PRINTED: 10/22/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345529	B. WING	<del></del>	09/12/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS	3	F 00	00	
	to conduct a complair 8/31/24. Additional ir through 9/12/24. Thei changed to 9/12/24. ( The following intakes NC00220528, NC002 NC00220811, NC002 NC00221112, NC002	s were investigated: 220672, NC00220759, 220937, NC00220962, 21200, NC00221227,			
	NC00221442, NC002 Thirty (30) of forty-set allegations resulted in	ven (47) complaint			
	Immediate Jeopardy	was identified at:			
	CFR 483.12 at tag F6	580 at a scope and severity J 600 at a scope and severity J 684 at a scope and severity			
	The tags F 600 and F Substandard Quality				
F 550 SS=G	removed on 9/9/24. A was conducted. Resident Rights/Exer	_	F 55	50	10/14/24
	self-determination, ar access to persons an	ght to a dignified existence, nd communication with and			
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE	(X6) DATE

Electronically Signed 10/07/2024

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.

Facility ID: 20040007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING		C <b>09/12/2024</b>		
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	03/12/2024		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLÉTION	٧	
F 550	with respect and digresident in a manner promotes maintenanther quality of life, recindividuality. The fact promote the rights of \$483.10(a)(2) The fact access to quality car severity of condition, must establish and in practices regarding the provision of services residents regardless. \$483.10(b) Exercise The resident has the rights as a resident of the Unit \$483.10(b)(1) The fact are severity of the facility. \$483.10(b)(2) The refree of interference, coercion from the facility.	ity must treat each resident nity and care for each and in an environment that ce or enhancement of his or cognizing each resident's ility must protect and the resident.  Incility must provide equal e regardless of diagnosis, or payment source. A facility maintain identical policies and ransfer, discharge, and the under the State plan for all of payment source.  Of Rights.  right to exercise his or her of the facility and as a citizen	F 55				
	interviews with resident Practitioner the facility	on, record review, and ent, staff, and Nurse ty failed to ensure Resident # ty while residing in the facility.		The facility sets forth the follow correction to remain in compliar federal and state regulations. Thas taken or will take the action	nce with all The facility		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C <b>09/12/2024</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	09/12/2024
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 550	bedbound resident, maggots located in hand within her contra maggots being found observed multiple flie landing on the reside facility. This was for residents reviewed fastaff. (Resident # 1 unable to express hawould express if they located on them whill Therefore, the reason applied in determining The findings included Resident # 1 was ad and had diagnoses in degenerative neuron disorder with psychologore with psychologor	as documented to be a was found with multiple her bed, under her breast, acted hand. Prior to the d on Resident # 1, staff had hes in the resident's room, ent, and in other parts of the hone (Resident # 1) of five had mental illness and was harm a reasonable person had multiple maggots he relying on others for care. hable person concept was had severity to this citation).  d:  mitted to the facility on 3/1/17 h part which included a huscular disease and bipolar tic features.  herly Minimum Data Set hi/19/24, coded Resident # 1 hand as being totally hard as being totally hard bathing, dressing, hygiene, hotes revealed an entry by 1/24 (Sunday) at 5:57 PM, har Resident # 1's care. The hoted right hand contracture hanse with wound cleanser highly apply then cover with hard Tuesday, Thursday,	F 55	in the plan of correction. The following plan of correction constitutes the facilial allegation of compliance. All deficiencited have been or will be corrected by date or dates indicated.  F550  Corrective actions accomplished for the residents found to be affected by the deficient practice:  Resident #1 head to toes skin inspect was conducted by the Unit Coordinate on 10/7/2024. No new skin alterations and/or Maggots identified on resident no other actions taken for resident #1 Identification of other residents having the potential to be affected by the sample deficient practice:  100% of skin inspection for all current residents in the facility conducted bet 09/19/2024, by Director of Nursing, Uccoordinator #1, and/or Unit coordinate #2, to identify any other resident with maggot(s) in their wounds or any part their body. No other resident identifies have maggots on their body. Findings this audit are documented on a skin inspection tool located in the facility compliance binder.  100% inspection for all current reside in the facility conducted on 10/07/202 Director of Nursing, Unit coordinator #2, and/or scheduler identify any other resident with flies landing on their body while in the facility conducted in the facility any other resident with flies landing on their body while in the facility conducted with flies landing on their body while in the facility conducted between the facility conducted with flies landing on their body while in the facility conducted with flies landing on their body while in the facility conducted with flies landing on their body while in the facility conducted with flies landing on their body while in the facility conducted with flies landing on their body while in the facility conducted with flies landing on their body while in the facility conducted with flies landing on their body while in the facility conducted with flies landing on their body while in the facility conducted with flies landing on their body while in the facility conducted with flies landing on their body whil	ity scies cies cy the  hose  tion or #1 s #1, g ne t ween nit or s of d to s of nts 4, by #1, -to
	noted the resident's	as needed)." Nurse #1 also family was called and I not signify the problem with the resident had a		No other resident identified to have fl landing on their body. Findings of this audit are documented on a Flies inspection tool located in the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		0.45500	D. WING			С	
		345529	B. WING			09/12/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē		
UNIVERSA	AL HEALTH CARE/NORT	TH RAI FIGH		5201 CLARKS FORK DRIVE NW			
OIVIV EIVO	AL HEALIN GAREMON	THE RELEGIE		RALEIGH, NC 27616			
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F 550	Continued From page	e 3	F 55	50			
	contracture.			compliance binder.			
	contractare.			Measures/systemic changes v	vill he nut		
	On 8/13/24 (Tuesday	) Nurse Practitioner # 1		into place to ensure that the d			
		Resident # 1 and noted the		practice does not recur:			
		. The resident was grimacing		Prince   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   100   1			
	when her hand was t			Effective 10/07/2024, the facili	ity staff will		
		nd was being seen for follow		treat each resident with respec			
	up after living larvae	had been identified in her		dignity and care for each resid	lent in a		
	right hand/fingers and	d manually removed.		manner and in an environmen	t that		
	, , ,	en provided and an antibiotic		promotes maintenance or enh	ancement		
		al antibiotics had been		of his or her quality of life, reco			
		time NP # 1 saw the resident		each resident□s individuality,			
		agitation or anxiety and was		ensuring each resident is clea			
		e was mild swelling of her		from maggots and flies on the			
		nd fingers 3 to 4 were tender		These systemic changes will be			
		no drainage or redness.		accomplished by implementing following measures:	g tne		
	**	iewed on 8/30/24 at 5:45 PM					
		owing. During the weekend		Effective 10/07/2024, the Clini			
		being seen by the NP on		which consists of the Director	_		
	8/13/24 (Tuesday), th			Assistant Director of Nursing,			
		and hurting. She had a		Data set (MDS), and/or Unit co			
		e (Nurse # 1) soaked the did the best to clean the		(#1, #2), will incorporate the p reviewing completion of skin in			
		ad a carrot device that she		ensure that each resident has	•		
		and for the contracture, but		completed skin inspection wee			
		llways keep the carrot in her		assure no maggots are identif	-		
		es said the resident would		resident skin. This systemic pr			
	refuse care at times.			take place Monday through Fr			
		weekend, there were no		identified issues will be addres			
	maggots in her hand.			promptly. This process will be			
				incorporated into the daily clin	ical		
	The weekend Treatm	nent Nurse was interviewed		meeting.			
		M and reported the following					
		24 MA (Medication Aide) # 1		DON, ADON, and/or Staff dev			
		had some dried blood on		coordinator will complete 1009			
		end Treatment Nurse also		education for all licensed nurs			
		(Saturday) Nurse # 1 said		include full time, part time, and			
	that therapy had bee	n working with the resident		employees (PRN). The emph	asis of this		

				) DATE SURVEY COMPLETED			
		245520	B. WING			l	С
		345529	B. WING _			09	0/12/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NOI	RTH RAI FIGH		52	201 CLARKS FORK DRIVE NW		
0.11.7 2.1107				R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From pa	ge 4	F 5	550			
	·	bleeding. Resident # 1 had a			education will be the maintaining		
		ep in her hand for her			resident⊟s rights and treating each		
		turday, Nurse # 1 took care of			resident with dignity and respect include	lina	
		because she (the weekend			ensuring each resident is free from	g	
		ad been busy. When she (the			maggots. The education also emphasi	zed	
		nurse) saw Resident # 1's			the importance of completing skin		
		unday) there was no active			inspection weekly. This education will be		
	,	ht contracted hand, the			completed by 10/14/2024. Any license		
		skin where she had previous			nurses not educated by 10/14/2024 wi		
	skin breakdown. Wi	ithin the fragile skin the			taken off the schedule until educated.	This	
	resident appeared a	as if she had a very small			education will also be implemented in	new	
	puncture wound fro	m her fingernails being			hire orientation for licensed nurses.		
		her skin. She (the weekend					
		sed a cotton tipped swab to			Monitoring of corrective actions to ens	ure	
		nd she applied a dressing. At			that the deficient practice is being		
		t see any signs of maggots in			corrected and will not recur:		
		or wound. The resident had					
		nails trimmed and cared for.			Effective 10/7/2024, DON and/or ADO		
		in Resident # 1's room and			will monitor compliance with completio	n or	
		flies in other parts of the			skin inspection by reviewing the daily		
	facility landing on p	eopie.			clinical meeting reports to ensure completion and validate that the clinical	اد	
	MΔ # 1 was intervie	ewed on 8/29/24 at 2:38 PM			team cross referenced skin inspection	11	
		llowing information. She had			schedule to assure completion and		
	•	# 1 both on 8/10/24 (Saturday)			identification of any new alterations to		
		ay). On 8/10/24 (Saturday)			include maggots. Any negative finding	s	
	•	se Aide (NA) had told her that it			will be addressed promptly by the DON		
		ent # 1's hand was bleeding.			and/or ADON. This will be done daily		
		On 8/10/24 (Saturday) there			Monday through Friday for two weeks,		
		Resident # 1's room. MA # 1			weekly for two weeks, then monthly fo		
	estimated there we	re about 12 or so flies in the			three months or until a pattern of		
		She (MA # 1) was "swishing,			compliance is maintained.		
		trying to get them away from			Effective 10/07/2024, Director of Nursi	ng	
		t of her room to the best of her			will report findings of this monitoring		
	·	land on the resident, who			process to the facility Quality Assurance	е	
		d items resting on her chest as			and Performance Improvement		
		MA # 1 also was aware blood			Committee for any additional monitoring	-	
		hand might attract the flies to			or modification of this plan monthly for		
	her. The Maintenan	ice Director was aware flies			three months, or until a pattern of		1

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 9/12/2024
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP C 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	•	3/12/2024
(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 ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 550	the problem with flie maintenance log an times. She (MA #1) desk and sit down w Sunday 8/11/24, she Treatment Nurse ha hand and cleaned it maggots on Resident #11:00 PM on 8/11/24 was interviewed on reported she had not #1 during her Sund 8/11/24. She had not #1 during her Sund 8/11/24 (Monday) w on Resident #1. Sh pass when Resident her and reported Reher. She (MA # 2) a alerted the former D 8/12/24 MA # 2 had room. MA # 2 report be infested with flies Nurse Aide # 2, who for Resident # 1 on interviewed on 8/29, the following informaturning and providin when she saw maggunit Manager # 1 to	t was her understanding that is had been added to the dhe had been told multiple could not go to the nursing vithout flies following her. On a knew the weekend do cared for Resident # 1's well. She (MA # 1) never saw int # 1 during the weekend.  The grecords, Nurse # 8 had if 1 on the shift which began at the following information. She had into seen maggots on Resident and the seen flies in the room.  The wed on 8/29/24 at 3:21 PM allowing information. She had are for Resident # 1 on the maggots were found the had started her medication the the maggots were found the had started her medication the the maggots on the seen a fly in Resident # 1's nurse and the pear to be sident # 1 had maggots on the seen a fly in Resident # 1's the following information. On Seen a fly in Resident # 1's the following information the first and the seen assigned to care 8/12/24 (Monday), was the following in the bed. She went to report the issue and they were the maggots. Then the	F 5	compliance is maintained. committee can modify this the facility remains in subs compliance. Compliance date: 10/14/20	plan to ensure tantial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C <b>9/12/2024</b>	
	ROVIDER OR SUPPLIER	ORTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CO 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		311212024	
(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 (  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 550	DON (Director of and help. At the tileast three in the ron her body. The the resident. The at the time and the pad in her hand. Seen the maggots pain in her hand a anything with the 8/12/24, the reside to her hand if she well who was tryin Aide # 2) left at 3: know what happe after that. She did facility and had se residents.  Nurse Aide # 1 wad 4:40 PM and reposhe had been told to body. She (NA #1 resident and in her for the resident. It maggots had craw hand. The "higher DON) had been puthe maggots. Fliest facility. She (NA #1 would at times land unit Manager # 1 10:38 AM and reposhe had heard about the sident and in her for the resident. It maggots had craw hand. The "higher DON) had been puthe maggots. Fliest facility. She (NA #1 would at times land unit Manager # 1 10:38 AM and reposhe had heard about the sident and the sident an	Director of Nursing) and former Nursing) were asked to come me NA # 2 recalled seeing at resident's bed and at least one DON picked the maggots off resident's hand was contracted to resident was holding a gauze She (Nurse Aide #2) had not sin her hand. The resident had and did not want staff to do thand on that day. Prior to the twould at times refuse care did not know the staff membering to provide care. She (Nurse OO PM on 8/12/24 and did not need with the resident's hand did see flies "everywhere" in the ten them at times land on the sinterviewed on 8/29/24 at the following information. Taking on 8/12/24 and had helped the Resident # 1. She knew NA # or clean the resident's bed and as when the resident's bed and as she was helping care was her understanding the well out from the resident's rups" (including the former resent in the room to deal with shad been a problem in the staf) saw them daily and they	F	550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C <b>9/12/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	•	05/12/2024	
(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 550	she (Unit Manager # but did not personall NA # 3, who at times interviewed on 8/29/the following information witnessed maggots did know the resider she would not allow at times. She (NA # She saw flies "all the residents complaine."  The ADON (Assistar interviewed on 8/29/the following information understanding that the when the resident with the issue at wound nurse to asset hand.  The facility's weekdar interviewed on 8/30/the following information treatment nurse) had maggots in her hand had not personally similar with the min the facility on Resident # 1 was interviewed at 8/29/24 at 8:20 AM.	she was called into the room, in the pulled back the covers by see them.  It is cared for Resident # 1, was 24 at 12:40 PM and reported ation. She had never in Resident # 1's hand. She int's hand hurt at times and the staff to care for the hand 3) did see flies in the facility. It is time" and she was aware in a dabout them.  In the Director of Nursing) was 24 at 11:30 AM and reported ation. It was her the maggots had been found as being given a bath one in N (Director of Nursing) had and given direction to the east and clean the resident's and the resident had also seen them. She had not ing on Resident # 1, but she room. She had also seen in a daily basis.	F 5	50			
	interviewed about he	er care in general, the ally bring up the maggots					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C <b>09/12/2024</b>	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		03/12/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 550	Continued From pag		F 5	50			
	conversation from to about something els she had neuropathy	She tended to wander in her spic to topic. While talking e, she abruptly mentioned in her hand and at one time hand. She then went off topic pound further.					
	8/29/24 at 4:20 PM in employed at the facilinated been aware their specific resident have related to flies in the were flies in the facility.	aintenance Director on revealed he had been lity for about a month. He had e had been a problem with a ring any medical issues ir room. He was aware there ity and he had called a pest d the company's technician month as of 8/29/24.					
		no had reportedly removed ot available for interview					
	9/5/24 at 8:55 AM an information. She had told the resident had been informed that the 26 maggots remove was called, she was had been cleaned where antibiotic topical creations, and the resident was placed any problems. The resident people at times and talk to Resident # 1	1 (NP#1) was interviewed on and reported the following dibeen called on 8/12/24 and maggots on her. She had here had been approximately different from her. At the time she told that the resident's hand ith soap and water, a triple arm had been applied to her ent was not in distress. On resident for evaluation. The on an antibiotic to prevent esident was considered to be also had some mental tended to talk to non-existent when she (NP # 1) tried to on 8/13/24 the resident was ent also had some short term					

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SO COMPLETE (X3) DATE						
			1 50120			(	c
		345529	B. WING			l	12/2024
NAME OF PR	ROVIDER OR SUPPLIER	ı		S	TREET ADDRESS, CITY, STATE, ZIP CODE	. 55/	
				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	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	5,2
F 550	Continued From page	e 9	F	550			
	memory problems. D	uring the 8/13/24					
	assessment, there wa						
	resident's nail bed on	fingers three and four of her					
	right hand. She (NP #	‡1) could tell the maggots					
		ails and in the nail bed.					
		nt inflammation around the					
		nd in the palm of her hand					
		ment. The resident had not					
		gots had been in her hand					
	_	ntified on 8/12/24. Due to the					
		agnoses, the resident did not					
		the hand to detect that they , and she did not have the					
		y from flies. The resident					
	_	s in her room. If she had					
	•	ner hand without adequate					
		uld have landed on her hand					
		ot take long for a fly to do					
		ssed Resident # 1's hand on					
	8/13/24 there was so	me warmth around her hand					
		rist and palm as well. This					
		ne from the maggots being					
	in her hand and the N						
		on in the hand, she felt the					
		her nail beds and under her					
		to 48 hours prior to being					
		ve some routine pain in her					
		some of the pain she was ssessment on 8/13/24 was					
		ots being in her hand. The					
		t be trusting of staff if she					
		le to her mental illness. If					
		, her distrust of some new					
		ave contributed to refusal of					
	•	the staff should be patient					
		ting relationship with the					
	resident so she would						
	hygiene assistance.						
					I and the second		

PRINTED: 10/22/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _		09/	12/2024
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	, 00	· <b></b> ·
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 559 SS=D	interviewed on 8/30/2 the Corporate Nurse had not informed the employees of any prohaving maggots in he former DON had done building would have to prevent the probler have been initiated. It the facility did not have with a service provide underwent new owner miscommunication with a service contraction of the facility had not have since 5/15/24. Choose/Be Notified on CFR(s): 483.10(e)(4): §483.10(e)(4): The rigor her spouse when resame facility and both arrangement.  §483.10(e)(5) The rigor her roommate of changements when the sidents conserved when both residents and the reason for resident's room or room changed. This REQUIREMENT by: Based on record revision with a since of the record revision of the contraction of the resident's room or room changed. This REQUIREMENT by: Based on record revision with a since of the record revision of t	e Nurse Consultant was 4 at 6:00 PM. According to Consultant the former DON Administrator or corporate oblems with the resident or bed and on her. If the e so, the issue of flies in the obeen addressed and a plan on from reoccurring would He had learned that day that or a pest control contract or. When the facility recently orship, there had been of the had not been extended. or and pest control services  of Room/Roommate Change	F 5			10/14/24

