pressure sore measured 4.2 X 4.5 X 1.0 cm with 90 % granulation tissue and 10 % fascia. The undermining continued.

On 1/25/24 the left medial knee wound was noted resolved.

On 1/25/24 the left medial ankle wound measured 1.5 X 1.0 X 0.5 cm with 100 % necrotic tissue.

On 1/25/24 the right lateral ankle wound measured 3.0 X 4.1 X 0.5 cm with 60 % necrotic tissue and 40 % dermis.

On 2/1/24 the sacral pressure sore measured 5.1 X 5.1 X 1.0 with 10 % necrotic tissue, 80 % granulation tissue, and 10 % fascia. The undermining continued.

On 2/1/24 the left medial ankle wound measured 1.5 X 0.8 X 0.3 cm with 20 % necrotic and 80 % granulation tissue.

On 2/1/24 the right lateral wound measured 2.5 X 4.2 X .6 cm with 30 % necrotic tissue, 40 % dermis, and 20 % slough, and 10 % granulation.

On 2/8/24 the sacral pressure sore measured 4.5 X 4. 6 X 1.5 cm with 10 % slough and 90 % granulation tissue. The undermining continued.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 6	F 686		

On 2/8/24 the left medial ankle wound measured 1.5 X 0.5 X 0.1 cm with 30 % slough and 70 % granulation tissue.

On 2/8/24 the right lateral ankle wound measured 1.8 X 2.4 X .4 cm with 30 % slough, 50 % granulation, and 20 % fascia.

On 2/15/24 the sacral pressure sore measured 5.3 X 4.0 X .7 with 90 % granulation and 10 % fascia. The undermining continued.

On 2/15/24 the left medial ankle wound measured 1.4 X 0.7 X 0.2 with 20 % slough and 80 % granulation.

On 2/15/24 the right lateral ankle wound measured 3.3 X 2.5 X 0.5 with 40 % necrotic tissue, 30 % granulation, and 30 % fascia/bone. The wound was documented to have .9 cm undermining at the 4:00 position.

On 2/22/24 the sacral pressure sore measured 4.5 X 4.7 X .9 cm with 90 % granulation and 10 % fascia. The undermining continued.

On 2/22/24 the left medial ankle wound measured 1.3 X .8 X .3 cm with 20 % slough and 80 % granulation.

On 2/22/24 the right later ankle wound measured 2.8 X 3.2 X .9 cm with 10 % necrotic tissue, 30 % slough, 30 % granulation, and 30 % fascia/bone. The wound continued with undermining.

On 2/29/24 the resident was assessed to have a new pressure area. The area was documented to be a deep tissue injury to the left distal medial foot which measured 1.7 X 1.8 X not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 7	F 686		

measureable depth in cm. It was noted to be purple/ maroon in discoloration.

On 2/29/24 the resident's sacral pressure sore measured 4 X 4.0 X 1.3 cm with 90 % granulation and 10 % fascia. The undermining continued.

On 2/29/24 the resident's left medial ankle wound measured 0.7 X 1.0 X 0.2 cm with 20 slough and 80 % granulation.

On 2/29/24 the resident's right lateral ankle wound measured 3.2 X 3 X .5 cm with 10 % necrotic tissue, 20 % slough, 40 % granulation tissue, 30 % facia,bone. The undermining continued.

On 3/7/24 the resident's sacral pressure sore measured 4.4 X 4.2 X 1.2 cm with 90 % granulation and 10 % fascia. The resident's left distal medial foot deep tissue injury measured 1.3 X 0.5 X unmeasurable depth in cm. The resident's left medial ankle wound measured 0.8 X 0.8 X .2 with 20 % slough and 80 % granulation. The resident's right ankle wound measured 2.7 X 2.9 X .6 cm with 20 % slough, 50 % granulation, and 30% fascia/bone. The undermining continued.

Review of an arterial study to the lower extremities, conducted on 1/29/24, revealed Resident # 4 had no significant obstructive disease.