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, , ,	(X3) DATE SURVEY COMPLETED	
		345529	B. WING_			C	
NAME OF D	ROVIDER OR SUPPLIER	040020		STREET ADDRESS, CITY, STATE, ZIP C		9/12/2024	
NAME OF FI	NOVIDER OR SUFFLIER				ODE		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE NW			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETION DATE	
F 559	Continued From page	e 11	F 5	59			
	resident was allowed room and meet the romoved to a new room for one (Resident # 1 for room change notifincluded:  Resident # 19 was ac 12/5/23.  Review of Resident # Data Set assessment resident was assessed A nursing noted on 8, 19 was notified of a romanagement reasons indicated the room changement responsible party was the room change price.  Resident # 19 was in AM and reported the	the opportunity to see the commate prior to being a within the facility. This was 9) of one resident reviewed fication. The findings  dmitted to the facility on  19's quarterly Minimum at, dated 8/2/24, revealed the ed to be cognitively intact.  126/24 noted that Resident # com change for medical as. The resident's record anage occurred on 8/27/24. The resident's record anage occurred on 8/27/24. The resident's attention of the tothe room change.		residents found to be affect deficient practice: Resident #19 was interview 10/07/24 by Assistant Adm if she would like to have a from the one, she was moveresident #19 declined to me 10/07/24. Identification of other reside potential to be affected by deficient practice: 100% audit of all residents room changes happened in days was completed on 10 Assistant Administrator to evere offered the option to wand meet the roommate if is documented on room changing into place to ensure that the practice does not recur: Effective 10/07/2024, where	wed on inistrator to see room change wed to, but ove on ents having the the same who had a the last 30 w/07/2024 by ensure that they wiew the room any. This audit anges cated in the es will be put e deficient a resident is		
	to move because of in Previously she had re was not allowed to se	6/24 (Monday) that she had nsurance reasons. esided in a private room. She see the new room or meet her to the room change that		being moved at the reques the resident, family, and/or representative will receive in writing of why the move	resident an explanation		
	occurred on 8/27/24. room change. Her roow was confused. It distunded not slept well. If s	She was not happy with the ommate would call out and urbed her at night, and she she was to have a roommate e someone with whom she		Effective 10/07/2024, the n change will be discussed in stand-up meeting that take Monday through Fridays by coordinator and/or designa	n the daily is place y the Admission ited person.		
	interviewed on 8/29/2	rker (Social Worker # 1) was 24 at 2:58 PM and reported tion. He was newly employed		change need discussed in meeting, the facility social the resident and provide ar	the daily worker will visit		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _				C / <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	112/2024
					201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH			ALEIGH, NC 27616		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 559	Continued From page	e 12	F 5	559			
F 559	to the facility and had two weeks. During the "stand up" meeting, rediscussed, and the achandled which rooms reassigned when the change. He was not abe allowed to see the change or to meet the would have made sur Resident # 19. He was and would have work find a room she liked. The facility admission interviewed on 8/30/2 the following. The busher when there was a	been at the facility for about e morning administration com changes routinely were dmissions coordinator residents were to be need arose for a room aware that residents were to be room before a room eir new roommate or he re that had occurred for anted residents to be happy ed with the resident more to the second coordinator was easier at 11:00 AM and reported siness office routinely alerted a change in payment for assigned a new room that	F	559	see the new location, meet the new roommate, and ask questions about the move, and complete the room change notification form, and document in electronic health records.  Assistant Administrator will complete a education to the facility social workers, Admission coordinator, and Director of nursing. The emphasis of this education will be the importance of discussing rook changes in the daily stand-up meeting. The education also emphasized the importance of social worker to visit the resident and provide an opportunity to the new location, meet the new roommate, and ask questions about the move, and complete the room change notification form, and document in electronic health records. This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken off the scheduluntil educated. This education will also implemented in new hire orientation for social workers, Admission coordinators and Director of Nursing Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:  Effective 10/7/2024, the Assistant Administrator will review all room move that were completed in the last 24 hour or from the last stand-up meeting to ensure that a written notice was provid documented and indicating that resides had the opportunity to view the room.	n n om see e on ule be ses es ed, nt	
					had the opportunity to view the room, a meet the roommate (if any). This monitoring process will be conducted		

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			1	C 12/2024
	ROVIDER OR SUPPLIER	TH RALEIGH		52	TREET ADDRESS, CITY, STATE, ZIP CODE 201 CLARKS FORK DRIVE NW ALEIGH, NC 27616	1 001	12/2027
(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 580 SS=J	S483.10(g)(14) Notificity A facility must immonsult with the residuence consistent with his or representative(s) where (A) An accident involvesults in injury and head of the physician intervention (B) A significant charmental, or psychosocideterioration in health status in either life-th clinical complications (C) A need to alter the a need to discontinuent treatment due to advice commence a new for (D) A decision to transcident from the facility status in the status of the properties of the properties of the status in either life-th clinical complications (C) A need to alter the aneed to discontinuent treatment due to advice the status of the properties of the properties of the status of the status of the properties of the properties of the status of the status of the properties of the prop	jury/Decline/Room, etc.)  (i)(i)-(iv)(15)  cation of Changes.  dediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; age in the resident's physical, cial status (that is, a n, mental, or psychosocial reatening conditions or ); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the		559	twice weekly for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance maintained. The findings of this proces will be submitted to QAPI for review an recommendation by the Assistant administrator and/or social worker monthly for three months or until the pattern of compliance is maintained.  Completion date: 10/14/2024	e e is s	10/14/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345529	B. WING		C
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  5201 CLARKS FORK DRIVE NW  RALEIGH, NC 27616	09/12/2024
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475
F 580	resident and the resimble resident and the resimble when there is- (A) A change in room as specified in §483. (B) A change in residence in specified in §483. (B) A change in residence in specified in §483. (B) A change in residence in specified in §483. (E) (10) of this section (iv) The facility must update the address ophone number of the representative(s).  §483.10(g)(15) Admission to a computation of the section of the representative (s).  §483.10(g)(15) Admission to a computation of the section of the phoof Resident 22's blood greater than 400 mill (normal blood glucos between 70 mg/dL to and to notify the resimple when Resident #22 monresponsive by a member hours befor Services (EMS) was found with an elevation.	also promptly notify the dent representative, if any, in or roommate assignment 10(e)(6); or dent rights under Federal or ons as specified in paragraph in.  record and periodically (mailing and email) and eresident  cosite distinct part. A facility distinct part (as defined in the inits admission agreement ation, including the various ise the composite distinct for the policies that apply to be in its different locations.  This not met as evidenced when, and staff, family, and the facility to provide accurate system of repeated episodes and glucose level registering digrams per deciliter (mg/dL) are level are considered to be a 100 mg/dL) over two days dent's physician and family	F 58	F580 Corrective actions accomplished for the residents found to be affected by the deficient practice: Resident #22 no longer in the facility, other actions taken for resident #22 Identification of other residents having potential to be affected by the same deficient practice: Clinical assessments of all current residents in the facility were completed 09/07/24 by the Director of Nursing, Assistant Director of Nursing, and/or Lacoordinator (#1 or #2) to identify any of	no the d on Unit

PRINTED: 10/22/2024 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI				c
		345529	B. WING				12/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
IINIVEDS	AL HEALTH CARE/NORT	U DAI EIGU		52	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	RALLIGH		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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page adults is between 60 in the 40s breaths perespiratory rate is bet minute), and with a configurous level more that transport by EMS. At department) physician 22 was diagnosed with complication of an infollowing too little insuling insuling properly.) This of three residents rever physician for a change Immediate jeopardy by Resident #22 was ideally glucose reading of own physician was not not was removed on 9/9/2 provided and implementallegation of Immediate facility will remain out scope and severity Docompleted and monitorare effective.  Findings included:	and 100 bpm), respirations r minute (a normal ween 12 and 20 breaths per ontinued reading of a blood an 400 mg/dL at time of the time of ED (emergency n assessment, Resident # th sepsis (a life-threatening ection) and hyperglycemia. The technical term for high that occurs due to the body nor when the body can't use was for one (Resident #22) iewed for notification of e in medical condition.  The entified as having a blood for 400 mg/dL and the stified. Immediate Jeopardy 2024 when the facility ented an acceptable credible at Jeopardy removal. The conformal forms of compliance at a lower to ensure education is poring systems put in place		580	resident with the change condition that require medical attention and/or notification to the physician. The clinical assessment focused on resident signs to include, blood pressure reading pulse, respiration rate, temperature, and/or presence of pain. The assessment also includes measuring blood glucose the residents with diagnosis of diabetes with orders for blood glucose check. The attending physician will be informed by Director of Nursing, Assistant Director of Nursing and/or Unit Coordinator #1 or #1 on any identified findings of a change in condition and appropriate measures to include, but not limited to activating emergency medical services if indicated 100% audit of all current resident bloglucose reading documented from 6/28/2024 to 09/07/2024 completed on 09/07/2024 and 09/08/2024, by the Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator (#1 or #2) to identify any other documentation a resident with episodes of hypoglycem and/or hyperglycemia to ensure notification to the attending physician wade. Any resident(s) identified with a change in condition, the Director of nursing will inform the physician of appropriate measures and or interventions and implement the interventions as ordered.	ent for some the pof do of of nia	
	receive Novolog insul	hysician order dated desident #22 was ordered to lin solution to be injected er the skin) three times day			Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:  Effective 09/07/2024, facility employees will ensure significant changes, to inclu	6	

Facility ID: 20040007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345529	B. WING		00	C 9/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/12/2024	
	10115211 011 001 1 21211			5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH					
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	Continued From pag	ge 16	F 58	30			
	following sliding scal was 201 mg/dL to 252 251 mg/dL to 300 mg/dL to 350 mg/dL mg/dL to 350 mg/dL mg/dL to 400 mg/dL call fast-acting insulin us glucose for people where the substitution of the substitutio	nentation on the July tration Record) (MAR) blood glucose level taken or sulin as ordered at 8:00 AM  ne July MAR revealed ad Aide) #4 took a blood mg/dL and administered 10 ulin on 7/10/2024 at 1:43 PM  nentation on the July MAR blood glucose level taken or ovolog insulin as ordered at		hypoglycemia and/or hyperglyd reported to the physician for ap intervention. This systemic mo will be accomplished by impler following measures:  Effective 09/09/2024, licensed duty will inform the resident; continued the resident physician; and resident involving the resident results in injury and has the porequiring physician intervention significant change in the resident physical, mental, or psychosomied to alter treatment significals, a need to discontinue an export of treatment due to adverse consequences, or to commence form of treatment), and/or a detransfer or discharge the resident facility, to including when resident blood glucose is excessive hig blood glucose. This notification documented on each resident electronic medical records by the nurse on duty.	oppropriate diffication menting the nurse on onsult with notify, the here is; an which stential for a, a ent scial status, a antly (that isting form the ent school of the ent		
	There was no docum medical record of Readditional intervention elevated blood glucon 1:43 PM.  Med Aide #4, an againterviewed on 9/6/2 revealed the following morning of 7/10/24 March 1:00 AM to 7:00	nentation in the electronic esident #22 that any ons were taken for the ose reading on 7/10/2024 at		Effective 09/09/2024, the facility administrative team, which included DON, ADON, Unit coordinators and/or wound nurse, incorporal process for reviewing clinical documentation for the last 24 hyphysician orders written in the hours, or from the last clinical rensure any needed notification to the physician, and/or resport was done in a timely manner.	udes the s (#1, #2), ted the hours and last 24 meeting to a of changes habile party		

PRINTED: 10/22/2024 FORM APPROVED OMB NO. 0938-0391

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		1 ,	С
		345529	B. WING			1	
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2024
					201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH			ALEIGH, NC 27616		
	0111111111				· 		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL AND LISC IDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
					DEFICIENCY)		
<b>5</b> 500							
F 580	Continued From page		F	580			
		already administered the			through Friday. Any identified issues w		
	morning medications				be addressed promptly. This process	will	
		sident #22 on the 7:00 PM to			be incorporated into the daily clinical		
	7:00 AM shift that en	ded on 7/10/2024. Med Aide			meeting. The nursing administrative te	am	
		not know what the blood			will review the clinical documentation a		
	•	dent #22 was at 8:00 AM.			physician orders written on Friday and		
	Med Aide #4 explaine				Saturday on the next clinical meeting of	n	
	remember which lice	nsed nurse was assisting			the following Monday.		
	her on 7/10/2024 at t	he 12:00 PM administration					
	time but she thought	it was Unit Manager #2. Med			Effective 09/07/2024, for residents with	า	
	Aide #4 confirmed sh	ne did not administer Novolog			orders for blood glucose check; certifie	ed	
	insulin to Resident #2	22 on 7/10/2024 at 1:43 PM,			medication aides will obtain and		
	because she was not	t allowed to administer			document blood glucose reading in ea	ch	
	insulin to residents u	nder her scope of practice as			resident□s medical records, and inforr	n a	
	a medication aide. A	ccording to Med Aide #4 on			Nurse on duty immediately, on any blo	od	
	7/10/2024 the blood	glucose level for Resident			glucose level less than 60, greater tha	n	
	#22 read as "HI" or a	bove 400 mg/dL on the			200 or based on the physician order.		
	glucose monitor and	Unit Manager #2 was made			Facility licensed nurses on duty will		
		"HI" on a glucometer means			assess the resident blood glucose leve	el	
	, -	the level readable by the			and provide appropriate intervention		
	glucometer.) She rev	ealed the MAR did not allow			including notifying the physician in a ti	nely	
	, -	checked off as administered			manner.	•	
	unless an actual num	nber was entered into the					
	MAR for the blood gl	ucose reading. Med Aide #4			100% education of all licensed nurses	to	
		t in 400 mg/dL although the			include full time, part time, and as nee		
		en over 400 mg/dL. Med			licensed nurses will be completed by the		
		e was told by Unit Manager			Director of Nursing, Assistant Director		
		Resident #22 was called and			Nursing, Staff Development Coordinat		
	• •	of Novolog insulin to be			and/or Unit Coordinators (#1, #2). The		
		dent #22 and to keep			emphasis of this education will be the		
		lucose level every hour. Med			importance of notifying physician and t	he	
		g the blood glucose level			responsible party in a timely manner for		
		ted to Unit Manager #2 the			any change in condition, change of		
		still registering as above 400			treatment/intervention, and/or incidents	s of	
		thought Unit Manager #2			sustained elevated blood glucose. This		
		ent everything and take care			education will be completed by 9/09/20		
	of the 4:00 PM sched				any licensed nurses not educated by	,	
		0/2024 because of the blood			09/09/24 will not be allowed to work ur	ntil	
			1				1

glucose readings that were over 400 mg/dL,

educated. This education will also be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C 9/12/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	5/12/2024	
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NO	RTH RALEIGH		RALEIGH, NC 27616			
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	Continued From pa		F 58	implemented in new hire orie			
	8:21 AM. Unit Manainformation. Unit Market information. Unit Market information. Unit Market information. Unit Market information information information. Unit thought she sent a Resident #22 information glucose levels on 7 recall specifically if There was no docu Resident #22 had a or was administered at 8:00 AM on 7/11. The facility nursing indicated Nurse #7	mentation on the July MAR blood glucose reading taken d Novolog insulin as ordered 2024. schedule dated 7/11/2024 was assigned to the hallway #22 resided for the 12 hour		Director of Nursing, Assistant Nursing, and/or Unit Coordina will monitor and track the conthis education and will comple education for any newly hired nurses during the new hire or effective 09/09/2024.  Monitoring of corrective action that the deficient practice is becorrected and will not recur:  Effective 10/7/2024, Director and/or Assistant Director of Nomonitor compliance with notifichanges to Physician and/or party by reviewing the daily comeeting reports to ensure contimely notification to Physicial responsible party for any item meet notification requirement issues identified during this more process will be addressed promonitoring process will be co	ators (#1, #2) inpletion of ete this I licensed rientation  ins to ensure reing  of Nursing, lursing, will rication of responsible linical inpletion, in and in identified to is. Any inonitoring comptly. This		
	Nurse #7 was intended to the PM. Nurse #7 state who only worked at and that was 7/11/2 PM shift. Nurse #7 the facility, she was the electronic medic given paper MARs of administration of on the hallway she revealed she was ushe took blood gluck have documented of	viewed on 9/5/2024 at 2:37 d she was an agency nurse the facility on one occasion 024 for the 7:00 AM to 7:00 revealed when she arrived at not given login information for cal record system and was to work with for documentation the medications for residents was assigned. Nurse #7 nable to recall what residents ose levels for, but she would calling the physician for an ose if that had been required		Monday to Friday for two week for two more weeks, then mo three months or until a patter compliance is maintained. Effective 10/7/2024, Director will report findings of this mor process to the facility Quality and Performance Improveme Committee for any additional or modification of this plan mothree months, or until a patter compliance is maintained. The committee can modify this plat the facility remains in substar compliance.	eks, weekly nthly for n of  of Nursing nitoring Assurance ent monitoring onthly for rn of ne QAPI an to ensure		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION  JULDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			I	C <b>12/2024</b>	
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	,		
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH		52	01 CLARKS FORK DRIVE NW			
				R/	ALEIGH, NC 27616			
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F 580	Continued From page	e 19	F 5	80				
	of her.				Compliance date: 10/14/2024			
	Aide #4 took a blood and administered ten 7/11/2024 at 11:47AM Documentation on a pencounter note for Re Physical Therapy Ass 7/11/2024 at 3:58 PM that [Resident #22] go purpose of attempting responded [by demorincoherent mumbling, movement to bright lig [Resident #22] sit [on #22 [demonstrating] i sleep/difficulty to hold #4], DON (Director of Therapist/Occupation regarding [Resident # Continue [with plan of	physical therapy treatment esident #22 written by sistant (PTA) #1 on revealed, "PTA facilitated et [out of bed] for the goals. [Resident #22] estrating] extreme lethargy, [nonresponsive] pupils/eye ght. PTA attempted to have edge of bed] with [Resident enability to arise from I head. Nursing [Med Aide Nursing), [Physical al Therapist] notified the edge of bed in status. If care.]"						
	9/6/2024 at 4:45 PM. following information. recall the exact time s #22 on 7/11/2024. PT Resident #22 in a nor that day, so she went the interim DON, the Occupational therapis concern for Resident	PTA #1 stated she did not she went to see Resident A #1 confirmed she found hresponsive condition on to the Med Aide on the hall, Physical Therapist, and st to let them know of her #22.						
	Aide #4 took a blood	e July MAR revealed Med glucose level of 400 mg/dL units of Novolog insulin on						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 9/12/2024		
	ROVIDER OR SUPPLIER	DRTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CO 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	•	3/12/2024		
(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 (  (EACH CORRECTIVE ACTIVE)  CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 580	Continued From p	age 20	F 5	580				
	PM. Med Aide #4 information. Med // blood sugar reading 7/11/2024 at 11:47 revealed that some for Resident #22 versident #22 versident #22 versident #22 versident #22 versident #20 mg/dL while a documented on the actually 400 mg/d told the licensed round for the administration time the blood glucose registering as "HI. licensed nurse on been contacted and be monitored. Med licensed nurse was #1 informed her or response from Reshe did tell the lice said. Med Aide #4 Manager #2 and so interim DON about readings of over 4 Med Aide #4 state from the interim Dof it." Med Aide #4 of her shift on 7/10 #4 know Resident blood glucose real Aide #4 indicated telling her that on when Nurse #4 we readings for Resident Med Aide. Med Aide #4 wereadings for Resident Med Aide.	interviewed on 9/6/2024 at 1:54 revealed the following Aide #4 confirmed she took the ngs for Resident #22 on 7 AM and 4:51 PM. Med Aide #4 e of the blood glucose readings were registering as HI or over at least one of the readings she le MAR on 7/11/2024 was L. Med Aide #4 confirmed she lurse who was assisting her on 12:00 PM and 4:00 PM e for the Novolog insulin, that levels were continuously "Med Aide #4 was told by the 7/11/2024 the physician had and ordered for Resident #22 to d Aide #4 did not recall who the last. Med Aide #4 confirmed PTA of concerns of the lack of sident #22. Med Aide #4 stated ensed nurse of what PTA #1 had estated she informed Unit sent a text message to the latt the continued blood glucose and mydL for Resident #22. The continued blood glucose and mydL for Resident #22. The continued blood glucose at the latt in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 she let Nurse at stated that in report at the end 10/24 and 7/11/24 sh						

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		345529	B. WING _				C <b>12/2024</b>
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From pag doctor."	e 21	F s	580			
	an order dated 7/11// #22 to be administer insulin solution to be time only for a blood mg/dL and contact th Humalog insulin is a absorbed quickly and minutes after injection levels.  There was no documentat the order for Human or administer to be administered to b	e physician orders revealed 2024 at 7:00 PM for Resident ed ten units of Humalog injected subcutaneously one glucose exceeding 400 he physician in two hours. fast-acting insulin which is distarts working in about 15 he to lower blood glucose hentation on the July MAR malog insulin was dent #22 on 7/11/2024 after					
	an order dated 7/11/: #22 to be administer insulin solution subce glucose exceeding 4 physician in two hou  There was no docum that the one-time order	e physician orders revealed 2024 at 9:00 PM for Resident ed ten units of Novolog utaneously one time for blood 00 mg/dL and contact the rs.  The entation on the July MAR der for Novolog insulin was Resident #22 on 7/11/2024					
	#22 dated 7/12/2024 revealed, "Physician glucose exceeding 4 received from physic Humalog or Novolog hours. After 2 hours,	e nursing notes for Resident at 9:48 AM by Nurse #4 contacted due to blood 00 (mg/dL) and order ian to administer 10 [units] of and report back after 2 resident blood [glucose] d 400 (mg/dL) and physician					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION  BUILDING			(X3) DATE SURVEY COMPLETED	
			D MANAGO			С		
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UNIVERSA	AL REALIN CARE/NOR	n RALEIGH		RALEIGH, NC 27616				
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F 580	Continued From page	e 22	F 5	580				
	made aware of result (Responsible Party) r sent to [emergency ro Physician made awar	s. Family arrived and RP equested for resident to be						
	9/5/2024 at 6:04 PM. following information Resident #22 on the 6 #4 started her 7:00 P PM on 7/11/2024. Nu information in a nursi that the blood glucose above 400 mg/dL on pass. Nurse #4 denies the blood glucose lev or above 400 for seven she assessed Reside signs at the start of her blood glucose lev registering as High or glucometer, a device levels. Nurse #4 rever Resident #22 were fir physician. Nurse #4 from the physician to acting insulin to Resident #22 did not elevated blood pressionate. Nurse #4 stated still registering as High the glucometer. Nurse #4 stated still registering as High the glucometer. Nurse #4 stated still registering as High the glucometer. Nurse	ng report from Med Aide #4 e level of Resident #22 was the 4:00 PM medication d she had any knowledge of el of Resident #22 being at eral shifts. Nurse #4 stated ent #22 and took her vital er shift. Nurse #4 revealed el of Resident #22 was r over 400 on the to measure blood glucose aled the vital signs of ne, so she called the on-call stated she received an order administer 10 units of fast dent #22 and call the hours. Nurse #4 stated she n Resident #22 again at vital signs were fine.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	0.0020		STE	REET ADDRESS, CITY, STATE, ZIP CODE	09/	12/2024	
TVAIVIL OF T	NOVIDEN ON GOIT EIEN				01 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH			ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Continued From page Resident #22 with the at her and rolled her family of Resident #2 stating they received unknown caller telling with Resident #22, at the emergency room looked at Resident #3 sent to the emergency did not know who call breathing and vital sinormal. Nurse #4 repto call the physician blood glucose readin physician, and the physician, and the physician, and the physician was comparty (RP) for Reside PM and the following On 7/8/2024 the RP before going out of to RP heard nothing all 7/11/24 around 7:30 had several missed of picked up on the next	e 23 e lancet, the resident looked eyes. Nurse #4 stated the 22 arrived at the facility a phone call from an 3 them something was wrong and she needed to be sent to 3. The family of Resident #22 22 and demanded she be 32 or Nurse #4 stated she 32 led the family because the 33 grown of the elevated 34 grown and she called the family wishes.  Inducted with the responsible on the family was provided. The week from the facility. On perform the facility on the saw she calls on her phone. She then the tone. It was from a private		580		AIE	DATE	
	themselves but told to now and check on you emergency. She need did not know what was facility did not notify hosick. The RP called a was local to the facility facility to see Reside arrived at the facility find Resident #22 was walked into the room	ds to be sent out." The RP as going on because the her that Resident #22 was another family member who ty and asked him to go to the nt #22. The family member around 8:30 to 8:45 PM to as not responding. Nurse #4						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE S COMPL	
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				5201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH		RALEIGH, NC 27616		
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F 580	glucose level, and ca hours. Since Resident the family member insent to the emergency called emergency me RP talked to the (formal to the RP that the facility therapy staff member resident earlier that does also and the staff of the RP that the family know if the blood glucose levels, to her. If she had know blood glucose levels are several days she wouthen the hospital to be chested and the blood glucose levels. An interview was conton 9/5/2024 at 1:58 Fishe was not made and the blood glucose levels. The she was not made and the blood glucose levels approximately 8:00 PDON was told by the received from a facility Resident #22 was very to the hospital. The incalled Nurse #4 and with still at the facility and	insulin, to monitor her blood If the doctor back in two t #22 was not responding sisted that Resident #22 be y room and finally Nurse #4 dical services (EMS). The her) Administrator about her mer) Administrator informed y had learned that a physical had noted a change in the ay (7/11/2024). The (former) ned that they did not have to Resident #22 had elevated which did not make sense wn that Resident #22's were running high for all d have wanted her sent to	F 58	<u> </u>		
	following intervention: assessment had been revealing an elevated lethargy, vital signs w called for orders, and responsive. The inter	s for Resident #22. An n completed by Nurse #4 blood glucose level, ere fine, the physician was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	B. WING		C <b>09/12/2024</b>
NAME OF PROVIDER OR SUPPLIE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	03/12/2024
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she was not awbeen high over a been high over a called a Resident #22 at information was Upon arriving at Resident #22 has glucose level all acting like herse they had been go instructed by the changes in the monitor. EMS nareading of High EMS documents are of 140 with the ambulance, unresponsive.  Documentation 7/11/2024 admit diagnosed with mental status, a and a urinary transoom.  An interview was (MD) #2, the phen 9/9/2024 at 1:12 recall if he was glucose levels of 7/10/2024, or	on the evening of 7/11/2024 but are the blood glucose level had	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED	
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and requested a call after continuous mon #2 indicated that if the 7/10/2024 or 7/11/202 was likely he was not did not recall receiving evening of 7/11/2024 received phone calls it difficult to recall a stype for a resident. Miglucose level of 400 miglicose level of 400 migl	insulin to be administered back if there was no change itoring of the resident. MD ose orders did not exist on 24 during the day shift then it a notified. MD #2 stated he ag a phone call on the from Nurse #4, but he of that type routinely making pecific phone call of that ID #2 stated that a blood mg/dL was "not good," but see level of 400 mg/dL was an a resident making it likely an condition was occurring for had to figure out.  If the facility Administrator Consultant were notified of the following immediate in:  Ints who have suffered, or serious adverse outcome as	F 5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		OATE SURVEY COMPLETED	
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F 580	Continued From pag	ge 27	F 5	80			
	lower extremity (a b within the deep vein occur in the arms).  Review of Resident Administration Reco	and thrombosis of distal lood clot condition that forms s, usually of the leg, but can #22's Medication ords (MAR), indicates; on the medication aide (MA#4)					
	notified Unit Manage blood glucose levels evidence that the ph #22's MAR indicates 10 units of Novolog	er #2 that Resident #22 had s registering over 400. No hysician was notified. Resident s that Resident #22 received insulin at 1:43pm. Further					
	7/11/2024, at 11:47 glucose was docum	#22's MAR indicates; on am, Resident #22's blood ented to be 400. No evidence as notified, and 10 units of ere administered.					
	documentation on 7 the resident was not of Nursing was notif actions taken. The I informed is no longer	cal Therapy Assistant /11/24 at 3:38 PM indicated n-responsive, and the Director ied. No documentation of Director of Nursing who was er working at the facility. No hysician was notified.					
	by MA #4 to be 400. #22 received 10 uni	m blood glucose documented The MAR indicates Resident ts of Novolog insulin. No hysician was notified, no ing else was done.					
	7/12/2024 (late entry #22's medical record contacted physician glucose exceeding 4	notes documented on y for 7/11/2024), in Resident ds indicate (in part); Nurse #4 due to Resident #22's blood 400. An order was received o administer ten units of					

	AND DI AN OF CORRECTION IDENTIFICATION NUMBER		' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C 1 <b>12/2024</b>
	ROVIDER OR SUPPLIER			52	REET ADDRESS, CITY, STATE, ZIP CODE 01 CLARKS FORK DRIVE NW ALEIGH, NC 27616	<u>1 09/</u>	12/2024
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F 580	Humalog or Novolog	and report back after 2	F	580			
	glucose reading still of physician made awar Resident #22's family Resident #22 to be se	cian made aware, and the d resident to hospital,					
	by the Assistant Directindicated; she contact 7:10pm on 7/11/2024 glucose exceeding 40 received an order to a Humalog or Novolog hours. Nurse #4 indicadministering 10 units per physician order. Nat approximately 9:00 Resident #22's blood exceeded 400. She a made aware of the re 9:03pm. Per Nurse #4 arrived at approximate for Resident #22 be sphysician was made approximately 9:10pm received to send the 4 contacted EMS at 9 EMS arrived on scene was still non-respons EMS report, Resident elevated heart rate of and with a continued	glucose, the reading still dded the physician was sults at approximately 4, Resident #22's family ely 9:05pm and requested ent to the hospital. The aware of the request at					
		tal for further evaluation and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			52	TREET ADDRESS, CITY, STATE, ZIP CODE 201 CLARKS FORK DRIVE NW ALEIGH, NC 27616	<u>1 09/</u>	12/2024
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F 580	approximately 9:53pr in the facility. No other the facility. No other the facility. No other the Governing body Operation, the facility. Director of Clinical Son Nursing conducted the 109/06/2024, to identify alleged noncompliant appropriate measure reoccurrences.  For Resident #22, the (RCA) identified the aresulted from the fail (Nurse # 4) to follow practice to inform the elevated blood gluco over a two-day time of the for Resident #22.  The governing body for identification for the alleged noncomposite measures below to a serious adverse out to Clinical assessments.	m. Resident #22 is no longer er actions taken.  led by the Vice President of Administrator, Regional ervices, and Director of the root cause analysis on the root cause analysis on the causative factor for this ce and implemented is to correct and prevent the eroot cause Analysis alleged noncompliance the professional standard of the attending physician of the se levels that were sustained frame and over multiple shifts appear of the following plan those residents who are likely everse outcome as a result of cliance and implemented the liter the process to prevent a some from occurring.	F	580	DEFICIENCY)		
	Director of Nursing, A and/or Unit coordinat other resident with the require medical atter physician. The clinical	pleted on 09/07/24 by the Assistant Director of Nursing, for (#1 or #2) to identify any see change condition that stion and/or notification to the all assessment focused on to include, blood pressure					

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG	, ,	ATE SURVEY OMPLETED
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	ACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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)	HOULD BE	(X5) COMPLETION DATE
reading, and/or p includes residents for blood will be in Assistant Coordina a change to include medical 100% au reading 09/07/20 09/08/20 Director or #2) to resident hypergly attending identified of nursin measure intervent Specify process adverse when the Effective ensure is hypoglyd reported.	resence of permeasuring I is with diagnoral glucose charter of permeasuring I is with diagnoral glucose charter in conditions and or interest of the action through the physician was a compared to the physician was a control of the physician of the action will inform the control of the action will inform the action through the action will inform the action will inform the action through the action will inform the action will inform the action through the action will inform the action will inform the action through the action will inform the action will inform the action will inform the action through the action will inform the action will inform the action will inform the action through the action will inform the action will inform the action through the action will inform the action will inform the action through the action will inform the action will inform the action through the action will inform the action will inform the action through the action will inform the action through the action through the action will inform the action through the	ration rate, temperature, rain. The assessment also blood glucose for the bis of diabetes with orders eck. The attending physician me Director of Nursing, Nursing and/or Unit on any identified findings of an and appropriate measures mited to activating emergency adicated.  The entresident's blood glucose from 6/28/2024 to ed on 09/07/2024 and Director of Nursing, Assistant and/or Unit Coordinator (#1 other documentation of a es of hypoglycemia and/or sure notification to the was made. Any resident(s) ange in condition, the Director the physician for appropriate erventions and implement the	F 5	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	\ , ,	TE SURVEY MPLETED
		345529	B. WING _			C <b>9/12/2024</b>
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		9/12/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 580	inform the resident; of physician; and notify, when there is; an acc which results in injury requiring physician in change in the resider psychosocial status, significantly (that is, a existing form of treatre consequences, or to treatment), and/or a discharge the resider including when reside excessive high or low notification will be do electronic medical reconduty.  Effective 09/09/2024, administrative team, ADON, Unit coordination nurse, incorporated to clinical documentation physician orders writted from the last clinical reconduction of t	licensed nurse on duty will consult with the resident's the resident representative cident involving the resident of and has the potential for an an ed to alter treatment and need to discontinue an an ed to discontinue an an ent due to adverse commence a new form of decision to transfer or an antiferior the facility, to ent's blood glucose is or blood glucose. This cumented on each resident's cords by the licensed nurse which includes the DON, tors (#1, #2), and/or wound the process for reviewing an for the last 24 hours, or meeting to ensure any of changes to the physician, arty was done in a timely nic process will take place ay. Any identified issues will the team will review the clinical thysician orders written on any on the next clinical	F 5			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C
NAME OF PR	ROVIDER OR SUPPLIER	0.10020		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	09/	12/2024
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH			CLARKS FORK DRIVE NW EIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	blood glucose check; will obtain and docume ach resident's medic Nurse on duty immed level less than 60, greathe physician order. Further duty will assess the reand provide approprianotifying the physician of all full time, part time, an nurses will be comple Nursing, Assistant Din Development Coordinators (#1, #2) education will be the physician and the resmanner for any change treatment/intervention sustained elevated ble will be completed by surses not educated allowed to work until also be implemented Director of Nursing, A and/or Unit Coordinators track the completion of complete this educati licensed nurses durin effective 09/09/2024.	for residents with orders for certified medication aides and blood glucose reading in cal records, and inform a iately, on any blood glucose eater than 200 or based on facility licensed nurses on esident blood glucose level ate intervention including in in a timely manner.  I licensed nurses to include a sed needed licensed the by the Director of rector of Nursing, Staff nator, and/or Unit  The emphasis of this importance of notifying ponsible party in a timely ge in condition, change of an and/or incidents of cood glucose. This education cood glucose. This education cood glucose. This education will in new hire orientation. In this education will in new hire orientation. In this education and will confor any newly hired gethen whire orientation.	F	580			
	Alleged immediate jed 09/09/2024.						
	On 9/12/24 the follow	ing was done to validate the					]

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING				C
		343329	D. WING			09/	12/2024
NAME OF PE	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS/	AL HEALTH CARE/NORT	H RALEIGH			201 CLARKS FORK DRIVE NW		
				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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	training per the facility  A review of staffing so was a designation on	opardy removal plan:  vealed documentation  etion of audits and in-service	F	580			
	Medication Aide so the could take place when Beginning at 9:45 AM members were intervitraining the facility has to report details of the they attended. Staff or regarding whether the resident go without moved for failure of asset the physician of channof a lack of medical candue to a lack of physician of the physician of channof a lack of medical candue to a lack of physician of the physician of channof and the physician of channof a lack of medical candue to a lack of physician of the physicia	at physician notification in needed.  on 9/12/24 multiple staff lewed regarding in-service d provided. Staff were able eir training and validated were also interviewed ey had witnessed any edical care during the past sessment and notification of ges. There were no reports are for acutely ill residents cian notification.  as conducted on 9/12/24 at					
F 584 SS=D	resident regarding he reported no problems to staff not communic.  The facility's immedia 9/9/24, was validated Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(1)-(2)(483.10(i)) Safe Envir The resident has a right reported to start the start of	ole/Homelike Environment (7) onment.	F s	584			10/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OMPLETED	
		345529	B. WING _			C 09/12/2024	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		03/12/2024	
(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 COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 584	Continued From pag	ue 34	F 5	84			
	but not limited to rec supports for daily livi						
	homelike environme use his or her person possible. (i) This includes ensourceive care and ser physical layout of the independence and d (ii) The facility shall e	vide- clean, comfortable, and nt, allowing the resident to nal belongings to the extent uring that the resident can vices safely and that the e facility maximizes resident loes not pose a safety risk. exercise reasonable care for resident's property from loss					
		keeping and maintenance to maintain a sanitary, orderly, rior;					
	§483.10(i)(3) Clean in good condition;	bed and bath linens that are					
		e closet space in each ecified in §483.90 (e)(2)(iv);					
	§483.10(i)(5) Adequates levels in all areas;	ate and comfortable lighting					
	levels. Facilities initia	rtable and safe temperature ally certified after October 1, a temperature range of 71 to					
	sound levels. This REQUIREMEN by:	e maintenance of comfortable  T is not met as evidenced  on, record review, and		F584			

NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/NORTH RALEIGH  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 584  Continued From page 35 interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a resident into the room. This was for one (Resident # 19) of four residents reviewed for a  STREET ADDRESS, CITY, STATE, ZIP CODE  5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616   ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584  Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #19 s room was inspected and	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/NORTH RALEIGH  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 584 Continued From page 35 interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a resident into the room. This was for one  STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616  PROVIDER'S PLAN OF CORRECTION PROFIXE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584 Continued From page 35  interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a residents found to be affected by the deficient practice:	C <b>09/12/2024</b>	
UNIVERSAL HEALTH CARE/NORTH RALEIGH  (X4) ID PREFIX TAG  F 584  Continued From page 35 interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a resident into the room. This was for one  5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616  F 7820 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584  Continued From page 35  interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a resident into the room. This was for one	09/12/2024	
UNIVERSAL HEALTH CARE/NORTH RALEIGH  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 584 Continued From page 35 interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a resident into the room. This was for one  RALEIGH, NC 27616  PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584 Continued From page 35 interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a residents found to be affected by the deficient practice:		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 584 Continued From page 35 interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a resident into the room. This was for one  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 584 Continued From page 35 interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a residents found to be affected by the deficient practice:		
interviews with resident and staff the facility failed to ensure a room was cleaned prior to moving a resident into the room. This was for one  Corrective actions accomplished for those residents found to be affected by the deficient practice:	(X5) COMPLETION DATE	
to ensure a room was cleaned prior to moving a residents found to be affected by the resident into the room. This was for one deficient practice:		
homelike and clean environment. The findings included:  Resident # 19 was admitted to the facility on 12/5/23.  Review of Resident # 19's quarterly Minimum Data Set assessment, dated 8/2/24, revealed the resident was assessed to be cognitively intact.  A nursing noted on 8/26/24 noted that Resident # 19 was notified of a room change that would occur. The resident's record indicated the room change occurred on 8/27/24.  Resident # 19 was interviewed on 8/29/24 at 9:15 AM and reported the following information. She had been told on 8/26/24 (Monday) that she had to move to a new room for insurance reasons. When they moved her on 8/27/24 she had to wait in the hall for 20 minutes because the new room was not cleaned. There had been lots of medical equipment left in her new room's bathroom and it did not belong to her roommate. During the interview, Resident # 19 asked the surveyor to open her bathroom door and observe.	d on he has ey of high ce	
Resident # 19 pointed to medical items such as oxygen equipment and a bedpan located in wheelchairs which did not belong to her or to her roommate.  On 8/29/24 at 9:30 AM Unit Manager # 1 was asked to view Resident # 19's bathroom and all  Effective 10/07/2024, the need for a room change will be discussed in the daily stand-up meeting that takes place Monday through Fridays by the Admission coordinator and/or designated person.  Effective 10/07/2024, the need for a room change will be discussed in the daily stand-up meeting that takes place Monday through Fridays by the Admission coordinator and/or designated person.	on	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C <b>12/2024</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			12/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 584	items had not been of resident was moved should have occurred.  The Housekeeping E 8/29/24 at 9:35 AM a information. She had the day Resident # 1 expectation that the lall used medical equithe room and sanitize	cated there. The Unit the was not aware why the eleaned out before the into the new room, and this d. Director was interviewed on and reported the following into been at the facility on 9 was moved. It was her housekeeping staff remove ipment that did not belong in the the entire room, which m, before a resident was	F		change need discussed in the daily meeting, the facility Housekeeping manager and/or Admission coordinator will visit the resident room (where resid will be moved to), and ensure the room clean and sanitary before room move. This systemic changes will be documented on Quality Control Inspect (QCI) form.  Assistant Administrator will complete at education to the facility social workers, Admission coordinator, and housekeep manager. The emphasis of this educati will be the importance of discussing roochanges in the daily stand-up meeting. The education also emphasized the importance of housekeeping manager inspect the room before the room changes take place. This education will completed by 10/14/2024. This educati will also be implemented in new hire orientation for social workers, Admissic coordinators and housekeeping manage Monitoring of corrective actions to ensuthat the deficient practice is being corrected and will not recur:  Effective 10/07/2024, the  Administrator/Assistant Administrator wereview all room moves that were completed in the last 24 hours or from a last stand-up meeting to ensure that a room was inspected before the move. This monitoring process will be conduct twice weekly for two weeks, wheekly for two more weeks, then monthly for three months or until a pattern of compliance maintained. The findings of this proces will be submitted to QAPI for review an recommendation by the Administrator	ent is ition in sing for it on to libe on ler. It be ted ted ted ted ted ted ted ted ted te		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 09/12/2024	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		3011212024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETION DATE	
F 584	Continued From pag	e 37	F	and/or Assistant administrative months or until the p compliance is maintained. Completion date: 10/14/20	attern of		
F 600 SS=J	§483.12 Freedom from Exploitation The resident has the neglect, misappropria and exploitation as dincludes but is not lin corporal punishment, any physical or chemit treat the resident's misself. §483.12(a) The facilities §483.12(a)(1) Not us physical abuse, corpinously seclusion This REQUIREMENT by:	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and nical restraint not required to redical symptoms.  ty must- e verbal, mental, sexual, or oral punishment, or	Fé			10/14/24	
	Based on record review, staff interviews, family interview, and physician interview the facility failed to protect a resident's right to be free from neglect when they failed to comprehensively assess and effectively monitor a resident with blood glucose levels registering over 400 milligrams per deciliter (mg/dL) (normal blood sugar levels are considered to be between 70mg/dL to 100 mg/dL) over two days, accurately notify the physician of the resident's medical status to ensure necessary care and services were implemented to treat the resident, and to identify the seriousness of the resident's change in medical status and the need to immediately			F600 Corrective actions accompresidents found to be affect deficient practice: Resident #22 no longer in other actions taken for residentification of other residentification of other residential to be affected by deficient practice: Clinical assessments of all residents in the facility were 09/07/24 by the Director of Assistant Director of Nursicoordinator (#1 or #2) to identify the second of the second o	the facility, no ident #22 lents having the the same I current re completed on f Nursing, ng, and/or Unit		