Review of Resident # 4's weights revealed the following weight history. These weights were in the record as of a record review date of 5/31/24.
12/6/23 136 pounds
12/30/23- 200 pounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 8	F 686		

1/30/24-119.2 pounds
2/2/24-119 pounds
3/7/24-123.2 pounds (This weight and date were crossed out in the record)
3/15/24-118.4 pounds
4/23/24-105.6 pounds

Review of Registered Dietician (RD) notes between the dates of 12/21/23 through 4/11/24 revealed the RD did not reference the most current weights in her assessment of the resident's needs and future plans to meet nutritional goals. Specifically, on 12/21/23 the RD documented the resident's current weight was 178.8 pounds which she noted was from a weight obtained on 10/13/23. The RD noted there was no new weight available for review. The RD noted the resident had wounds and estimated the resident's caloric and protein needs. The RD's recommendation was to obtain weight and monitor. On 1/24/24 the RD noted the resident's current weight was 200 pounds based on a weight obtained on 12/30/23. The RD noted this indicated a weight gain for the resident. The RD noted the resident had wounds. She estimated the resident's needs and her recommendation was to continue the current plan of care and monitor. On 2/27/24 the RD again documented the resident's current weight was 200 pounds and referenced the 12/30/23 weight. She further noted no new weight was available for review. The RD noted the resident's plan of care would be continued and she would monitor the weights as available. The RD did not note the resident's Prostat had been decreased to once per day from the former dose of twice per day.

On 3/9/24 an order was given to initiate a hospice consult due to poor oral intake and wounds. On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 9	F 686		

3/20/24 the resident was admitted to hospice per an order. On 4/15/24 the resident's tube feeding was discontinued per an order. On 5/16/24 the resident expired while under hospice care according to a progress note. Review of Wound Physician notes revealed the resident continued to be treated for pressure sores up until her death.

The RD was interviewed on 5/31/24 at 12:31 PM and reported the following information. She had not had the weights which were documented in the vital signs electronic record as of the review date of 5/31/24 when she was making recommendations for the resident. She was aware the resident had wounds. The 12/30/23 weight of 200 pounds was most likely not correct if viewing all of her weights as a whole, which she had not been able to do. She based recommendations on a report entitled weight change history. At times there were no current weights available on the report for her to reference and therefore she based recommendations on previous weights. If she had known the resident was trending down and losing weight, she would have asked for a reweight and would have made adjustments in her tube feedings to try to stabilize her weight loss. She was not involved in the resident's care plan. After she made recommendations, she would send her report to the DON, the Administrator, and the Unit Managers.
During an interview with the DON (Director of Nursing) on 6/4/24 at 4:37 PM , the DON reported if a weight is crossed out, it was entered in error. Therefore, the DON validated that the 3/7/24 weight of 123.2 pounds was an error. The DON also reported the weight of 200 pounds was likely incorrect. She knew the resident was not eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 10	F 686		

The RD had not mentioned a plan to address the weight loss. From observing the resident when she had resided at the facility, the DON felt the weights of 119.2 in January 2024 and 119 in February 2024 were likely correct. The DON did not know why the resident's Prostat was decreased in February 2024. She commented that it did not make sense since she was not eating well.

During an interview on 6/4/24 at 4:51 PM with the former MDS nurse, the nurse reported the following information. She had been responsible for the assessments of the resident. She always looked at the resident during the MDS assessment periods, and there was "no way" the resident ever weighed 200 pounds. According to the MDS nurse, when she completed an MDS assessment for Resident # 4 on 2/28/24 there had been no weight in the resident's chart for the last 30 days. She had mentioned the problem to the DON. The RD had also talked to her (the MDS nurse) about not having weights available on which to base their assessments of her nutritional status. From observing the resident for the 2/28/24 MDS assessment, the MDS nurse felt the February weight of 119 pounds was plausibly an accurate weight for the resident.