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI				,	
		345529	B. WING				12/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				5	201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOF	RTH RALEIGH		R	RALEIGH, NC 27616			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE	
F 600	Continued From pa	ne 38	_	600				
. 000	-	-	'	000	regident with the change condition that			
		medical services (EMS) when entified as nonresponsive.			resident with the change condition that require medical attention. The clinical			
		ed until hours after the resident			assessment focused on resident⊟s vita	. l		
		as nonresponsive by a			signs to include, blood pressure readin			
		aff member. Resident #22			pulse, respiration rate, temperature,	ອ,		
	1	MS with an elevated heart rate			and/or presence of pain. The assessm	ent		
		nute (bpm) (a typical resting			also includes measuring blood glucose			
		is between 60 and 100 bpm),			the residents with diagnosis of diabetes			
		0s breaths per minute (a			with orders for blood glucose check. The			
	normal respiratory r	ate is between 12 and 20			attending physician will be informed by	the		
	breaths per minute)	, and with a continued reading			Director of Nursing, Assistant Director	of		
		evel more than 400 mg/dL at			Nursing and/or Unit Coordinator #1 or a	· 1		
		EMS. An Emergency			on any identified findings of a change i			
		nysician assessment indicated			condition and appropriate measures to			
		liagnosed with sepsis (a			include, but not limited to activating			
	_	plication of an infection)			emergency medical services if indicate			
	briefly explain and h				100% audit of all current resident □s blo	ood		
		medical condition in which			glucose reading documented from 6/28/2024 to 09/07/2024 completed on			
		ucose level is higher than glucose happens when the			09/07/2024 to 09/07/2024 completed on 09/07/2024 and 09/08/2024, by the			
		isulin or when the body can't			Director of Nursing, Assistant Director	of		
		.) This was for one (Resident			Nursing, and/or Unit Coordinator (#1 or			
		ts reviewed for neglect.			#2) to identify any other documentation			
		io reviewed for flegicot.			a resident with episodes of hypoglycei			
	Immediate jeopard	ly began on 7/10/2024 when			and/or hyperglycemia that was not			
		rovide the necessary care and			addressed appropriately in accordance			
		t #22 when she was identified			with professional standards of practice			
	as having a blood g	lucose reading of over 400			the comprehensive person-centered ca	ıre		
	mg/dL. Immediate J	leopardy was removed on			plan, and the residents□ choices. Any			
		facility implemented an			resident(s) identified with a change in			
		allegation of immediate			condition, the Director of nursing will			
		he facility will remain out of			inform the physician for appropriate			
		ver scope and severity D to			measures and or interventions and			
		completed and monitoring			implement the interventions as ordered			
	systems put in place	e are effective.			the identified issues indicate neglect, the			
	Finalinana in divide i				were not previously reported to the sta	e,		
	Findings included:				law enforcement, and Adult protective	-		
	Booldont #22 was a	riginally admitted to the facility			services (APS), the facility Administrate			
	∣ rcesident #∠∠ was d	originally admitted to the facility	1		will protect all residents by immediately	<i>(</i>		

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			С	
NAME OF D		345529	B. WING _			9/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE NW			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 39	F 60	00			
F 600	on 8/2/2023 with multiwhich included demerication mellitus, schizoaffect depressive disorder, #22 was readmitted to a hospitalization for the urinary tract infection (Hydronephrosis is a characterized by excellockage in the tuber the bladder.)  Documentation on a assessment dated 6/ #22 was assessed as and vision with clear the same assessment was usually understoability to understand coded as having the mellitus and received of the assessment per Documentation on the 6/22/2024 revealed at Resident #22's risk for diagnosis of diabetic diagnosis of diabetes interventions was to of hypo/hyperglycem pallor, nervousness, confusion, and or lact interventions were to monitoring and medications.	tiple diagnoses some of intia, type 2 diabetes ive disorder, major and hypertension. Resident of the facility on 6/21/24 after the diagnoses of sepsis, and hydronephrosis. Intelligence of the diagnoses of the kidney to the diagnoses of the diagnoses of the diagnosis of type 2 diabetes of the diagnosis of type 2 diabetes diagnosis of	F 61	suspending the alleged perpet the identified issue of neglect agency, law enforcement, and two hours of identification and thorough investigation, immediacility Administrator will report of the investigation to the Stat within five working days.  Measures/systemic changes into place to ensure that the operactice does not recur:  Effective 09/09/2024, facility of residents remain free from about neglect by following the facility abuse prohibition policy and procare in accordance with standard practice and notifying the phytimely manner for any change resident secondition.  Effective 09/07/2024, facility of will ensure residents received care to include assessing, more addressing a change in condition the seriousness of a change in and recognize the need to initie emergency medical services accordance with professional practice, the comprehensive person-centered care plan, and residents choices. This system modification will be accomplising implementing the following metifective 09/07/2024, licensed	to the State of APS within a dinitiate diately. The end the result the agency will be put deficient will ensure all cuse and by company providing dard of estician in a ses in employees I necessary position, identify in condition, tiate in standards of end the emic shed by easures: dinurses will		
	receive Novolog insu	onysician order dated Resident #22 was ordered to lin solution to be injected lied under the skin) three		oversee care and services for resident in the facility. A licens will be informed at the beginn shift, through the daily schedu	sed nurse ing of the		

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 09/12/2024		
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2024	
				52	201 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 600	Continued From page times day at 8:00 AM	e 40 , 12:00 PM, and 4:00 PM	F 6	800	responsibility to oversee certified			
	per the following slidi				medication aide(s) if any.			
	glucose level was 20 251 to 300 administe administer 8 units; 35	1 to 250 administer 4 units; r 6 units; 301 to 350 f1 to 400 administer 10 units; the physician. Novolog is a ed to treat high blood			Effective 09/07/24, Director of Nursing, Assistant Director of Nursing, Unit Coordinator (#1 or #2), Weekend Supervisor, and/or Scheduling Coordinator will be responsible to upda daily schedule for nursing staff (license	nte		
	receive 5 units of Ser injected subcutaneou PM for hyperglycemia	Resident #22 was ordered to englee insulin solution to be also sly one time a day at 8:00 a. Semglee is a long-acting also blood glucose levels for			nurses, medication aides, and certified nursing aides). The daily schedule will inform each nursing staff of their assignment and responsibilities to incluresponsibility for licensed nurses to oversee medication aides (if any).			
	revealed on 7/9/2024 399 and Medication A administered ten unit Med Aide #5, an agei interviewed on 9/5/20 the following informati	d (MAR) for Resident #22 the blood glucose level was kide (Med Aide) #5 s of insulin at 6:22 PM.  here employee, was 124 at 1:08 PM and revealed ition. Med Aide #5 confirmed			The Facility Administrator will educate Director of Nursing, Assistant Director of Nursing, Weekend Supervisor, Unit Coordinator #1/or #2 and Scheduling Coordinator. The education focused on the importance of ensuring a daily nurs schedule is completed and indicate the responsibility of each nursing staff to include the responsibilities of the licens nurse to oversee the medication aides.	n sing e		
	7/9/2024 and that she Resident #22. Med A licensed nurse was w perform medication a her scope of practice explained when she preading into the elect administration of the go under her name. It had to trust that the li	ronic MAR, the insulin would also incorrectly Med Aide #5 indicated she censed nurse, to whom she ucose level of Resident #22,			This education will be completed by 9/8/2024. Any licensed nurses and/or medication aide not educated by 09/08 will not be allowed to work until educate The Director of Nursing will complete the education for any newly hired, Assistar Director of Nursing, Weekend Supervis Unit Coordinator #1/or #2 and Scheduli Coordinator during the orientation proceffective 9/8/2024.  Effective 09/07/2024 the assigned licensed nurse will be responsible to	ed. nis nt sor, ing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		ATE SURVEY OMPLETED	
			A. BOILDING	·		С	
		345529	B. WING		09/12/2024		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI			
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PRÉFIX TAG	i i	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETION DATE	
F 600	Continued From pag	e 41	F 60	00			
	document the admin	istration, and notify a		provide necessary care to in-	clude		
	physician of any con	•		assessing, monitoring, addre			
				change in condition, identifyi	ng the		
	Documentation on th	e July MAR revealed Nurse		seriousness of a change in c	ondition, and		
		nglee insulin as ordered to		recognizing the need to initia			
	Resident #22 on 7/9/	/2024 at 8: 24 PM.		medical services in accordar			
				professional standards of pra			
		nentation on the July MAR		comprehensive person-center			
		blood glucose level taken or		plan, and the residents□ cho			
	on 7/10/2024.	sulin as ordered at 8:00 AM		assigned residents, and/or the to the medication aide under	_		
				supervision.	the nurse_s		
	Med Aide #4, an age						
		024 at 1:54 PM. Med Aide #4		Effective 09/07/2024, for resi			
		g information. On the		orders for blood glucose che			
	AM to 7:00 PM shift	he was assigned for the 7:00		medication aides will obtain a document blood glucose rea			
		d. Med Aide #4 was told		resident s medical records,	-		
		of administering medications		Nurse on duty immediately, of			
		uring the 7:00 PM to 7:00 AM		glucose level less than 60, g	-		
		2024. Resident #22 was one		200 or based on the physicia			
		Nurse #4 told Med Aide #4		Facility licensed nurses on d			
	1 -	ninistered the morning		assess the resident blood glu			
	medications to. Med	Aide #4 stated she expected		and provide appropriate inter	rvention		
	Nurse #4 to docume	nt on the MAR the		including assessing, monitor	ing,		
		s told had already been		addressing a change in cond			
		explanation for why there was		identifying the seriousness o			
		the Novolog insulin for		condition, and recognizing th			
	Resident #22 at 8:00	0 AM on 7/10/2024.		initiate emergency medical s			
	Documentation as the	no July MAD roycolod Mod		notifying the attending physic			
		le July MAR revealed Med glucose level of 400 mg/dL		accordance with professiona practice, the comprehensive			
		units of Novolog insulin on		person-centered care plan, a			
		If to Resident #22, one hour		residents choices.			
	and 43 minutes after	•		. Solderite _ Sholder.			
	administration time.			Effective 09/07/2024, facility	licensed		
				nurses on duty will administe			
	There was no docum	nentation on the July MAR		related to hypoglycemia and			
		blood glucose level taken or		hyperalycemia, including glu			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 501251	_		(	
		345529	B. WING			1	12/2024
NAME OF P	ROVIDER OR SUPPLIER	0.0020		S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	12/2024
TO THE OT THE	TO VIDER OR GOLF EIER				201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH			RALEIGH, NC 27616		
				- 1	 T		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 42	F	600			
		volog insulin as ordered at			blood sugar, and/or insulin for high bloo	nd	
	4:00 PM on 7/10/202	_			glucose, based on physician orders an		
					document the administration of such	_	
	Med Aide #4, an agei	ncy employee, was			medication in each resident□s clinical		
		024 at 1:54 PM. Med Aide #4			record.		
	relayed the following	information. Med Aide #4			Effective 09/07/2024, residents with blo	ood	
	explained that she co	ould not remember which			glucose over 400 will receive 10 units of	of	
		ssisting her on 7/10/2024			fast acting insulin, (Humalog or Novolo	• / -	
		d not administer Novolog			blood glucose will be rechecked within		
		22 on 7/10/2024 at 1:43 PM.			minutes, or per physician order, after the		
		the licensed nurse, assisting			administration of insulin, if blood glucos		
	her on 7/10/24, was l				remains over 400, resident ☐s physicial	ו	
		glucose level for Resident			will be notified for further evaluation		
		bove 400 on the glucose f "HI" on a glucometer			and/or treatment. This protocol is implemented effective 09/07/2024.		
	, -	above the level readable by			100% education of all current staff to		
	_	licensed nurse who was			include full-time, part-time, and as need	ded	
		4 was told the blood glucose			employees will be completed by the		
		above 400 and the physician			Administrator, Director of Nursing,		
	_	The licensed nurse told Med			Assistant Director of Nursing, and/or S	taff	
	Aide #4 the physician	ordered 12 units of Novolog			Development Coordinator. The emphasi	sis	
	insulin to be administ	ered to Resident #22 and to			of this education includes but is not lim	ited	
	keep checking the blo	ood glucose level every			to, the importance of providing care to	all	
		ept checking the blood			residents in the facility. The education		
	glucose level every h	our and reported to the			also focused on facility abuse prohibition	n	
		ading was still registering as			policy and procedures to include		
	_	ed Aide #4 thought the			prevention of resident neglect by follow	-	
		oing to document everything			physician orders related to administrati	on	
		4:00 PM scheduled Novolog on 7/10/2024 because of			of insulin for residents with high blood glucose and notifying physician in		
		adings that were over 400			accordance with physician orders and		
		nysician to be notified.			when there is an instance of sustained		
	mg/ac, roquining a pir	goldan to be notined.			elevated blood glucose levels over a		
	Unit Manager #2 was	s interviewed on 9/10/2024 at			period of time. This education also		
	_	er #2 revealed the following			emphasized the definition of neglect as	;	
	_	nager #2 did recall Med Aide			the failure to provide goods and service		
		out an elevated glucose level			to a resident that are necessary to avoi		
	_	7/10/2024. Unit Manager #2			physical harm, pain, mental anguish, o		
		ed Resident #22 and thought	1		emotional distress.		

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				CIVID INC	7. 0930 <del>-</del> 0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(	c
		345529	B. WING _				12/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET 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	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	e 43	F 6	800			
		but was arousable and able			This education will be completed by		
		anager #2 stated she was			09/08/2024. Any staff members not		
		, in addition to being the unit			educated by 09/09/2024, will not be		
	manager, the only re				allowed to work until educated. The		
	building, doing wound	-			Administrator, Director of Nursing,		
		aving her with little time for			Assistant Director of Nursing, and/or S	taff	
		of the Med Aides in the			Development Coordinator will monitor		
		er #2 revealed she thought			track the completion of this education a		
	she sent a text to the	physician for Resident #22			provide it for any newly hired employee	•	
	informing him of the	elevated blood glucose			during the new hire orientation, and		
	levels on 7/10/2024.	Unit Manager #2 stated she			annually.		
	trusted the judgemen	it of Med Aide #4 and felt she					
		ively if she needed any			100% education of all licensed nurses		
		ager #2 could not recall			Medication aides, to include full time, p		
		rventions were put in place			time, and as needed nursing employee	S	
		nan administration of insulin			will be completed by the Director of		
		trust the recollections of Med			Nursing, Assistant Director of Nursing,		
		er #2 revealed she kept a			and/or Unit Coordinators (#1, #2). The		
		notes on which residents she			emphasis of this education includes bu	τ	
	_	omplete documentation on			not limited to:		
		Manager #2 thought perhaps elevated blood sugars was			<ol> <li>The importance of administering medication to include insulin, glucagon</li> </ol>		
	_	is and she forgot to go back			and other medications per physician	,	
	and document.	is and she lorger to go back			order.		
	and document.				2. The importance of ensuring each		
	Documentation on th	e July MAR revealed Nurse			resident is assigned to a licensed nurse	e to	
		nglee insulin as ordered to			oversee his/her care including provisio		
	Resident #22 on 7/10	•			for assessing, monitoring, addressing a		
					change in condition, identifying the		
	There was no docum	entation in the electronic			seriousness of a change in condition, a	ınd	
	medical record of Re	sident #22 that any			recognizing the need to initiate emerge		
	additional intervention	_			medical services in accordance with		
	elevated blood glucos	se reading on 7/10/2024.			professional standards of practice, the		
					comprehensive person-centered care		
		entation on the July MAR			plan, and the residents□ choices.		
		blood glucose level taken or			3. The importance for each medication	on	
		volog insulin as ordered at			aide to be aware of their assigned		
	8:00 AM on 7/11/202	4.			licensed nurse at the beginning of their shift (through the daily schedule that w		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C	
NAME OF D	20/4050 00 011001150	343329	J B: WING _		FREET ARRESTON OFFICE ZIR CORE	09/	12/2024	
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH			201 CLARKS FORK DRIVE NW			
				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 600	Continued From page	e 44	F 6	500				
F 600	The facility nursing so indicated Nurse #7 who for which Resident #2 "day shift (7:00 AM to Nurse #7 was intervie PM. Nurse #7 stated who only worked at the and that was 7/11/202 not recall what hall shift stated when she at 7/11/2024, the scheding paper MARs and told the medication pass. told she would not has medical record system "chaos", but she stay explained that at 2:30 by the Interim Director electronic medical record information she need papers for a new admitted process. Nurse #7 satisfaction paperwork and told her she was revealed she had never Med Aide #4 was interested. Med Aide #4 states 7/11/2024 for the 7:00 another hall next to the resided. Med Aide #4 mess" on the hallway because there was at who was trying to figure 12.	chedule dated 7/11/2024 as assigned to the hallway 22 resided for the 12 hour 37:00 PM)."  ewed on 9/5/2024 at 2:37 she was an agency nurse he facility on one occasion 24. Nurse #7 stated she did he was assigned to. Nurse her to go to the hall to begin her to go to the hall to begin hurse #7 explained she was her excess to the electronic h. Nurse #7 further her by Mahe was approached her of Nursing (DON) with the her to go to the hall to begin hurse #7 further hurse #7 further hurse #7 further half was approached her of Nursing (DON) with the her to go to the hall to begin her to go to the hall to begin hurse #7 further hurse #7 revealed it was her to half was approached her of Nursing (DON) with the her to go to the half to he handed the new hack to the Interim DON half to doing it. Nurse #7 her returned to the facility.  Her returned to the facility.  Her was assigned on half to 7:00 PM shift to he hall which Resident #22 her half which Resident #22 her half which Resident #22 her half was half	F6	600	indicate the nurse who is responsible to oversee them)  4. The implementation of hyperglycer protocol includes administration of fast acting insulin and rechecking blood sugwithin 30 minutes and notifying physiciator any other orders.  5. The importance of calling 911 for medical emergencies that require mediattention at the acute care center. (The education emphasized that any staff member can call 911 when indicated.)  6. The importance of documenting bliglucose findings in resident smedical records.  7. For medication aides, the education also covered the importance to report to the charge nurse immediately any blooglucose level less than 60, greater than 200 or based on the physician order. This education will be completed by 9/8/2024. Any licensed nurses and/or medication aide not educated by 09/08 will not be allowed to work until educated Director of Nursing, Assistant Director Nursing, and/or Unit Coordinators (#1, will monitor and track the completion of this education for any newly hired licensed nurses and/or medication aides during new hire orientation.  Monitoring of corrective actions to ensuthat the deficient practice is being corrected and will not recur:	mia gar an ical cod on co od n s/24 ed. of #2) f		
		edications. Med Aide #4 nurse (Nurse #7) left and t return list.			Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG	(X	(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C <b>09/12/2024</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	00/12/2021	
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From pag	e 45	F 6	500			
	Aide #4 obtained a bing/dL and administer insulin on 7/11/2024  Documentation on a	ne July MAR revealed Med blood glucose level of 400 ered ten units of Novolog at 11:47AM to Resident #22. physical therapy treatment		complete the monitoring pand maintain compliance prevention of abuse and/omonitoring process will be by reviewing medication a records for all residents w	related to or neglect. This e accomplished administration		
	Physical Therapy As 7/11/2024 at 3:58 PM that [Resident #22] gurpose of attempting responded [by demonstrate]	If revealed, "PTA facilitated get [out of bed] for the g goals. [Resident #22] instrating] extreme lethargy,		blood glucose monitoring licensed nurses reviewed outside the physician order and address elevated and glucose reading per phys This monitoring process was to be the control of the contr	blood glucose ered parameters d/or blood ician orders. will be completed		
	movement to bright I [Resident #22] sit [or #22 [demonstrating] sleep/difficulty to hol #4], DON, [Physical Therapist] notified re	g, [nonresponsive] pupils/eye ight. PTA attempted to have n edge of bed] with [Resident inability to arise from d head. Nursing [Med Aide Therapist/Occupational garding [Resident #22's] Continue [with plan of care.]"		daily (Monday through Fri weeks, weekly for two mo monthly for three months, pattern of compliance is a negative findings will be a DON, ADON and/or Unit or #2 promptly. This moni will be documented on a	ore weeks, then , or until the established. Any addressed by the Coordinator #1 itoring process blood glucose		
	9/6/2024 at 4:45 PM following information recall the exact time #22 on 7/11/2024. P Resident #22 in a not that day, so she wer the interim DON, the	nducted with PTA #1 on . PTA #1 revealed the . PTA #1 stated she did not she went to see Resident TA #1 confirmed she found onresponsive condition on at to the Med Aide on the hall, Physical Therapist, and ist to let them know of her t #22.		monitoring tool located in compliance binder. Effective 10/07/2024, faci and/or Assistant administ five randomly selected recare is provided timely an noted. Any negative findir addressed promptly by the and/or Assistant Administ monitoring process will be Monday through Friday for weekly for two weeks, the	lity Administrator rator will observed no neglect is neglect is neglect. This endone daily or two weeks,	e e	
	Aide #4 took a blood and administered ter 7/11/2024 at 4:51 PM Med Aide #4 was int	ne July MAR revealed Med I glucose level of 400 mg/dL In units of Novolog insulin on II.  erviewed on 9/6/2024 at 1:54 Infirmed she took the blood		three months or until a part compliance is maintained Effective 10/07/2024, Dire will report findings of this process to the facility Quarand Performance Improve Committee for any additional process.	attern of . ector of Nursing monitoring ality Assurance ement		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(	С
		345529	B. WING			09/	12/2024
NAME OF PR	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		R	RALEIGH, NC 27616		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	e 46	F	600			
	glucose readings for	Resident #22 on 7/11/2024			or modification of this plan monthly for		
	•	1 PM. Med Aide #4 revealed			three months, or until a pattern of		
	that some of the bloc	od glucose readings for			compliance is maintained. The QAPI		
		ctually registering as HI or			committee can modify this plan to ensu	ıre	
		e at least one of the readings			the facility remains in substantial		
	she documented on t	the MAR on 7/11/2024 was			compliance.		
	actually 400 mg/dL. I	Med Aide #4 revealed the			Compliance date: 10/14/2024		
	MAR did not allow No	ovolog insulin to be checked					
	off as administered u	ınless an actual number was					
		R for the blood glucose					
		4 stated she had to put in 400					
		eading may have been over					
		e #4 confirmed she told the					
	licensed nurse who v	•					
	7/11/2024 for the 12:						
		or the Novolog insulin, that					
	_	vels were continuously HI. ed the licensed nurses were					
		after she documented the					
	blood glucose readin						
	-	ent the administration of					
		was told by the licensed					
		he physician had been					
		ed for Resident #22 to be					
		#4 did not recall who the					
		Med Aide #4 confirmed PTA					
		oncerns of the lack of					
	response from Resid	ent #22. Med Aide #4 stated					
	· · · · · · · · · · · · · · · · · · ·	ed nurse of what PTA #1 had					
	said. Med Aide #4 sta	ated she informed Unit					
	Manager #2 and sen	t a text message to the				ĺ	
	interim DON about th	ne continued blood glucose				ĺ	
		mg/dL for Resident #22.					
	Med Aide #4 stated s	she got a text message back				ſ	
		I that she "would take care				ĺ	
		ated that in report at the end				ĺ	
		4 and 7/11/24 she let Nurse				ĺ	
		22 was continually having				ſ	
	blood glucose readin	gs of over 400 mg/dL. Med					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345529	B. WING			l	C <b>12/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2024
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH	5201 CLARKS FORK DRIVE NW				
				RAL	_EIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 600	Continued From page	e 47	F	500			
	Aide #4 indicated Nu telling her that on the when Nurse #4 worke readings for Residen mg/dL. Med Aide #4	rse #4 did not seem to care, shift, 7:00 PM to 7:00 AM,					
	party (RP) for Reside PM and the following On 7/8/2024 the RP of before going out of to RP heard nothing all 7/11/24 around 7:30 had several missed of picked up on the nex number. The person themselves but told the toler of the picked up on the nex number. The person themselves but told the toler of the person themselves but told the person themselves but told the person themselves but told the person themselves the terminate of the person themselves the per	ds to be sent out." The RP as going on because the her that Resident #22 was nother family member who ty and asked him to go to the ht #22. The family member around 8:30 to 8:45 PM to s not responding. Nurse #4					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING	_		09/	12/2024	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	'H RALEIGH		5	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	phone caller was, but contacted as it may have sident #22. The RFA Administrator about have former) Administrator facility had learned the member had noted a earlier that day. The (maintained that they know if Resident #22 levels, which did not rehad known that Residevels were running have wanted have wanted have wanted hadministrator about a Documentation in the an order dated 7/11/2 #22 to be administered insulin solution to be it time only for a blood of mg/dL and contact the Humalog insulin is a fabsorbed quickly and minutes after injection levels.  There was no documentation of the order for Humalog insulin solution to Documentation in the an order dated 7/10 per levels.  There was no documentation of the order for Humalog insulin solution to Resid 7:00 PM.	she was grateful she was ave saved the life of containing the life o	F	600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345529	B. WING				C <b>12/2024</b>
	ROVIDER OR SUPPLIER	TH RALEIGH	•	52	REET ADDRESS, CITY, STATE, ZIP CODE 201 CLARKS FORK DRIVE NW ALEIGH, NC 27616	<u>,                                    </u>	
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page Documentation in the an order dated 7/11/2 #22 to be administered insulin solution subcut glucose exceeding 40 physician in two hour. There was no documentated the one-time ord ever administered to after 7:00 PM.  There was no other of electronic medical reference of Resident #22 on 7.  Documentation in the #22 dated 7/12/2024 revealed, "Physician glucose exceeding 40 received from physic Humalog or Novolog hours. After 2 hours, reading still exceeded made aware of results."	e 49 e physician orders revealed 2024 at 9:00 PM for Resident ed ten units of Novolog utaneously one time for blood 00 mg/dL and contact the rs.  The entation on the July MAR er for Novolog insulin was Resident #22 on 7/11/2024  Cocumentation in the cord of any vital signs taken 1/11/2024.  The enursing notes for Resident at 9:48 AM by Nurse #4 contacted due to blood 00 [mg/dL] and order ian to administer 10 [units] of and report back after 2 resident blood [glucose] d 400 [mg/dL] and physician its. Family arrived and RP		600			
	room] for evaluation. order received to ser room]. [Director of Nu An interview was con 9/5/2024 at 6:04 PM. following information Resident #22 on the #4 started her 7:00 PPM on 7/11/2024. Nu information in a nursi that the blood glucos	nducted with Nurse #4 on Nurse #4 relayed the and timeline of events for evening of 7/11/2024. Nurse PM to 7:00 AM shift at 7:00					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD			Ι,	С
		345529	B. WING				-
NAME OF D	ROVIDER OR SUPPLIER	0.10020			STREET ADDRESS, CITY, STATE, ZIP CODE	09/	12/2024
NAME OF FI	NOVIDER OR SUFFLIER						
UNIVERSA	AL HEALTH CARE/NO	RTH RALEIGH			5201 CLARKS FORK DRIVE NW		
					RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From pa	nge 50	F	600			
	pass. Nurse #4 der	nied she had any knowledge of					
	the blood glucose I	evel of Resident #22 being at					
	or above 400 mg/d	L for several shifts. Nurse #4					
	stated she assesse	ed Resident #22 and took her					
		art of her shift. Nurse #4					
		glucose level of Resident #22					
		HI or over 400 mg/dL on the					
		ce to measure blood glucose					
		vealed the vital signs of					
		fine, so she called the on-call					
		4 stated she received an order					
		to administer 10 units of fast					
		sident #22 and call the wo hours. Nurse #4 stated she					
		on Resident #22 again at					
		r vital signs were fine.					
		ot have a temperature,					
		ssure, or an elevated heart					
		ed her blood glucose level was					
		II or above 400 mg/dL on the					
		#4 was adamant Resident #22					
		esponsive. Nurse #4 related					
		ed the finger of Resident #22					
		resident looked at her and					
	rolled her eyes. Nu	rse #4 stated the family of					
	Resident #22 arrive	ed at the facility stating they					
	received a phone of	all from an unknown caller					
	telling them someth	ning was wrong with Resident					
	#22, and she need	ed to be sent to the emergency					
	l •	f Resident #22 looked at					
		demanded she be sent to the					
		Nurse #4 stated she did not					
		e family because the breathing					
		Resident #22 were normal.					
		she was about ready to call the					
	' '	of the elevated blood glucose					
	_	led the physician, and the					
		Resident #22 could be sent out					
	per the family wish	es. Nurse #4 relayed that she					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING		3) DATE SURVEY COMPLETED
		345529	B. WING _			C <b>09/12/2024</b>
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	I_	03/12/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	did all her documents end of her shift so the for each resident coulexplanation for why here was dated 7/12/2 #22 discharged from An interview was cornon 9/5/2024 at 1:58 here was not made as the blood glucose leven RP called her on the approximately 8:00 here approximately 9:00 here approxima	ation for the residents at the at all the events of the shift ald be documented, for an over nursing note for Resident 2024, the day after Resident the facility.  Inducted with the interim DON PM. The interim DON stated ware of any concerns with yels of Resident #22 until the evening of 7/11/2024 at PM or 8:30 PM. The interim RP of a phone call she try staff member telling her ery ill and needed to be sent enterim DON relayed she was fine. The interim DON se #4 had explained the las for Resident #22. An en completed by Nurse #4 d blood glucose level, were fine, the physician was at Resident #22 was fim DON stated she knew yel of Resident #22 was high the evening of 7/11/2024 but the blood glucose level had a shifts.  The Emergency Medical ent dated 7/11/2024 revealed 7 PM and arrived at room of	F			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345529	B. WING			C		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		09/12/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 600	they had been giving instructed by the resi changes in the reading monitor. EMS noted reading of HI on their EMS documented Rerate of 140 with respi the ambulance, Residunresponsive.  Documentation on a 7/11/2024 admission diagnosed with sepsimental status, acute and a urinary tract in room. Resident #22 whospital on 7/24/2024 home health services  An interview was comphysician for Resident PM. MD #2 stated he notified of the elevate Resident #22 on 7/9/7/11/2024. MD #2 ex notified of elevated be Resident #22 during would have ordered a fast-acting insulin to requested a call back after continuous mon #2 indicated that if the 7/10/2024 or 7/11/20 was likely he was not did not recall receiving evening of 7/11/2024	Resident #22 insulin as dent's physician with no ng level of HI on the glucose Resident #22 had a glucose glucose monitor as well. esident #22 as having a heart rations in the 40s. Once in dent #22 remained  hospital record dated for a revealed Resident #22 was s, hyperglycemia, altered renal failure, dehydration, fection in the emergency was discharged from the 4 into the care of the RP with s, per the RP's request.  Iducted with MD #2, the nt #22, on 9/9/2024 at 1:12 e could not recall if he was ed blood glucose levels of 2024, 7/10/2024, or plained that if he had been lood glucose levels for normal business hours, he a change in the amount of	F6	500				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345529	B. WING _			C 09/12/2024
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	TH RALEIGH		STREET ADDRESS, CITY, STATE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616		00/12/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)	DATE
F 600	glucose level of 400 having a blood gluco isolated event for this underlying medical cowhich he would have.  The facility's medical 9/9/24 at 4:19 PM ar failed to respond to Freadings of high blood unresponsiveness prodiscussed with the midirector reported facility any incidents who will be a second of the facility and Corporate Nurse Immediate Jeopardy Resident # 22.  On 9/10/24 the facility immediate jeopardy Identify those recipies are likely to suffer, a a result of the noncomplete Resident #22 was at 08/02/2023 and discibled Between the original she was readmitted or recent readmission, a diagnoses that including diabetic retinopathy complication of diabetic retinopathy complication diabetic retinopathy complication diabetic retinopathy complication of diabetic retinopathy complication diabetic retinopathy complication of diabetic retinopathy complication diabetic retinopath	ID #2 stated that a blood mg/dL was "not good," but se level of 400 mg/dL was an a resident making it likely an condition was occurring for a had to figure out.  director was interviewed on ad details of how the staff had Resident # 22's multiple and glucose readings and fior to EMS transport were redical director. The medical lity staff had not shared with mich would indicate Resident cted and he was unaware of with Resident # 22.  If the facility Administrator is Consultant were notified of based on findings related to the sy provided the following removal plan:  Ints who have suffered, or serious adverse outcome as	Fé	500		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG	_	(X3) DATE COMP	SURVEY LETED
		345529	B. WING _			1	C <b>12/2024</b>
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY 5201 CLARKS FORK DI RALEIGH, NC 27616	RIVE NW	1 03/	12/2027
(X4) ID PREFIX TAG			ID PREFI TAG	X (EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	where one or more by pulmonary arteries), lower extremity (a blow within the deep veins occur in the arms).  Review of Resident of Administration Record 7/10/24 at 1:43pm the notified Unit Manage blood glucose levels evidence that the phyology of Resident of Resident of Resident of Resident of Resident of Resident of Fast-acting insuling evidence that the phyology of Review of Resident of Fast-acting insuling evidence that the phyology of Resident was not of Nursing was notificated.	mbolism (long-term condition blood clots block the and thrombosis of distal bood clot condition that forms is, usually of the leg, but can be defined and the leg, but can be defined as the leg, but can be medication aide (MA #4) ar #2 that Resident #22 had registering over 400. No existing a single legistering over 400. No existing at 1:43pm. Further legistering at 1:43pm. Further legistering legistering legistering over 400. Resident that Resident #22 received legistering legister	F	600	DEFICIENCY)		
	on 7/11/24 at 4:51pr by MA #4 to be 400. #22 received 10 unit indication that the ph anything else was do Review of progress r 7/12/2024 (late entry #22's medical record	r of Nursing who was r working at the facility.  In blood glucose documented The MAR indicates Resident is of Novolog insulin. No hysician was notified, or one.  Inotes documented on for 7/11/2024), in Resident is indicate (in part); Nurse #4 due to Resident #22 blood					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345529	B. WING			C <b>09/12/2024</b>		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		19/12/2024		
				5201 CLARKS FORK DRIVE NW				
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		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	(X5) COMPLETION DATE		
F 600	from the physician to Humalog or Novologhours. After two hour glucose reading still physician made aware Resident #22's famil Resident #22 to be sevaluation. The physorder received to se documentation concorder received an order to Humalog or Novologhours. Nurse #4 indicated; she contare received an order to Humalog or Novologhours. Nurse #4 indicated; approximately 9:00 Resident #22's blood exceeded 400. She made aware of the resident #22 be physician was made approximately 9:10 preceived to send the 4 contacted EMS at EMS arrived on scenario settlements.	200. An order was received to administer ten units of and report back after 2 rs, Resident #22's blood exceeded 400 and the are of results, the note added. By arrived and requested that seent to the hospital for sician made aware, and the and resident to hospital,	F 6	00				
	elevated heart rate of	nt #22 was found with an of 140, respirations in the 40s, d reading of a blood sugar in						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345529	B. WING _			C <b>09/12/2024</b>
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP 6 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	CODE	00/12/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	
F 600	was sent to the hosp treatment, Resident approximately 9:53pi in the facility. No other than the facility of the Governing body Operation, the facility Director of Clinical S Nursing conducted the 109/06/2024, to identialleged noncompliant	e of transport. Resident #22 ital for further evaluation and #22 left the facility at m. Resident #22 is no longer er actions taken.  led by the Vice President of y Administrator, Regional ervices, and Director of ne root cause analysis on fy the causative factor for this	F	600		
	(RCA) identified the resulted from the fail (Nurse # 4) to follow practice on managing hyperglycemia for Renon-responsive on 7 identified that the facin place medication a licensed nurse responduty.  The governing body for identification for the suffer a serious according to the suffer a serious according to the facing place.	/11/2024. The RCA further illity failed to have a system aides to be informed of the insible to oversee them while put forth the following plan hose residents who are likely liverse outcome as a result of				
	measures below to a serious adverse outo On 7/11/2024, the fo completed an initial r	-				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			I ' '		RUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C <b>12/2024</b>
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	TH RALEIGH		5201 CLA	DDRESS, CITY, STATE, ZIP CODE RKS FORK DRIVE NW I, NC 27616	1 00/	12/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Resident #22. The all unsubstantiated. Per completed on 7/15/20 Resident #22 was not enforcement and Add. The former Administr at the facility. On 09/Administrator has be President of Operation to include reporting to include reporting to the facility were compliantly were compliantly with the facility were compliantly and/or Unit coordinated include, blood pressurespiration rate, temple pain. The assessment blood glucose for the diabetes with orders attending physician with Director of Nursing, All and/or Unit Coordinated identified findings of appropriate measure to activating emergent indicated.  100% audit of all curreading documented 09/07/2024 complete 09/08/2024, by the Director of Nursing, a or #2) to identify any	legation was investigation report 024, the allegation for of reported to law ult Protective Services (APS). rator is no longer employed 09/2024 the new en educated by the Vice on on reporting requirements of Law enforcement and APS.  Is of all current residents in poleted on 09/07/24 by the Assistant Director of Nursing, for (#1 or #2) to identify any the change condition that fution. The clinical for resident's vital signs to fire reading, pulse, for erature, and/or presence of for blood glucose check. The for blood glucose check. The for his informed by the for his informed	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345529	B. WING				C / <b>12/2024</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR			520	REET ADDRESS, CITY, STATE, ZIP CODE  1 CLARKS FORK DRIVE NW  LEIGH, NC 27616	1 09/	12/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 600	standards of practice person-centered care choices. Any residen in condition, the Dire physician for approprinterventions and impordered. If the identification were not previous enforcement, and Add the facility Administration by immediately suspeperpetrator, report the to the State agency, within two hours of identification and investigation Administrator will rep	rdance with professional , the comprehensive e plan, and the residents' t(s) identified with a change ctor of nursing will inform the riate measures and or olement the interventions as ied issues indicate neglect, asly reported to the state, law ult protective services (APS), ator will protect all residents ending the alleged e identified issue of neglect law enforcement, and APS lentification and initiate n, immediately. The facility	F	600				
	process or system fa	e entity will take to alter the ilure to prevent a serious m occurring or recurring, and be complete:						
	residents remain free following the facility of policy and providing standard of practice a timely manner for a condition.  Effective 09/07/2024 ensure residents recinclude assessing, m	facility will ensure all from abuse and neglect by company abuse prohibition care in accordance with and notifying the physician in any changes in resident's facility employees will eived necessary care to onitoring, addressing a identify the seriousness of a						