Nurse # 1 was interviewed on 5/31/24 at 3:10 PM and reported the following information. She routinely cared for Resident # 4 and was very familiar with her. Resident # 4 appeared to be losing weight. She would not eat although they tried to feed her. She did recall speaking to the RD about possibly putting the resident on a continuous tube feeding and the RD stated she would look into it, but this was not ever tried. Nurse # 1 thought this was mentioned at some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 11	F 686		

time since the first of 2024.

The week-end facility wound nurse was interviewed on 6/3/24 at 3:29 PM and reported she recalled by the time the resident was placed on hospice she did not have to use as much strength to turn the resident for wound care and felt this was due to weight loss.
The Nurse Aide (NA # 1) who routinely did the facility's weights was interviewed on 6/5/24 at 10:30 AM and reported the following information. She had recognized that Resident # 4's weight was going "down-down-down" starting around December 2023. She had told the DON the resident was losing weight. The resident had never weighed 200 pounds in December 2023 and she did not know why that had been entered in the record. She turned the weights into the DON for someone else to enter into the medical record.

Resident # 4's Responsible Party was interviewed on 5/30/24 at 11:20 AM and again on 6/5/24 at 3:50 PM and reported the following information. She did not understand how the resident's wounds had gotten so extensive and deep. She felt the resident was losing weight. She had talked to the resident's physician about her condition, and he said she had "a brain thing." She did not recall the facility having a conversation with her about how to address the weight loss before the resident was placed on hospice services. After hospice services were initiated and the weight had already been lost and the wounds were so extensive, she had spoken to hospice and agreed to stop the tube feeding. Prior to the resident being placed on hospice, she had wanted the resident to receive nutrition by her gastrostomy tube if she was not eating well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12	F 686		

Resident # 4's Nurse Practitioner was interviewed on 6/5/24 at 5:18 PM and reported the following information. The resident had never gained weight since she resided at the facility, and the 200 pounds would not have been correct. The resident had not needed to lose weight as quickly as she did while residing at the facility. She (the NP) could look at the resident and tell she was getting "smaller and smaller." She was not sure what all was contributing to her failure to thrive. She thought a continuous feeding would have been a possibility for the resident to avoid the rapid loss that was occurring. She relied on the RD to make recommendations for the enteral feedings. At sometime in the past she had written a consult for the RD thinking the RD would consider a continuous feeding but she did not recall when that was. It had been difficult to make assessments of all the resident's weight loss because when she visited to see the resident at times the weights were not in the record nor how much she was eating. She saw the resident in February 2024 and wrote the order to place the resident on Prostat. She had not realized the resident was already on Prostat twice per day when she wrote the order. She found it difficult to find information in the chart. She would have expected the nurses to recognize when they were carrying out the Prostat order that it was a decrease in what she was already receiving and brought it to her attention. Her goal had been that the resident receive more supplementation and not less. The maximum recommended dosage for Prostat was 30 ml three times per day and therefore the resident could have gotten more and not less if it had been brought to her attention. That would have been the goal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 13	F 686		

During the interview with the facility Wound Physician on 6/4/24 at 12:37 PM, the wound physician reported the following. Good nutrition is a "big" factor in working towards getting pressure sores to heal. If a resident is losing weight this is generally an indicator of poor nutrition. Albumin levels are also an indicator of nutritional health. Towards the end of the resident's residency, there was an evident weight loss but she had not perceived there was a massive drop within a short time period based on observations of the resident. She felt judging the accuracy of the weights is subjective but she felt that the resident had seemed larger than 119.0 pounds. A contributing factor to Resident # 4's wounds was that she was so uncomfortable with movement and her contractures. She also had fragile skin.

During an interview with a licensed physical therapist on 6/2/24 at 10:50 AM, the therapist reported therapy had tried working with the resident for contracture management but the resident was not able to tolerate stretching or splinting and did not like to be touched.