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 / <b>12/2024</b>	
	ROVIDER OR SUPPLIER	TH RALEIGH		5201	EET ADDRESS, CITY, STATE, ZIP CODE  1 CLARKS FORK DRIVE NW  LEIGH, NC 27616	1 03/	12/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)			(X5) COMPLETION DATE	
F 600	change in condition, initiate emergency maccordance with profipractice, the comprecare plan, and the resystemic modification implementing the following the following the following the facility. A license the facility. A license the beginning of the schedule, of his/her acertified medication at Effective 09/07/24, Director of Nursing, Weekend Supervisor Coordinator will be reschedule for nursing medication aides, an The daily schedule wo of their assignment at	and recognize the need to redical services in fessional standards of hensive person-centered sidents' choices. This in will be accomplished by owing measures:  I licensed nurses will rivices for each resident in dinurse will be informed at shift, through the daily responsibility to oversee raide(s) if any.  Director of Nursing, Assistant Unit Coordinator (#1 or #2), r., and/or Scheduling responsible to update daily staff (licensed nurses, did certified nursing aides).  Will inform each nursing staff and responsibilities to include insed nurses to oversee	F	600				
	Nursing, Assistant D Supervisor, Unit Coo Scheduling Coordina on the importance of schedule is complete responsibility of each responsibilities of the the medication aides completed by 9/8/202	trator will educate Director of irector of Nursing, Weekend ordinator #1/or #2 and ator. The education focused fensuring a daily nursing ed and indicate the innursing staff to include the elicensed nurse to oversee it. This education will be 24. Any licensed nurses de not educated by 09/08/24						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C <b>9/12/2024</b>	
	ROVIDER OR SUPPLIER	ΓΗ RALEIGH		STREET ADDRESS, CITY, STATE, ZIP COD 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		3/12/2024	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	Director of Nursing w for any newly hired, A Weekend Supervisor	work until educated. The vill complete this education Assistant Director of Nursing, Unit Coordinator #1/or #2 vinator during the orientation	F 6	00			
	will be responsible to include assessing, m change in condition, a change in conditior to initiate emergency accordance with prof practice, the comprel care plan, and the re assigned residents, a	the assigned licensed nurse provide necessary care to onitoring, addressing a identifying the seriousness of a, and recognizing the need medical services in ressional standards of the nesive person-centered sidents' choices for their and/or those assigned to the er the nurse's supervision.					
	blood glucose check, will obtain and docume each resident's medi Nurse on duty immed level less than 60, gr the physician order. It duty will assess the rand provide appropri assessing, monitoring condition, identifying in condition, and rece emergency medical sattending physician in professional standard	ds of practice, the on-centered care plan, and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING				C 12/2024
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 09/	12/2024
UNIVERSA	AL HEALTH CARE/NORT	TH 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 PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page 61		F	500			
	duty will administer mypoglycemia and/or glucagon for low blood high blood glucose, be and document the admedication in each research the per physician order, as insulin, if blood glucor resident's physician vevaluation and/or treating in the per physician order and full-time, part-time, and be completed by the Annursing, Assistant Distaff Development Country this education include importance of providing facility. The education abuse prohibition politinclude prevention of physician orders relating insulin for residents we notifying physician in orders and when the elevated blood glucostime. This education adefinition of neglect agoods and services to	hyperglycemia, including d sugar, and/or insulin for lased on physician orders ministration of such esident's clinical record.  residents with blood receive 10 units of fast log or Novolog), blood cked within 30 minutes, or after the administration of se remains over 400, will be notified for further atment. This protocol is e 09/07/2024.  I current staff to include and as needed employees will Administrator, Director of rector of Nursing, and/or coordinator. The emphasis of es but is not limited to, the also focused on facility and procedures to resident neglect by following ted to administration of with high blood glucose and accordance with physician re is an instance of sustained se levels over a period of also emphasized the is the failure to provide					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 09/12/2024
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	03/12/2024
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
F 600	Continued From page 62  This education will be completed by 09/08/2024.		F 60	00	
	Any staff members will not be allowed to Administrator, Director of Nursing, Coordinator will more of this education and	not educated by 09/09/2024, o work until educated. The tor of Nursing, Assistant and/or Staff Development hitor and track the completion d provide it for any newly ng the new hire orientation,			
	Medication aides, to and as needed nurs completed by the Di Director of Nursing, #2). The emphasis on the limited to:  1. The importance to include insulin, gl medications per phy 2. The importance assigned to a licens care including provismonitoring, address identifying the serior condition, and recogemergency medical professional standa comprehensive persthe residents' choice 3. The importance be aware of their as beginning of their sh that will indicate the oversee them)	rsician order.  of ensuring each resident is ed nurse to oversee his/her sion for assessing, ing a change in condition, usness of a change in gnizing the need to initiate services in accordance with rds of practice, the son-centered care plan, and			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  IG		E SURVEY IPLETED
		345529	B. WING _		0.9	C 9/12/2024
	ROVIDER OR SUPPLIER AL HEALTH CARE/NOR	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	, <u> </u>	
(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 SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	minutes and notifying orders.  5. The importance emergencies that recacute care center. (That any staff member indicated.)  6. The importance glucose findings in reference findings in reference flucose	ag blood sugar within 30 g physician for any other of calling 911 for medical quire medical attention at the the education emphasized er can call 911 when of documenting blood esident's medical records. And the education also note to report to the charge my blood glucose level less of 200 or based on the ecompleted by 9/8/2024. And/or medication aide not and/or Unit Coordinators (#1, track the completion of this simplete this education for any nurses and/or medication.  Seopardy removal date:  Ving was done to validate the ecopardy removal plan:  Vealed documentation etion of audits and in-service	F6			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C <b>09/12/2024</b>
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	00/12/2024
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 600	Medication Aide.  Beginning at 9:45 AM members were intervitraining the facility had to report details of the attended. Staff were whether they had wit without medical care past week for failure notification of the phywere no reports of a neglect reported for a Medication Aide, who was aware of which assigned nurse was Medication Aide to e was not in need of an A random interview of 1:35 PM with an aler resident regarding hereported no problem reported the staff were	Alon 9/12/24 multiple staff viewed regarding in-service ad provided. Staff were able eir training and validate they also interviewed regarding messed any resident go or be neglected during the of assessment and visician of changes. There lack of medical care or	F 6		
F 609 SS=D	9/9/24 was validated Reporting of Alleged CFR(s): 483.12(b)(5) §483.12(c) In respon	Violations	F 6	09	10/14/24
	§483.12(c)(1) Ensure	e that all alleged violations			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345529	B. WING _		C <b>09/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00:12:2021
				5201 CLARKS FORK DRIVE NW	
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		RALEIGH, NC 27616	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 609	Continued From page involving abuse, neglimistreatment, includir		F 6	09	
	source and misappro are reported immedia hours after the allega	priation of resident property, itely, but not later than 2 tion is made, if the events tion involve abuse or result in			
	the events that cause abuse and do not res	or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to ne facility and to other			
	the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established				
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her ative and to other officials in e law, including to the State in 5 working days of the eged violation is verified e action must be taken.			
	Based on record revireport an allegation of enforcement and adu (Resident #22) of threabuse. Findings incluing Documentation in the abuse/neglect/misappand procedures dated revealed under procedurement of report adult protective service.	facility propriation/crime policies d as effective 2/5/2023 dure, there was the ing to the state agency,		F609 Corrective actions will be accomplish for those residents found to be affected the deficient practice? Resident #22 no longer in the facility, other actions taken for resident #22 On 09/09/2024 the new Administrator been educated by the Vice President Operation on reporting requirements include reporting to Law enforcement Adult Protective Services (APS). How will you identify other residents having the potential to be affected by same deficient practice?	no has of and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILD	NG _		Ι,	_	
		345529	B. WING				C 12/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
				52	201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		R	ALEIGH, NC 27616			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTI			(X5)	
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 609	Continued From pag	ne 66	F	F 609				
					100% audit was done on 10/01/2024, t	y y		
		n initial allegation report			the facility Administrator on all Facility			
		7/16/2024 at 12:14 AM			Reported Incidents (FRI) that were			
		was made aware of an			completed and sent to the State agenc	-		
		on 7/15/2024 at 9:05 PM for irred on 7/11/2024. The			the last 30 days to ensure that they we	re		
		aled a family member of			reported to the administrator, Law enforcement, and Adult protective			
		d "resident's catheter wasn't			services. No other resident identified to	,		
		gar was high, and resident			have not been reported to the			
		uis. Eliquis was [discontinued			administrator, law enforcement, and Ad	dult		
	•   •	eged the [Certified Nursing			protective services. Findings of this aud			
	Assistant] improperly	placed briefs on the			are documented on a FRI review tool			
		as sent to [Emergency			located in the facility compliance binde			
		llegation report was blank			Measures/systemic changes will be pu	t		
		law enforcement and			into place to ensure that the deficient			
		Department of Social			practice does not recur:			
	Services adult protect	ctive services.			Effective 09/09/2024, facility Administra			
	Documentation on a	n investigation submitted to			will ensure all alleged violations involving abuse, neglect, exploitation or	ig		
		24, as the 5-day report			mistreatment, including injuries of			
		had unsubstantiated the			unknown source and misappropriation	of		
		. The investigation stated in			resident property, are reported			
		family arrived at the facility			immediately, but not later than 2 hours			
		she (Resident #22) be sent			after the allegation is made, if the even			
		leglect is unsubstantiated			that cause the allegation involve abuse			
		owing MD (medical doctor)			result in serious bodily injury, or not late			
	_	eport was blank under			than 24 hours if the events that cause t			
		forcement and notification of			allegation do not involve abuse and do	not		
		of Social Services adult			result in serious bodily injury, to the			
	protective services.				administrator of the facility and to other			
	   Documentation in a r	removal plan for F600			officials (including to the State Survey Agency and adult protective services).			
		Services for Resident #22			100% education of all key personnel in	the		
		e jeopardy level of scope and			facility to include an Administrator,			
	severity the facility a				Director of Nursing, Social workers, an	d		
		completed on 7/15/2024, the			Rehab Director will be completed by th			
		nt #22 was not reported to			Regional Director of Clinical Services.			
	law enforcement and	Adult Protective Services			emphasis of this education includes bu	t		
	(APS). The former A	dministrator is no longer			not limited the importance of reporting	any		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			09/12/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BI	D.4.T.E.
F 609	Administrator has be President of Operation to include reporting to APS."	e 67 ity. On 09/09/2024 the new en educated by the Vice on on reporting requirements o Law enforcement and rator was not available for	F	alleged violations involved neglect, exploitation or resident including injuries of unker misappropriation of residente Administrator immediator turn report to the State of enforcements and Adult services immediately, be hours after the allegation. This education will be considered by 10/14/2024 allowed to work until educated by 10/14/2024 allowed to work until education, and annually director of Clinical servithis education, and annually director of Clinical servithis education for any new effective 10/14/2024.  How will the facility morn actions to ensure that the practice is being correct recur?  Effective 10/07/2024, Recompliance with notification ensure state survey again enforcement is informed identified during this more will be addressed prompliance with notification of two more weeks, the three months or until a prompliance is maintained effective 10/07/2024, the compliance is maintained effective 10/0	mistreatment, nown source ar dent property to diately who will survey agency, t protective ut not later than is made. ompleted by ersonnel not 4 will not be ucated. The irrector of Nursing the new hire y. The Regional cies will complete w Administrate and will not be deficient ted and will not be deficient ted and will not be deficient ted and will not be will monitor ation of FRI steency, APS, and d. Any issues onitoring processiptly. This be conducted do to weeks, weeklen monthly for pattern of ed.	or in law and 2 and 3 an

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
							c
		345529	B. WING _			09/	12/2024
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH	5201 CLARKS FORK DRIVE NW				
				R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)				(X5) COMPLETION DATE
F 610 SS=D	•	orrect Alleged Violation		609 610	Administrator will report findings of this monitoring process to the facility Qualit Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or use pattern of compliance is maintained. The QAPI committee can modify this pito ensure the facility remains in substantial compliance. Compliance date: 10/14/2024	y ıntil	10/14/24
	§483.12(c) In responsing neglect, exploitation, of must:  §483.12(c)(2) Have eviolations are thoroug  §483.12(c)(3) Prevent neglect, exploitation, of investigation is in progression in progression in the adesignated represent accordance with State Survey Agency, within incident, and if the alloappropriate corrective This REQUIREMENT by:	se to allegations of abuse, or mistreatment, the facility vidence that all alleged hly investigated.  It further potential abuse, or mistreatment while the gress.			F610		
	family, staff, and physensure a thorough inv	ew, and interviews with sicians the facility failed to restgation was conducted n allegation of neglect for			Corrective actions will be accomplished for those residents found to be affected the deficient practice?		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			71. 501251	_		، ا	С
		345529	B. WING				12/2024
NAME OF PE	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2024
	10 113 211 011 001 1 21211				201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH			RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC 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 610	Continued From page	e 69	F	610			
	· -	of one sampled resident			Resident #22 no longer in the facility, r	10	
	,	a complaint of neglect.			other actions taken for resident #22		
		y member filed an allegation			On 10/07/2024 the new Administrator h	nas	
		ving an anonymous phone			been educated by the Vice President of		
	_	2 needed to be sent to the			Operation on the company abuse		
	hospital. Interviews r	evealed the anonymous			investigation policy to include the		
		by a medication aide when			importance initiating a thorough interna	ıl	
	she feared the reside	ent was about to die and was			investigation of the alleged/suspected		
	not receiving medica	I care while under the care of			occurrence, the education emphasized	on	
		with the medication aide			the investigation protocol to include, but	ıt	
		eviously reported concerns			not be limited to, collecting evidence,		
	regarding Nurse # 4 not responding to an emergeny situation and former administration did				interviewing alleged victims and witnes	s,	
					and involving other appropriate		
	not investigate. The f	indings included:			individuals, agents, or authorities.		
	Daview of the feeilitui	la malian amiilad			How will you identify other residents		
	Review of the facility	s policy entitled sappropriation/ Crime			having the potential to be affected by the same deficient practice?	ie	
	_	ents/ Investigations" revealed			100% audit was done on 10/01/2024, k	<b>N</b> /	
		ely initiate a thorough			facility Administrator on all Facility	у	
	_	of the alleged/suspected			Reported Incidents (FRI) that were		
		estigation protocol will			completed and sent to the State agence	v in	
		nited to, collecting evidence,			the last 30 days to ensure that they we		
		l victims and witness, and			thoroughly investigated to include, but		
		priate individuals, agents, or			limited to statement(s) from the alleged		
	authorities.				perpetrator and/or victims. Findings of	this	
					audit are documented on a FRI		
	Documentation on ar	n Emergency Medical			investigation review tool located in the		
	, , .	rt dated 7/11/2024 revealed			facility compliance binder.		
		7 PM for Resident # 22 while			Measures/systemic changes will be pu	t	
		cility. EMS arrived at the			into place to ensure that the deficient		
		2 at 9:37 PM. The following			practice does not recur:		
		aled in the EMS report.			Effective 09/09/2024, facility Administra		
		scene, the facility staff stated			will ensure all alleged violations involvi	ng	
		en having an elevated blood			abuse, neglect, exploitation or		
	•	and had been alert but not			mistreatment, including injuries of	of	
		ne facility staff also told EMS Resident #22 insulin as			unknown source and misappropriation	UI	
		dent's physician with no			resident property, are thoroughly investigated, to include statement from		
	_	na level of High on the			the alleged perpetrator, and/or witness		

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	
		345529	D. WING_			09/	12/2024
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH		52	201 CLARKS FORK DRIVE NW		
0111121107				R	ALEIGH, 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 BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	<del>2</del> 70	F 6	310			
F 610	glucose monitor. EMS glucose reading of Hi as well. EMS docume having a heart rate of 40s. Once in the amb remained unresponsition on a language of the transport of the transpo	Sonoted Resident #22 had a gh on their glucose monitor ented Resident #22 as a 140 with respirations in the relations, Resident #22 we.  Inospital record dated for a revealed Resident #22 was as, hyperglycemia, altered renal failure, dehydration, rection in the emergency  ducted with the responsible and #22 on 9/3/2024 at 3:42 information was provided. The checked on Resident #22 win and she was okay. The week from the facility. On PM to 8:00 PM she saw she alls on her phone. She then to one. It was from a private on the phone did not identify the RP, " You need to come	F	610	if any.  Effective 09/09/2024, the facility Administrator will report the results of a investigations to the State Survey Ager within 5 working days of the incident, a if the alleged violation is verified appropriate corrective action will be take by the administrator based on facility policies and procedures.  100% education of all key personnel in facility to include an Administrator, Director of Nursing, Social workers, and Rehab Director will be completed by the Regional Director of Clinical Services. Emphasis of this education includes but not limited the importance of completing thorough investigation for any alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. Education emphasized that the investigation will be led by the Administrator who will in turn report to result of the investigation to the State survey agency within 5 working days. This education will be completed by 10/14/2024. Any key personnel not educated by 10/14/2024 will not be allowed to work until educated. The Administrator, and/or Director of Nursir will complete this education for any new hired key personnel during the new hire orientation, and annually. The Vice president of Operation will complete this education for any new Administrator.	ncy, nd the the g a	
		the doctor back in two ned angry because the ent #22 sent to the			effective 10/14/2024.  How will the facility monitor its corrective	/e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI		(X3) DATE SURVEY COMPLETED		
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		345529	B. WING _			1	12/2024
NAME OF P	ROVIDER OR SUPPLIER	1		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				5201	CLARKS FORK DRIVE NW		
UNIVERS	AL HEALTH CARE/NOR	RTH RALEIGH		RAL	EIGH, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	emergency room. Si responding the fami Resident #22 be ser finally Nurse #4 calles services (EMS). Late called the RP wantir from the facility to lenot well. The RP state anonymous phone of grateful she was conthe life of Resident #5 former Administrator former Administrator facility had learned to member had noted a earlier that day. The maintained that they know if Resident #2 levels, which did not had known that Resilevels were running would have wanted checked. She felt the neglected and she had ministrator about Review of Resident documentation Resilextreme lethargy ho and that her pupils we documentation writted Assistant (PTA) #1 and per found for the goals. [Resident #22] demonstrating] extremumbling, [nonrespot to bright light. PTA and per found for the goals. [Resident #22] demonstrating] extremumbling, [nonrespot to bright light. PTA and per found for the goals.]	ince Resident #22 was not ly member insisted that int to the emergency room and ed emergency medical er that night the interim DON ing to know who had called her it her know Resident #22 was ited she did not know who the caller was, but she was intacted as it may have saved #22. The RP talked to the rabout her concerns and the rabout her concerns and the rabout her resident informed the RP that the chat a physical therapy staff is change in the resident former Administrator radid not have to let the family 2 had elevated blood glucose it make sense to her. If she ident #22's blood glucose high for several days she her sent to the hospital to be resident had been in the former all of her concerns.  # 22's record revealed dent # 22 was incoherent with urs prior to EMS being called would not react to light. The en by the Physical therapy at 3:58 PM on 7/11/24 at 3:58 facilitated that [Resident #22] the purpose of attempting	F 6	a profession of the control of the c	actions to ensure that the deficient practice is being corrected and will not ecur?  Effective 10/07/2024, Regional Directo Clinical Services (RDCS), and/or Vice President of Operation will monitor compliance with investigation of all FRI to ensure the investigation is thorough, and appropriate measures are taken to exploitation, or mistreatment while the exploitation, or mistreatment while the exploitation is in progress. Any issuest dentified during this monitoring process will be conducted of Monday to Friday for two weeks, week for two more weeks, then monthly for three months or until a pattern of compliance is maintained.  Effective 10/07/2024, the Facility Administrator will report findings of this monitoring process to the facility Quality Administrator will report findings of this monitoring process to the facility Quality Administrator of compliance is maintained. The QAPI committee can modify this process to the facility remains in substantial compliance.  Compliance date: 10/14/2024	r of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C <b>9/12/2024</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	TH RALEIGH		STREET ADDRESS, CITY, STATE 5201 CLARKS FORK DRIVE NV RALEIGH, NC 27616	, ZIP CODE	9, 12, 232 1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 610	#4], [Director of Nurs Therapist/Occupation regarding [Resident Continue [with plant documentation, according a comparison of the continue [with plant documentation, according a comparison of the continue [with plant documentation of the continue	dility to arise from d head. Nursing [Med Aide sing], [Physical nal Therapist] notified #22's] decrease in status. of care.]" The PTA #1 ording to the RP, had been diministrator as having resident was not well prior to 9:17 PM without any aken.  Inducted with PTA #1 on PTA #1 revealed the PTA #1 stated she did not she went to see Resident TA #1 confirmed she found onresponsive condition on to the Med Aide on the hall, of Nursing, the Physical pational therapist to let them for Resident #22.  Insident #22's July 2024 ration record (MAR), orders, revealed elevated blood onsecutive days prior to the ferred by EMS on 7/11/24 in a with multiple blanks on the mould have been ders.  Inducted with MD #2, the multiple could not recall if he was ed blood glucose levels of	F	510			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
				_		(	2	
		345529	B. WING			09/	12/2024	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	TH RALEIGH		5:	TREET ADDRESS, CITY, STATE, ZIP CODE 201 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 610	MA (Medication Aide 9/3/24 at 10:55 AM a AM and reported the person who had and 22's RP. She had be heard staff talking ab to go to glory." She w # 22, but she was co her to pass away. She knew the resident was to do something, and playing Gray's Anatomind her own busine administrative staff ir 4 had not responded and nothing was don Resident # 22's RP to needed to come righto Resident # 22 needed following morning, she had called the fact Administrator, "No," I anything before. She for going outside her reported that she had Administrator, Unit M when Resident # 21 responding and had That had been a few Nurse # 4 did not resident was on 6/28/24. On the domain of the did not resident was on 6/28/24. On the did not provide write with the provide write with th	) # 3 was interviewed on and again on 9/9/24 at 10:14 following. She had been the nymously called Resident # en working that night and rout the resident was "about was not assigned to Resident neering and did not want are did not think the family as sick. She asked Nurse # 4 If Nurse # 4 told her to "quit my (a television show) and ress. She had reported to a previous times that Nurse # in an emergency situation re. Therefore, she called to let the RP know she to a way to the facility because to to go to the hospital. The re was asked about whether mily by the former	F	610				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C <b>09/12/2024</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	'H RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		00712	7202-
(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 PLAI ( (EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 610	Administrator had suffive- day report regard to Nurse # 4 and Res allegation had been in in the report findings, state agency, did it m had been observed b responding hours bef while the resident had Nurse # 4. The Admithere had been no ne resident.  The facility Nurse Cor 9/11/24 at 11:52 AM a information. The Admiresponsible for the inneglect by Nurse # 4, He had looked and for staff regarding alleger. Nurse # 4 had cared Resident # 22. The N interviewed regarding the Administrator had Resident # 22 was not the PTA documentation that the resident was before transport and a Administrator could his he did if a thorough when the former Admid documentation that the responding hours ear facility Nurse Consult say how the previous	ed on 7/19/24 the former omitted to the state agency a ding alleged neglect related ident # 22. The neglect nitiated by the RP. No where which was submitted to the ake note that the resident y therapy staff to not be ore EMS was finally called dibeen under the care of nistrator had concluded glect substantiated for the estigation into alleged was no longer at the facility. From the consultant was interviewed on and reported the following inistrator, who had been westigation into alleged was no longer at the facility. From the consultant was interviewed on the formed in the record not responding how for Resident # 21 and the properties of the properties of the properties of the properties of the former ave come to the decision investigation had been done inistrator was aware of the	F	310			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG	COMP	(X3) DATE SURVEY COMPLETED	
		345529	B. WING_			C 1 <b>2/2024</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOI			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		12/2024	
(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 CORRE  (EACH CORRECTIVE ACTION SHO  CROSS-REFERENCED TO THE APP  DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 624 F 624 SS=D	Preparation for Safe CFR(s): 483.15(c)(7) §483.15(c)(7) Orien discharge. A facility must provi preparation and orie	de/Orderly Transfer/Dschrg  The property of th	F 6			10/14/24	
	facility. This orienta form and manner th understand. This REQUIREMEN by: Based on record re family interviews the resident for home h	NT is not met as evidenced eview, staff interviews, and e facility failed to refer a ealth services and order int for 1 of 1 resident reviewed dent #6).		F624 What corrective actions will be accomplished for those residents be affected by the deficient practi Resident #6 is no longer in the fa How will you identify other reside having the potential to be affected	ice? icility. ints		
	7/25/24 with diagnoral disease.  Resident #6's admis (MDS) assessment was cognitively inta symptoms or behave	Imitted to the facility on ses including cerebrovascular ssion Minimum Data Set dated 7/31/24 revealed she ct. She had no mood riors. She was coded as ge to the community.		same deficient practice?  100% of all planned discharges to community for the last 30 days we audited on 10/07/2024 by the Ass Administrator to identify any other residents who were sent home we preparation for a safe/orderly transfer/discharge.  What measures will be put into play what systemic changes will your	ere sistant er iithout lace or		
	Review of the disch indicated that Resic from the facility on 8 summary was signe discharge summary had been recomme assistance with acti	arge summary dated 8/26/24 lent #133 was discharged 8/26/24. The discharge ed by Social Worker #2. The rindicated a rollator walker nded. Home Health vities of daily living and home apy had been recommended		ensure that the deficient practice recur?  Effective 10/07/204, the facilities administration team including soc services, and assistant administration resumed the process of reviewing discharges for the last 24 hours a from the last clinical meeting to in safe and orderly discharge has be	cial ator, g and/or nsure a		