Resident # 4's primary physician was interviewed on 5/31/24 at 4:50 PM and reported the following. Resident # 4 had been a very sick resident. At a young age she had gone from being healthy to problems which resulted in syncope, cognitive changes, and encephalopathy. Her cognitive status deteriorated and never returned to baseline. There had been multiple tests, including cancer tests, while she was in the hospital without a determination of what had caused all her medical problems. It was his opinion that part of her neurological problems contributed to the development of contractures. She did have deep non healing wounds and nutrition could partially

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 14 have been a factor in non-healing, but it was hard to say if the wounds would have healed regardless of nutritional issues she may have had.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and physicians, for a resident whose weights showed a trending decline, the facility failed to ensure a system was in place for the registered dietician to become aware of accurate weights and develop a plan of care to address weight loss. This was for one (Resident # 4) of two sampled residents reviewed for nutritional status	F 692	F692-Nutrition/Hydration Status Maintenance 1.Resident #4 has been discharged from the facility 2- DON and unit manager completed an audit of weights for residents currently in the facility on 6/17/24. Any significant weight changes that were identified were	7/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 15 interventions. The findings included: Resident # 4 was initially admitted to the facility on 8/19/22 with a most recent readmission date on 8/29/23 following hospitalization. The resident had diagnoses which included chronic encephalopathy (a change in brain function), hypertension, history of remote infarcts to the basal ganglia and thalami (brain damage in specific areas of the brain) , gastrostomy placement, and history of ileus. Review of Resident # 4's quarterly Minimum Data Set assessment, dated 12/1/23, revealed the resident was severely cognitively impaired. Additionally, the resident was assessed to be totally dependent on staff for her eating. She received both a mechanical soft diet and nutritional support from a feeding tube which provided 26 to 50 % of her caloric intake. She was 63 inches tall and weighed 179 pounds according to the 12/1/23 assessment. According to the resident's care plan, dated 2/28/24, the resident had inadequate nutrition as a problem and also received enteral feedings via a gastrotomy tube. One of the interventions to address the resident's nutritional problem was to refer the resident to the RD (Registered Dietician) for evaluation of current nutritional status and determine further formula options. Review of physician orders revealed Resident # 4 was prescribed to receive a mechanical soft diet. This order was in effect from 8/31/23 to 5/15/24. Additionally, Resident # 4 was prescribed to receive Nutren 1.5 250 ml (milliliters) four times per day via gastrostomy tube between her meals. (Nutren is a formula used for enteral feedings).	F 692	communicated to the RD and appropriate interventions were implemented. 3. The DON or designee will educate the nursing leadership team on the requirement to obtain monthly weights on current residents, weekly and daily weights as indicated and the requirement to validate any weight variances with a reweight. Education will also include notification to the RD on any significant weight changes. Education began on 6/17/24. 4- The DON or designee will complete weekly weight audits weekly during weekly risk meetings and communicate any significant weight changes to RD. Audits were implemented on 6/17/24 The DON or designee will review monthly weights by the 5th of the month, communicate any significant changes to RD and validate any weight changes with reweighing residents. 5-Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis. 6. Date of compliance: July 1, 2024 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 16	F 692		

This order was in effect from 9/1/23 to 4/16/24. The resident was also ordered to receive Prostat 30 ml (milliliters) twice per day via gastrostomy tube. This order originated on 9/12/23 and was in effect until 2/24/24. On 2/24/24 the resident's Prostat was decreased to 30 ml once per day without explanation in the record. (Prostat is a concentrated protein liquid supplement). The resident was also ordered to receive Megace 400 mg (milligrams) daily. This was in effect from 8/29/23 to 2/24/24. On 2/24/24 the resident's Megace dosage was increased to 400 mg twice per day.

Review of wound physician notes from December 2023 through April 2024 revealed Resident # 4 was seen weekly by the wound physician for care of wounds caused by pressure and shearing. In December 2023, one of the wounds was documented to be a Stage 4. By the date of 1/4/24, the Wound Physician noted Resident # 4 was receiving care for four different wounds.