PRINTED: 10/22/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345529	B. WING _			09/	12/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
LIMINEDO	N. LIEALTH CARE/NORT	THE DATE OF THE STATE OF THE ST		5	5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	HRALEIGH		F	RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 624	Continued From page	e 76	F 6	624				
	by the physical therap				up for residents who are discharged to	the		
	by the physical therap	olot.			community. This systemic process will	1110		
	An interview was con-	ducted with Resident #6's			take place Monday through Friday. Any	,		
		28/24 at 2:47 PM who stated			identified issues will be addressed	′		
	_	ed home on 8/26/24 but			promptly. This process will be			
	_	equipment the resident			incorporated into the daily clinical			
	might need when she	got home. The resident			meeting.			
		and the family had asked			Assistant Administrator will re-educate			
		port chair and some sort of			social worker on the importance of			
	lift. The facility had n				completing discharge planning			
		dical equipment. Once			psychosocial assessment and implement	ent		
	home, the family member communicated with Social Worker #1, and he tried to assist with				the discharge planning/preparation			
		equipment arranged. She			process that focuses on the resident ☐s discharge goals, with the resident as the			
		managed to care for the			active partners for effectively transition			
	· ·	ordered home health nurse			the discharge location. The education			
		ipment. She further stated			emphasized that; discharge care plan	4100		
	-	sical therapist had come and			must be developed on admission base	d		
	seen the resident on				on resident⊡s desires. This education completed on 10/14/2024 and will be	is		
	Record review reveal	ed no lift had been			added on the new hire orientation for a	II		
	recommended by the	facility physical therapist.			new social worker.			
					How will the facility monitor its corrective	/e		
	A physician's order fo	r Resident #6 dated 8/29/24			actions to ensure that the deficient			
		licated an order for a referral			practice is being corrected and will not			
	for home healthcare,	occupational and physical			recur?			
	therapy.				Effective 10/07/2024, Assistant			
					Administrator and Social Worker will			
	Social Worker #2 was	s unavailable for interview.			monitor compliance with preparing a sa	ate		
	An interview was son	ducted with Social Worker			and orderly discharge. Any issues	_		
		PM. He stated he was not			identified during this monitoring proces will be addressed promptly. This	S		
		arge planning for Resident			monitoring process will be conducted or	lailv		
		g to assist the family with			Monday to Friday for two weeks, week			
		ent had been discharged.			for two more weeks, then monthly for			
		ted he was not sure what			three months or until a pattern of			
		to plan for Resident #6's			compliance is maintained.			
	discharge. He stated	•			Effective 10/14/2024, Assistant			
		member to help facilitate			Administrator will report findings of this			

Facility ID: 20040007

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 _			1	C 12/2024	
	ROVIDER OR SUPPLIER	H RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		1 03/	12/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 635 SS=D	An interview was cond Nurse Consultant on a stated he was not awardischarge planning. It was new to the facility place to ensure discharge planning syfuture.  Admission Physician CFR(s): 483.20(a)  §483.20(a) Admission At the time each residemust have physician cimmediate care.  This REQUIREMENT by:  Based on family interview.	ued From page 77 nealth services on 8/28/24.  review was conducted with the Corporate Consultant on 8/31/24 at 11:30 AM and he he was not aware of the issues with rge planning. He stated Social Worker #1 review to the facility and was putting systems in one ensure discharge planning occurred as d. The Corporate Nurse Consultant when Worker #2 returns to the facility those rge planning systems will be utilized in the sion Physician Orders for Immediate Care p: 483.20(a)  O(a) Admission orders time each resident is admitted, the facility ave physician orders for the resident's iate care. EQUIREMENT is not met as evidenced  I on family interview, record review, staff ews, and emergency medical services  F 624  monitoring process to the facility Assurance and Performance Improvement Committee for any additional monitoring or modificat this plan monthly for three month a pattern of compliance is maint The QAPI committee can modify to ensure the facility remains in substantial compliance. Compliance date 10/14/2024.  F 635  F 635  F 635  Corrective actions accomplished		Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or u a pattern of compliance is maintained. The QAPI committee can modify this pi to ensure the facility remains in substantial compliance.  Compliance date 10/14/2024.	until	10/14/24		
	reviewed for admission included:  There was no docume medical record of Reshospital discharge surby the facility on 7/10/discharge summary, 1/10/2024 hospital stand the discharge diamuscle weakness, chage related physical of	entation in the electronic sident #4 other than the mmary dated as uploaded (2024. The hospital or the 7/3/2024 to ay, revealed Resident #4 gnoses of generalized ronic lymphocytic leukemia,			Resident #4 no longer in the facility, no other actions taken for resident #4 Identification of other residents having potential to be affected by the same deficient practice:  100% of all new admission to the facilit for the last 30 days were audited on 10/07/2024 by the Director of Nursing, Assistant Director of Nursing, and/or ur coordinator (#1 or #2) to identify any ot resident with no admission orders. No other resident identified. Findings of the audit are documented on the new	the Ty nit ther		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF FI	NOVIDER OR SUFFLIER					
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE NW		
				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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 635	Continued From pag	e 78	F 63	5		
	discharge summary l	tack (stroke). The hospital isted an expected charge but did not include		admission order audit tool local facility compliance binder.  Measures/systemic changes wi into place to ensure that the de practice does not recur:	ill be put	
	There was no documadmission document medical record to indobtained for Resident An interview was commember of Resident PM. The family meminformation about the facility. Resident #4 at the facility on 7/10/20 was paralyzed and wown. Resident #4 was facility from an oxygelike a jet engine and aide told the family the hall know of the concentrator. The nu down to the room so the desk to seek her	dentation of any orders or any ation in the electronic licate initial orders were t #4 from a facility physician.  Inducted with the family #4 on 8/28/2024 at 12:53 ber provided the following e stay of Resident #4 in the arrived from the hospital at 024 at 5:30 PM. Resident #4 was unable to move on his is receiving oxygen at the en concentrator that sounded was very loud. The nurse for concern for the oxygen ree for the hall never came the family member went to assistance. The nurse at the		Effective 10/07/2024, an admitt licensed nurse on duty will reviduscharge summary and transcorders to resident smedical reinclude medication orders and orders that are necessary for in care in the facility. Any identifie immediate care that is not includischarge summary will be comto the facility attending physicial immediately for clarification.  Effective 10/07/2024, the Clinic leadership team, which consists DON, ADON, Minimum Data set Unit coordinators (#1, #2), and/nurse, modified the review produce admission/readmission to the review include all residents in the facility and leave before the	ew hospital ribe all ecords to other nmediate d need for ided in the nmunicated in eal s of the et (MDS), for wound cess for ensure that who arrive the next	
	desk told the family r would be down to the minute and that she we moment. The family with the fa- nobody had come to was receiving adequal Resident #4 called for back to the hospital at Resident #4 was being on a stretcher the nu	nember of Resident #4, she eroom to help them in a was very busy at that stated at that point Resident acility for several hours and assess him or make sure he ate oxygen. The family of or EMS to take Resident #4 at approximately 7:00 PM. As any wheeled out of the facility rese at the desk told the they did not feel welcome in		clinical meeting and validate the resident had an admission orde immediate care. Additionally, if any immediate care needs not on the discharge summary, the team will validate the clarification obtained from the discharging from and/or resident sattending phermiology. Any finding documented on the daily clinical form and maintained in the dail meeting binder.	ose ers for there are included clinical on was facility ysician. ed into the ngs will be al meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345529	B. WING	· · · · · · · · · · · · · · · · · · ·	09	/12/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
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UNIVERSA	AL HEALTH CARE/N	ORTH RALEIGH		RALEIGH, NC 27616			
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F 635	Continued From p	page 79	F 63	25			
	AM with Nurse #2 Resident #4 on 7, #2 stated she ren facility was receiv Nurse #2 reveale admission paperv was a licensed pr registered nurse of she did not do an initial documental registered nurse of assist her with ad did not go down to but did speak to t resident to return  Nurse Aide (NA); at 4:14 PM. NA #1 nurse aide who w Resident #4. NA; already in bed who did not know whe facility. NA #5 sta	#5 was interviewed on 8/29/2024 5 revealed she was an agency as assigned to care for #5 stated Resident #4 was arrived for work, so she n the resident arrived at the ted the oxygen concentrator in		DON, ADON, and/or Staff de coordinator will complete 100 education for all licensed nui include full time, part time, at employees (PRN). The empleducation will be the importate ensuring each resident has a order for immediate care. The also emphasized that these should, at a minimum, included medications (if necessary) at care to maintain or improve the resident should a comprehensive assessment and develop an interdisciplinary care plan. The will be completed by 10/14/2 licensed nurses not educated 10/14/2024 will be taken off until educated. This education implemented in new hire originates.  Monitoring of corrective actions.	0% of rses to nd as needed hasis of this ance of admission are education orders de dietary, nd routine the s until staff ve his education 2024. Any d by the schedule on will also be entation for		
	the room for Resident #4 was making a loud rumbling noise and was aggravating the resident. NA #5 stated she was trying to be helpful, so she went looking for another oxygen concentrator and located one in another resident's room. NA #5 stated she did not know anything about oxygen concentrators, so she went to ask the nurse at the desk (Nurse #2) for assistance. Nurse #2 said she was too busy to come to the room, so NA #5 revealed she asked a Medication Aide on another hall for assistance.			that the deficient practice is I corrected and will not recur:  Effective 10/14/2024, DON a will monitor compliance with order transcription for immed reviewing the daily clinical m to ensure completion and va clinical team validated each the admission orders in reside electronic medical records. I monitoring process will be confused to the control of the control	and/or ADON admission diate care by neeting reports lidate that the resident had dent s This completed daily		
		9/3/2024 at 12:13 PM. Med		(Monday through Friday) for weekly for two more weeks,			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345529	B. WING			(	
	201/1252 02 01/221/52	345529	D. WING		TREET ARRESTS OF A STATE THE CORE	09/	12/2024
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH			201 CLARKS FORK DRIVE NW		
				R	RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 635	Aide #3 was a medica hall to the hall for whi Aide #3 went to the ro NA #5 requested assi concentrator because was too loud. Med Aid the hospital were laying Resident #4 she assucalled into the facility #3 stated she thought oxygen concentrator #3 stated she tried to bottle on another oxygen concentrator and the state of the sta	following information. Med ation aide on an adjoining ich Resident #4 resided. Med from of Resident #4 because istance with an oxygen at the oxygen concentrator de #3 stated the orders from ing in a folder in the room of from the hospital. Med Aide it the physician orders for the were in that folder. Med Aide hook up the humidifier gen concentrator, but ggling a little to breathe. The MS before she could get an centrator to work.  ducted with Unit Manager #2 difficult admitting residents in the facility was trying to redical record database to rer #2 stated she was only #2 and an issue with an as the family was ready to int. Unit Manager #2 concentrator for Resident #2 is louder than normal. Unit resident #4 was not in the building and was calm and it is the orders for the care of inducted with the facility nurse	F	635	for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Direct of nursing promptly. This monitoring process will be documented on a Admission orders review monitoring too located in the facility compliance binder Effective 10/14/2024, Director of Nursing 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 for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.  Compliance date 10/14/2024.	e tor ol r. ng e	
		024 at 7:58 AM. The facility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE COMF	SURVEY PLETED
		345529	B. WING				C 12/2024
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	TH RALEIGH		52	TREET ADDRESS, CITY, STATE, ZIP CODE 201 CLARKS FORK DRIVE NW ALEIGH, NC 27616	, 50.	
(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 635	beginning of July 202 unable to locate any information regarding #4.	e 81 mission process in the 24 and he confirmed he was additional documentation or g the admission of Resident		635			
F 655 SS=E	Planning §483.21(a) Baseline §483.21(a)(1) The far implement a baseline that includes the instruction of the professional that meet professional that meet professional the baseline care plate (i) Be developed with admission.  (ii) Include the minimal necessary to properly including, but not limit (A) Initial goals based (B) Physician orders.  (C) Dietary orders.  (D) Therapy services.  (E) Social services.  (F) PASARR recommal §483.21(a)(2) The factor of the comprehensive care care plan if the complex (ii) Is developed with admission.  (iii) Meets the required	Care Plans cility must develop and e care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. an must- in 48 hours of a resident's  um healthcare information y care for a resident ited to- d on admission orders.	F	3555			10/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENITIEICATION NILIMBED:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C <b>9/12/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	L	<del>'</del>	STREET ADDRESS, CITY, STATE, ZIP CODE		3/12/2024	
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	TH 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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 655	Continued From page	e 82	F 6	55			
F 655	§483.21(a)(3) The faresident and their report the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fon behalf of the facilit (iv) Any updated infor of the comprehensive This REQUIREMENT by:  Based on record revistaff interview the factor person-centered bases summary to the residing party within 48 hours #6, Resident #7, Resident #7, Resident #7, Resident #7 was a 8/19/2024 with multipincluded:  1. Resident #7 was a 8/19/2024 with multipincluded Type 2 Diab malnutrition, gastrost kidney disease stage.  Documentation in the Minimum Data Set (Minitiated on 8/20/2024 address discharge plants)	decility must provide the presentative with a summary plan that includes but is not at the resident.  If the resident.  If the resident is medications and a treatments to be accility and personnel acting by.  If the resident interview, and interview, and interview, and interview, and interview, and interview is not met as evidenced a length of admission for 3 (Resident interview) interview. If the facility on the diagnoses some of which the etes, protein calorie to omy status, and chronic and interview is a care plan written by the and interview is a care plan coordinator in the facility of the facility on the diagnoses some of which the etes, protein calorie to omy status, and chronic and for Resident #7 did not interview is not interview.	F 6	F655 What corrective actions will be accomplished for those resider be affected by the deficient pra Resident #6 is no longer in the Resident #7 is no longer in the Resident #10 is no longer in the How will you identify other resi having the potential to be affect same deficient practice? 100% audit was done on all rest the facility by the Minimum dat nurse on 10/01/2024 to ensure have a baseline care plan in ple comprehensive care plan compute facility electronic health result what systemic changes will be put into what systemic changes will you ensure that the deficient practiceur? Effective 10/07/2024, an admit licensed nurse on duty will con	nts found to actice? facility. facility. e facility. dents cted by the sidents in a set (MDS) e that they face or pleted in cords. o place or u make to ce does not		
	was coded as previou	nitively intact. Resident #7 usly, prior to current illness, t with self-care, mobility,		admission/readmission data co in electronic health records, the automatically develop a baselii	at will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER:  A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345529	B. WING _			09/	12/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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UNIVERSA	AL HEALTH CARE/NORT	HRALEIGH		R	RALEIGH, NC 27616		
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F 655	Continued From page	≥ 83	F 6	655			
F 655	stairs, and functional coded as requiring suassistance for all activadmission to the facili which he required parameters are the facility hich he required parameters are the facility hich he required parameters are the facility hich here are the facility and the facility and the facility to be unbeared had to. Resident #7 stated here facility to be unbeared had to. Resident #7 ereturn home and no low the facility to be unbeared had to. Resident #7 ereturn home and no low atching television. For a social worker a courto go home but heard stated nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody had dishim and nobody lister wanted to go home nobody lister wanted to	cognition. Resident #7 was abstantial or maximal vities of daily living upon ity, except for eating, for ritial or moderate assistance.  ducted with Resident #7 on /2024 at 10:24 AM and again 3 AM for follow-up questions. Ithe following information. Is greatest desire was to go cknowledged that when he illity, he required a lot of help are resident #7 stated that he walk around, catheterize at, and drink on his own, and of daily living needs. It is found the food at the ble, but he ate it because he expressed he wanted to onger sit in the facility resident #7 revealed he told ple of days ago he wanted and in Income in the resident #7 scussed his care plan with the dwhen he told them he ow.  Occupational therapist note ten by the Rehabilitation evealed, "[Resident #7] in arrival in room. [Resident #7] and in made aware of [Resident #7] and made aware of [Resident #7] made aware of [Resi	F	655	plan care plan for each resident that we includes the instructions needed to provide effective and person-centered care of the resident that meet profession standards  Effective 10/07/2024, the Clinical leadership team, which consists of the DON, ADON, Minimum Data set (MDS Unit coordinators (#1, #2), and/or wour nurse, modified the review process for new admission/readmission to ensure the review include validation that admission/readmission data collection is completed, and hence baseline care plan is developed for all residents who was admitted to the facility in the last 2 hours or from the last clinical meeting. This process will be incorporated into the daily clinical meeting. Any negative findings will be addressed promptly and documented on the daily clinical meeting form and maintained in the daily clinical meeting binder.  DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as need employees (PRN). The emphasis of the education will be the importance of ensuring admission/readmission data collection tool is completed and hence baseline care plan is developed. The education also emphasized that; basel care plan should include the minimum healthcare information necessary to properly care for a resident including, the not limited to; Initial goals based on	onal ), nd that tool 4 he d ng il t	
	stated nobody had discussed his care plan with him and nobody listened when he told them he wanted to go home now.  Documentation in an occupational therapist note dated 8/27/2024, written by the Rehabilitation Services Manager, revealed, "[Resident #7] in bed upon this writer's arrival in room. [Resident #7 informed his writer that [Medical Director] told him yesterday that nursing to remove catheter. Resident #7] educated on plan of [treatment] and [Interdisciplinary team] made aware of [Resident #7] requesting a [discharge] care plan."				coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as need employees (PRN). The emphasis of the education will be the importance of ensuring admission/readmission data collection tool is completed and hence baseline care plan is developed. The education also emphasized that; basel care plan should include the minimum healthcare information necessary to properly care for a resident including, but the second control of the education also emphasized that including, but the education also emphasized that is t	ded nis a ine out	