Review of Resident # 4's weights revealed the following weight history. These weights were in the record as of a record review date of 5/31/24.
12/6/23 136 pounds
12/30/23- 200 pounds
1/30/24-119.2 pounds
2/2/24-119 pounds
3/7/24-123.2 pounds (This weight and date were crossed out in the record)
3/15/24-118.4 pounds
4/23/24-105.6 pounds

Resident # 4's lab values included the following values:
2/14/24-Albumin 2.6 (normal 3.5 to 5.2)
2/14/24 -Total protein 5.6 (normal 6.0 to 8.7)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 17 2/20/24 Albumin 2.4 2/28/24- Albumin 2.2 Review of Resident # 4's December 2023 MAR (Medication Administration Record) revealed multiple blanks beside the area where the nurses were to document the administration of the Nutren bolus. Although not inclusive of all the blanks, an example was that on fifteen of the December dates, the resident was documented as receiving the bolus only once. Review of Resident # 4's January 2024 MAR also revealed multiple blanks beside where the nurses were to document the administration of the Nutren bolus. Although not inclusive off all the blanks, an example was that on twenty- four of the January 2024 dates, Resident # 4 was documented to have received the bolus once rather than four times. Review of Resident # 4's February 2024 MAR revealed multiple blanks by the Nutren also. The December 2023, January 2024, and February 2024 MAR also contained multiple blanks for the administration of the resident's Prostat as well. Review of Registered Dietician (RD) notes between the dates of 12/21/23 through 4/11/24 revealed the RD did not reference the most current weights in her assessment of the resident's needs and future plans to meet nutritional goals. Specifically, on 12/21/23 the RD documented the resident's current weight was 178.8 pounds which she noted was from a weight obtained on 10/13/23. The RD noted there was no new weight available for review. The RD noted the resident had wounds and estimated the resident's caloric and protein needs. The RD's recommendation was to obtain weight and monitor. On 1/24/24 the RD noted the resident's	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 18	F 692		

current weight was 200 pounds based on a weight obtained on 12/30/23. The RD noted this indicated a weight gain for the resident. The RD noted the resident had wounds. She estimated the resident's needs and her recommendation was to continue the current plan of care and monitor. On 2/27/24 the RD again documented the resident's current weight was 200 pounds and referenced the 12/30/23 weight. She further noted no new weight was available for review. The RD noted the resident's plan of care would be continued and she would monitor the weights as available. On 2/27/24 the RD did not note the resident's Prostat had been decreased to once per day from the former dose of twice per day or a reason why it had been done. The RD noted the resident was still receiving Prostat twice per day. On 3/14/24 the RD noted the resident's current weight was 123.2 pounds and she had been admitted to hospice. On 4/11/24 the RD noted the resident's current weight was 123.2 pounds.

Review of Nurse Practitioner notes revealed the following notations. On 2/16/24 the NP noted the resident was declining physically and had significant weight loss. She noted that she was on Megace and that she would consult hospice about the resident's failure to thrive. On 2/23/24 the NP noted she would place the resident on Prostat daily. At the time of the 2/23/24 NP's notation that she would add Prostat, the resident was already ordered to receive the Prostat on a twice per day schedule.

On 3/9/24 an order was given to initiate a hospice consult due to poor oral intake and wounds. On 3/20/24 the resident was admitted to hospice per an order. On 4/15/24 the resident's tube feeding was discontinued per an order. On 5/16/24 the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 19	F 692		

resident expired while under hospice care according to a progress note.

The RD was interviewed on 5/31/24 at 12:31 PM and reported the following information. She had not had the weights which were showing up in the vital sign electronic record as of the review date on 5/31/24 when she was making recommendations for the resident. She was aware the resident had wounds. The 12/30/23 weight of 200 pounds was most likely not correct if viewing all of the resident's weights as a whole, which she had not been able to do when making the recommendations. She based recommendations on a report entitled weight change history. At times there were no current weights available on the report for her to reference and therefore she based recommendations on previous weights. If she had known the resident was trending down and losing weight, she would have asked for a reweight and would have made adjustments in the resident's tube feedings to try to stabilize her weight loss. She was not involved in the resident's care plan. After she made recommendations, she would send her report to the DON, the Administrator, and the Unit Managers. The RD was interviewed again on 6/5/24 at 4:21 PM and reported she did not know why the resident's Prostat had been decreased. It had not been decreased through her recommendation. She was also interviewed regarding whether she had observed the resident during her assessments. She reported she had looked at her following the 200 pound weight entry, and she did not look like she weighed 200 pounds. Thus, she had recommended a reweight.

During an interview with the DON (Director of Nursing) on 6/4/24 at 4:37 PM , the DON reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 20	F 692		

if a weight is crossed out, it was entered in error. Therefore, the DON validated that the 3/7/24 weight of 123.2 pounds was an error. The DON also reported the weight of 200 pounds was likely incorrect. She knew the resident was not eating. The RD had not mentioned a plan to address the weight loss. From observing the resident when she had resided at the facility, the DON felt the weights of 119.2 in January 2024 and 119 in February 2024 were likely correct. The DON did not know why the resident's Prostat was decreased in February 2024. She commented that it did not make sense since she was not eating well. The DON reported they had been trying to get in touch with the responsible party about the resident not eating and losing weight at the first of 2024 and had trouble getting in touch with her.

During an interview on 6/4/24 at 4:51 PM with the former MDS nurse, the nurse reported the following information. She had been responsible for the assessments of the resident. She always looked at the resident during the MDS assessment periods, and there was "no way" the resident ever weighed 200 pounds. According to the MDS nurse, when she completed an MDS assessment for Resident # 4 on 2/28/24 there had been no weight in the resident's chart for the last 30 days. She had mentioned the problem to the DON. The RD had also talked to her (the MDS nurse) about not having weights available on which to base their assessments of the resident's nutritional status. From observing the resident for the 2/28/24 MDS assessment, the MDS nurse felt the February weight of 119 pounds was plausibly an accurate weight for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 21	F 692		

The Nurse Aide (NA # 1) who routinely did the facility's weights was interviewed on 6/5/24 at 10:30 AM and reported the following information. She always did the weights. She wrote them on paper and then she gave the results to the DON. She kept copies of her weights. Someone else entered them into the record other than her. She had recognized that Resident # 4 was going "down-down-down" starting around December 2023. She had told the DON the resident was losing weight. During the interview, the Nurse Aide referenced her recorded weights and said there was not a weight for the resident in December 2023 for 200 pounds. She did not know why that had been entered into the resident's electronic record because the resident had not weighed 200 pounds.

Nurse # 1 was interviewed on 5/31/24 at 3:10 PM and reported the following information. She routinely cared for Resident # 4 and was very familiar with her. Resident # 4 appeared to be losing weight. She would not eat although they tried to feed her. She did recall speaking to the RD about possibly putting the resident on a continuous tube feeding and the RD stated she would look into it, but this was not ever tried. She thought this had been since the first of 2024 when this was mentioned to the RD.

The week-end facility wound nurse was interviewed on 6/3/24 at 3:29 PM and reported she recalled by the time the resident was placed on hospice in March 2024, she (the nurse) did not have to use as much strength to turn the resident for wound care and felt this was due to weight loss.

Resident # 4's responsible party was interviewed on 6/5/24 at 3:50 PM and reported the following. She felt the resident was losing weight. She did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 22	F 692		

not recall the facility having a conversation with her about how to address the weight loss before the resident was placed on hospice services. After hospice services was initiated and the weight had already been lost, she had spoken to hospice and agreed to stop the tube feeding. Prior to the resident being placed on hospice, she had wanted the resident to receive nutrition by her gastrostomy tube if she was not eating well.

On 5/31/24 at 2:20 PM the Administrator was interviewed and reported the following information. She reviewed the RD's recommendations logs. During January and February 2024, the RD was in the facility on 1/8/24, 1/16/24, 1/19/24, 1/23/24, 2/1/24, 2/5/24, 2/8/24, 2/12/24, 2/15/24, and 2/16/24 and did not review Resident # 4 according to the recommendation logs. The RD should have been able to see the weights when she did review the resident and the Administrator did not know why she was not able to do so. During a follow up interview with the Administrator on 6/4/24 at 2:57 PM the Administrator was interviewed about all the blanks on the enteral bolus feeding and Prostat administrations. The Administrator reported that Nurse # 1 had been one of the primary nurses to care for Resident # 4 and she had been responsible for Resident # 4's care for most of the days on which there were blanks about giving the enteral feeding and Prostat.