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 _			09/	12/2024
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F 655	Continued From pa	age 84	F	655			
F 655	Rehabilitation Serv 11:15 AM. The Rel explained on 8/28// request of Residen interdisciplinary teameeting. The Rehaexplained that hom services would have to go home, and the not in the morning to let him know of the Resident #7. The Find Manager stated Rel have a "jump start" meeting within 48 facility. The Rehabstated she did not start meeting for Resident #7 Rehabstated she would in Worker know to be Resident #7 now the attention by the sur to go home.	rices Manager on 8/29/2024 at habilitation Services Manager 2024 she discussed the at #7 to go home with the am during the morning abilitation Services Manager are health services and therapy are to be set up for Resident #7 to facility Social Worker was meeting on 8/28/2024 for her he request to go home of Rehabilitation Services are plan and the services of the illitation Services Manager receive any notice of a jump resident #7 and she did not illitation Services Manager receive any notice of a jump resident #7 and she did not illitation Services Manager remediately let the Social gin discharge planning for not it had been brought to her reveyor how urgently he wanted	F	855	services, and Preadmission Screening and Resident Review (PASARR) recommendation, if applicable. Monitoring of corrective actions to ensithat the deficient practice is being corrected and will not recur:  Effective 10/07/2024, the Administrato Assistant Administrator, DON and/or ADON will monitor compliance with baseline care plan completion by validating its completion in electronic health records and validate that the clinical team had verified each new admitted resident had a completed admission/readmission data collection that triggers baseline care plan in resident selectronic medical records. This monitoring process will be completed aily (Monday through Friday) for two weeks, weekly for two more weeks, the monthly for three months, or until the pattern of compliance is established. A negative findings will be addressed by Director of nursing promptly. This monitoring process will be documented.	tool eted en any the	
	Worker on 8/29/20 Worker revealed it employment at the	24 at 2:51 PM. The Social was his second week in facility. The Social Worker meeting was held within 42			a Baseline review monitoring tool loca in the facility compliance binder. Effective 10/14/2024, Director of Nursi will report findings of this monitoring	ted	
	hours of admission explain goals and of with the resident of Worker stated he will care plan conferent conferences prior to facility. The Social start meeting was leading.	during which a nurse would discharge would be discussed their family. The Social was unsure who was setting up ces or jump start care plan to his employment at the Worker did not know if a jump held for Resident #7. The ed he immediately started			process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensithe facility remains in substantial compliance.	ng	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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F 655	(8/29/2024) since it by the Rehabilitation Social Worker stated home health service equipment delivery the Worker stated the faresident #7 hostage cried and hugged his able to go home.  An interview was conceased by the modern of the modern	ons for Resident #7 that day was brought to his attention a Services Manager. The did he was working to set up is and durable medical for Resident #7. The Social acility was not holding and revealed Resident #7 im when he found out he was inducted with the facility 8/30/2024 at 8:23 AM. The sted he did not attend the for Resident #7 and he did not Resident #7 to obtain his sees. The Dietary Manager is had a family emergency he jump start meeting for inducted with the MDS/Care 8/30/2024 at 9:53 AM. The redinator stated baseline care and by the unit managers	F 6	Compliance date 10/14/2024.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	ULTIPLE CONSTRUCTION  LDING			(X3) DATE SURVEY COMPLETED	
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F 655	Continued From page Resident #6's admis (MDS) assessment was cognitively intack.  Resident #6 was distand a review of the refacility failed to have baseline care plan.  An interview was complant Coordinator on MDS/Care Plan Coordinator on MDS/Care Plan Coordinator on MDS/Care Plan Coordinate was were generated during the admission MDS/Care Plan Coordinated the base #6.  An interview was composed to consultant on 8/31/2 nurse consultant act problems with the act 2024. He stated pi	ge 86 sion Minimum Data Set dated 7/31/24 revealed she ct.  charged home on 8/26/24 medical record revealed the documented evidence of a  inducted with the MDS/Care 8/30/2024 at 9:53 AM. The ordinator stated baseline care and by the unit managers	F	1				
	7/22/24 with diagnost osteoarthritis and an admitted to the hosp readmitted to the factor of the fac	xiety disorder. Resident was vital on 8/17/24 and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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MDS/Care Plan Coording plans were generated during the admission MDS/Care Plan Coording he created the base #10.  An interview was conconsultant on 8/31/2 nurse consultant and problems with the accompleted.  F 656 SS=E  Develop/Implement CFR(s): 483.21(b)(1)  §483.21(b) Compreted §483.21(b)(1) The fair implement a compression for each recreased plan for each recreased plan for each recreased plan for each recreased trights set for §483.10(c)(3), that is objectives and times medical, nursing, and needs that are identical assessment. The condescribe the following (i) The services that or maintain the resident physical, mental, and required under §483.(ii) Any services that under §483.24, §483. provided due to the	a 8/30/2024 at 9:53 AM. The ordinator stated baseline care ed by the unit managers in assessments. The ordinator was unable to recall seline care plan for Resident and ordinator was unable to recall seline care plan for Resident and ordinator was unable to recall seline care plan for Resident and ordinator was unable to recall seline care plan for Resident and ordinator was unable facility had dission process in July rocesses were being to baseline care plans were accomprehensive Care Plan (1)(3)  The sive Care Plans accility must develop and develop and develop and develop and develop ensive person-centered desident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial diffied in the comprehensive care plan must are are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and the would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights using the right to refuse		656		10/14/24	

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			
		345529	B. WING _		C <b>09/12/2024</b>
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	1 00/12/2021
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F 656	rehabilitative service provide as a result of recommendations. I findings of the PASA rationale in the reside (iv) In consultation we resident's represent (A) The resident's good desired outcomes.  (B) The resident's post future discharge. Fast whether the resident community was assolical contact agencial entities, for this purpose, f	services or specialized es the nursing facility will of PASARR f a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the ative(s)- oals for admission and reference and potential for acilities must document t's desire to return to the essed and any referrals to es and/or other appropriate	F 6:	F656  What corrective actions will be accomplished for those residents be affected by the deficient practice. Resident #1 has had her care plaupdated to include the issues relaskin and refusal of care by MDS 10/08/2024.  Resident #2 has had his care plaupdated to include the issues related to the issues related to the issues related to the issues related to include the issues related to the	ice? In lated to lates on late

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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F 656	Continued From page 89		F	656			
	included:			skin to by MDS nurse on 10/08/2024.			
	3/1/17 and had diagn	admitted to the facility on oses in part which included			Resident #6 is no longer in the building		
	_	muscular disease and			Resident #16 is no longer in the buildin	ıg.	
	bipolar disorder with	pipolar disorder with psychotic features.			How will you identify other residents having the potential to be affected by the	ne	
	Resident # 1's quarterly Minimum Data Set				same deficient practice?	.0	
	assessment, dated 6/19/24, coded Resident # 1				100% audit was done on 10/1/2024 of		
	as cognitively intact a				residents by the MDS nurse to ensure		
		r bathing, dressing, hygiene, e resident was not coded as			comprehensive care plans were in place for all residents.	е	
	refusing care during t				ioi dii residents.		
	assessment.	·			What measures will be put into place o		
					what systemic changes will you make t		
		ehensive care plan was not acility's new medical record			ensure that the deficient practice does recur?	not	
		ne into effect in July 2024.			Effective 10/07/2024, following the		
		ded a copy of the resident's			completion of Omnibus Budget		
		plan from the previous			Reconciliation Act (OBRA) required		
	I .	cord. Review of this provided			Minimum Data Set (MDS) assessment		
		noted to be active and			the MDS nurse will develop/review and		
	1	ed no identification of the dent distrusted new staff			revise a comprehensive person-center care plan for each resident that include		
	'	tal illness and that his could			measurable objectives and timeframes		
		of care. There were no			meet a resident's medical, nursing,	.0	
	interventions to direct	t staff in how to deal with this			mental, and psychosocial needs that a	re	
	issue.				identified in the assessment.		
					Administrator will re-educate MDS		
	,	) Nurse Practitioner # 1			nurse(s) on the importance of developi	-	
	I .	Resident # 1 and noted the			and/or revising comprehensive care plate for each resident following the complet		
	_	She was a bedbound ng seen for follow up after			of OBRA required assessments. The	1011	
		s) had been identified in her			education also emphasized that;		
	right hand/fingers and				comprehensive care plan should be		
		en provided and an antibiotic			person-centered with measurable		
		al antibiotics had been			objectives and timeframes to meet a		
	initiated also. At the t	ime NP # 1 saw the resident			resident's medical, nursing, mental, an	d	
the resident had no agitation or anxiety and was				psychosocial needs that are identified i	n		

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F 656	Continued From pag	e 90	F 6	56			
	right hand fingers, ar	re was mild swelling of her nd fingers 3 to 4 were tender no drainage or redness.		the assessment. This education completed on 10/7/2024 and when the new hire orientation for MDS pursue.	vill be added		
	and reported the folloprior to Resident # 1 8/13/24 (Tuesday) a the resident had been hurting. She had a condition Aides said the resident times.  The weekend treatmes 8/31/24 at 9:30 AM a information. She (the saw Resident # 1's he saw Resident # 1's he cared for a small resident's fingernails.	iewed on 8/30/24 at 5:45 PM being. During the weekend being seen by the NP on and the maggots being found, in complaining of her hand contracted hand. The Nurse ent would refuse care at ent nurse was interviewed on and reported the following weekend treatment nurse) and on 8/11/24 (Sunday) and I puncture wound where the had been against the skin. used to have her nails or. There were no maggots		MDS nurses.  Monitoring of corrective action that the deficient practice is be corrected and will not recur:  Effective 10/07/2024, Administrator, DON ADON will monitor compliance comprehensive care plan by vompletion in electronic health following the completion of OE assessment. This monitoring pube completed twice weekly for weekly for two more weeks, the for three months, or until the pompliance is established. Any findings will be addressed by the nurse promptly. This monitoring property.	trator, and/or with alidating its records BRA process will two weeks, en monthly eattern of y negative the MDS		
	at that time.  Nurse Aide # 2, who for Resident # 1 on 8 interviewed on 8/29/2 the following information been providing care the resident and in haresident would at time she did not know the trying to provide care NA # 3, who at times interviewed on 8/29/2 the following information witnessed maggots it did know the resident	had been assigned to care 8/12/24 (Monday), was 24 at 7:47 PM and reported tion. On 8/12/24 she had when she saw maggots on er bed. Prior to 8/12/24, the les refuse care to her hand if e staff member well who was 25.		will be documented on a Care monitoring tool located in the f compliance binder.  Effective 10/14/2024, Assistan Administrator and/or MDS nurreport findings of this monitoring to the facility Quality Assurance Performance Improvement Coany additional monitoring or mof this plan monthly for three nuntil a pattern of compliance is maintained. The QAPI commit modify this plan to ensure the remains in substantial compliance date 10/14/2024.	plan review facility  at se will ng process se and ammittee for nodification months, or se ittee can facility		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG	(XS	(X3) DATE SURVEY COMPLETED	
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UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		
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F 656	at times.  Resident # 1 was into AM and went from to conversation in a ram morning the resident appeared as an oran her gown which appeor sweet potatoes. In following this observation allow the previous when it was soiled with the allow the previous when it was soiled with the resident had been informed that the 26 maggots removed considered to be cog some mental illness. It onon-existent peopl (NP # 1) tried to talk the resident was doin to keep snacks in her some food in her hand then flies could have eggs. It did not take I resident tended to not did not know them. Tillness. If she had refisome new staff mem to refusal of hygiene. talking to the resident relationship could contains the could contain the resident relationship could contains the could contain the resident relationship could contains the could contain the resident relationship could contains the contains the resident relationship could contain the resident relationship cou	erviewed on 8/29/24 at 8:20 pic to topic in her abling manner. At this time of was observed to have what ge vegetable food item on eared similar to soft carrots atterview with NA # 3 directly ation made on 8/29/24 at a eresident may have refused shift to change the gown	F	656		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F 656	8/30/24 at 9:54 AM information. He had the other care plan/assessment nurse whe was not familiar know who would ha him for developing a resident's refusal of He did think that if a that it should be add 2. Record review re admitted to the facil diagnoses included heart failure, a histo stroke. The resident peripheral neurofibr that can lead to mul Resident # 2's signi Set assessment, da resident was also as dependent on staff in needs, and bathing Review of Resident had been updated or resident required as daily living due to contour medical connoted the resident was also as dialy living due to contour medical connoted the resident was also as daily living due to contour medical connoted the resident was assist the resident was assist the resident was assist the resident was also as daily living due to contour medical connoted the resident was assist the resident was assist the resident was assist the resident was also and the resident was also as daily living due to contour medical connoted the resident was assist the resident was assist the resident was also as daily living due to contour medical connoted the resident was assist the resident was also as daily living due to contour medical connoted the resident was also as daily living due to contour medical connoted the resident was also as daily living due to contour medical connoted the resident was also as daily living due to contour medical connoted the resident was also as dependent on staff was a single properties.	an nurse was interviewed on and reported the following just started in June 2024 and MDS (Minimum Data Set) was also new and in training. with Resident # 1 and did not we been responsible prior to a care plan to address the care due to distrust of staff. It resident was refusing care dressed on the care plan.  It was also new and in training. with Resident # 1 and did not we been responsible prior to a care plan to address the care due to distrust of staff. It resident was refusing care dressed on the care plan.  It was also had a diagnosis of congestive bry of spinal stenosis and at also had a diagnosis of comatosis (a genetic condition tiple skin tumors).  If it can the change Minium Data and the diagnosis of congestive beto to be totally for bed mobility, hygiene needs.  If also had a diagnosis of congestive heart failure and additions. The care plan also was incontinent of bladder and the directed on the care plan to	F 6	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	<b> </b>	03/12/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	drainage. Some of the good to clean his beach to the changed day his current Nurse good, and she had have to lie in the Resident # 2's responsively. The was also and this helped whe shower, but that was lit depended on who whether his soiled lie if his back was wash drained.  Nurse Aide # 1 was 4:40 PM and reported back would drain and found his linens the for him on initial rou drainage and in need routinely bathed, dried showers was aware and the showers was aware and the for him on initial round his linens and directions a	Id lie on the sheets in the he Nurse Aides were very lick and change his linens. Would not wash his back and lines were okay and did not lines as they cared for him. That line Aide (NA # 1) was very nelped change his linens and was washed so that he would	F 6	56		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345529			` ′	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED  C 09/12/2024	
		B. WING _		_		
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	TH RALEIGH		STREET ADDRESS, CITY, 5201 CLARKS FORK DR RALEIGH, NC 27616		03/12/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)	
F 656	frequency of his linendrainage from the tun.  The facility's care plate 8/30/24 at 9:54 AM at information. He was a areas on his back due neurofibromatosis. He resident was very foothe had requested to he because of the areas part not to have including this problem on the cain June 2024 and the nurse who was new a nurse was being train a lot for him to do. It we before he started to we care plan nurse positis several weeks. He we coordinating and deveresidents before he apresent time he was a list of care plans.  3. Resident # 16 was 6/17/24. One of the reurinary retention.  Review of Resident # Data Set assessment the resident an indwere revealed no mention care of the indwelling.	n nurse was interviewed on and reported the following aware Resident # 2 had be to his diagnosis of the was also aware the sused on his back, and that have a bath every day. It was an oversight on his ded specific care related to the following are was one other care plan also. The other care plan also. The other care plan also. The other care plan also was his understanding that work in June 2024 that the find had been vacant for the following the care plans for the following the followi	F	656		
		orders on 8/29/24 revealed or the care of the catheter.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 09/12/2024
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	· · · · · ·	3371272024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	Continued From paç	ge 95	F 6	56		
	(RP) on 8/28/24 at 3 routinely saw a urold catheter was to be of had not been done a after he was admitted communication was to be done for the result of the facility's care play 8/30/24 at 9:54 AM information. The cartification of the was not far he was not sure who was sold of the facility of the was not sure who was cognitively into symptoms or behavior planning to discharge Review of the resider revealed no mention return to the communication of the communication of the resider revealed no mention return to the communication of the resider revealed no mention return to the communication of the resider revealed no mention return to the communication of the resider revealed no mention return to the communication of the resider revealed no mention return to the communication of the resider revealed no mention return to the communication of the resider revealed no mention return to the communication was considered as a considered revealed no mention return to the communication was not such as a considered revealed no mention return to the communication was not such as a considered revealed no mention return to the communication was not such as a considered revealed no mention return to the communication was not such as a considered revealed not return to the communication was not such as a considered revealed not return to the communication was not such as a considered revealed not return to the communication was not such as a considered revealed not return to the communication was not such as a considered revealed not return to the communication was not such as a considered revealed not return to the communication was not such as a considered revealed not return to the communication was not such as a considered revealed not return to the communication was not such as a considered revealed not return to the considered revealed not return to the communication was not such as a considered revealed not return to the communication	very poor about what needed esident's urinary catheter.  an nurse was interviewed on and reported the following to of the resident's indwelling and be addressed on the care miliar with the resident, and to had devised his care plan.  So admitted to the facility on sees including cerebrovascular targed to the community on the set of the community on the set of the community.  So admitted to the facility on sees including cerebrovascular targed to the community on the set of the community.  So admitted to the facility on sees including cerebrovascular targed to the community on the community on the community.  So admitted to the facility on sees including cerebrovascular targed to the community on the community on the community.  So admitted to the facility on sees including cerebrovascular targed to the community on the community.  So admitted to the facility on sees including cerebrovascular targed to the community on the community on the community.  So admitted to the facility on sees including cerebrovascular targed to the community on the community on the community on the community.  So admitted to the facility on sees including cerebrovascular targed to the community on the community on the community on the community.  So admitted to the facility on sees including cerebrovascular targed to the community on				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C <b>09/12/2024</b>		
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	E			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 656	The facility's care pla 8/30/24 at 9:54 AM a facility social workers planning goal on the would not do it.  Care Plan Timing and CFR(s): 483.21(b)(2)  §483.21(b) Comprehe §483.21(b)(2) A complete (i) Developed within 7 the comprehensive at (ii) Prepared by an inincludes but is not lim (A) The attending phy (B) A registered nurse resident.  (C) A nurse aide with resident.