Nurse # 1 was interviewed again on 6/5/24 at 11:16 AM and reported she had given the enteral feeding and Prostat. There had been a problem with the electronic record and she had documented some things on paper.

Interview with the Administrator on 6/5/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 23	F 692		

12:01 PM revealed there had been a problem at the first of the year with the server being down on a week-end for a few hours which would have affected access to the electronic medical record, but it was resolved quickly and did not account for all the missing administration data for the resident's tube feeding and Prostat. She thought that Nurse # 1 was a good nurse and had provided the enteral feeding and administered the Prostat but just did not document it. There was no paper chart showing the documentation of the enteral feeding and Prostat on all the multiple missing days of documentation.
Resident # 4's Nurse Practitioner was interviewed on 6/5/24 at 5:18 PM and reported the following information. The resident had never gained weight since she resided at the facility, and the 200 pounds would not have been correct. The resident had not needed to lose weight as quickly as she did while residing at the facility. She (the NP) could look at the resident and tell she was getting "smaller and smaller." She was not sure what all was contributing to her failure to thrive. She thought a continuous feeding would have been a possibility for the resident to avoid the rapid loss that was occurring. She relied on the RD to make recommendations for the enteral feedings. At some time in the past she had written a consult for the RD thinking the RD would consider a continuous feeding but she did not recall when that was. It had been difficult to make assessments of all the resident's weight loss because when she visited to see the resident at times the weights were not in the record nor how much she was eating. When she visited in February, 2024 and wrote the order to place the resident on Prostat, she had not realized the resident was already on Prostat twice per day. She found it difficult to find information in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 24 chart. She would have expected the nurses to recognize when they were carrying out the Prostat order that it was a decrease in what she was already receiving and brought it to her attention. Her goal had been that the resident recieve more supplementation and not less. The maximum recommended dosage for Prostat was 30 ml three times per day and therefore the resident could have gotten more and not less if it had been brought to her attention. That would have been the goal. Resident # 4's primary physician was interviewed on 5/31/24 at 4:50 PM and reported the following. Resident # 4 had been a very sick resident. At a young age she had gone from being healthy to problems which resulted in syncope, cognitive changes, and encephalopathy. Her cognitive status deteriorated and never returned to baseline. There had been multiple tests, including cancer tests, while she was in the hospital without a determination of what had caused all her medical problems.	F 692		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		7/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 25	F 842		

professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 26 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff and the Nurse Practitioner the facility failed to ensure the medical record was complete and accurate regarding administration of treatments, administration of medications, administration of enteral feedings, and weights. This was for one (Resident # 4 of one sampled resident reviewed for accuracy of medical records. The findings included: Resident # 4 was initially admitted to the facility on 8/19/22 with a most recent readmission date on 8/29/23 following hospitalization. The resident resided at the facility until 5/16/24. 1 a. Review of Wound Physician notes from December 2023 through the resident's discharge revealed she was to receive wound care for multiple pressure sores. Review of Resident # 4's TARs (Treatment Administration Records) for the month of January 2024 revealed multiple "N"s beside treatments where the nurses were to document a check mark to signify the treatment was done. The facility's Nurse Consultant was interviewed on 5/31/24 at 2:52 PM and reported	F 842	F842-Resident Records -Identifiable Information 1.Resident #4 has been discharged from the facility 2.Electronic medical record audit was completed on current residents to identify any omissions. Identified omissions were communicated to the medical provider. 3. DON or designee will educate licensed nurses and medication aides on the requirement of signing MARS and TARS immediately after administering any medication or treatment. Any newly hired employee will receive this education during orientation and prior to assignment. Education began on 6/17/24. 4. The DON or designee will monitor MAR/TAR compliance daily Monday through Friday on current residents in the building at that time, during the clinical morning meeting x 4 weeks to ensure documentation compliance. 5.Results of the reviews will be presented	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 27 the following information. They usually employed two wound nurses. One of the wound nurses worked through the week and the other worked on the week-end. For an interim, there was no designated wound nurse through the week. The floor nurses were responsible for doing the treatments and documenting them on the TAR. They had not been documenting them. She felt as if the care was being done but just not the documentation. She went back and entered a "N" in the blanks for the missing documentation to signify "No documentation" because otherwise when a nurse started to do a current treatment, the system displayed all the missing documentation before it would display the treatment which the nurse actually needed to complete. The nurse would have to scroll through each missing treatment. After she inserted the "N," then when a nurse started to perform a treatment, she could pull the current treatment up right away. 1 b. Review of Resident # # 4's MARs (medication administration records) revealed for the months of December, 2023, January 2024, and February 2024 there were multiple blanks for medications, supplements, and enteral feedings that were ordered to be given. Although not all inclusive of all the missing documentation, some examples are as follows: In December 2023 there were 59 blanks out of 124 scheduled times the resident's bolus tube feeding was ordered to be given. In January 2024 there were 80 blanks for the resident's bolus tube feedings. In March 2024 there were 19 blanks for the resident's bolus tube feedings. In December 2023 there was no documentation the resident received her potassium medication 40 times for times on which she was scheduled to receive it. In January	F 842	to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis. 6. Date of compliance: July 1, 2024 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 28	F 842		

2024 there was no documentation the resident received her potassium 53 times for times on which she was scheduled to receive it. In February 2024 there were 12 times there was no documentation for times on which she was scheduled to receive her potassium medication.

The Administrator was interviewed on 6/4/24 at 2:57 PM about all the blanks on the resident's MARs. The Administrator reported that Nurse # 1 had been one of the primary nurses to care for Resident # 4 and she had been responsible for Resident # 4's care for most of the days on which there were blanks.

Nurse # 1 was interviewed on 6/5/24 at 11:16 AM and reported she had given the enteral feeding, supplements, and medications. There had been a problem with the electronic record, and she had documented some things on paper.

Interview with the Administrator on 6/5/24 at 12:01 PM revealed there had been a problem at the first of the year with the server being down on a week-end for a few hours which would have affected access to the electronic medical record, but it was resolved quickly and did not account for all the missing administration data. There was not a paper record for all the missing documentation.

1 c. On 5/31/24 a review of Resident # 4's weights revealed the following weight history.
12/6/23 136 pounds
12/30/23- 200 pounds
1/30/24-119.2 pounds
2/2/24-119 pounds
3/7/24-123.2 pounds (This weight and date were crossed out in the record)
3/15/24-118.4 pounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 29	F 842		

4/23/24-105.6 pounds

As of 5/31/24 there had been no notation or clarification in the record that the weight of 200 pounds was not correct.
During an interview on 6/4/24 at 4:51 PM with the former MDS nurse, the nurse reported the following information. She had been responsible for the assessments of the resident. She always looked at the resident during the MDS assessment periods, and there was "no way" the resident ever weighed 200 pounds in December 2023.

The Nurse Aide (NA # 1) who routinely did the facility's weights was interviewed on 6/5/24 at 10:30 AM and reported the following information. She always did the weights. She wrote them on paper and then she gave the results to the DON. She kept copies of her weights. Someone else entered them into the record other than her. She had recognized that Resident # 4 was going "down-down-down" starting around December 2023. During the interview, the Nurse Aide referenced her recorded weights and said there was not a weight for the resident in December 2023 for 200 pounds. She did not know why that had been entered into the resident's electronic record because the resident had not weighed 200 pounds.

Resident # 4's Nurse Practitioner was interviewed on 6/5/24 at 5:18 PM and reported the following information. The resident had never gained weight since she resided at the facility, and the 200 pounds would not have been correct. She had been steadily losing weight. She (the NP) could look at the resident and tell she was getting "smaller and smaller."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	**5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE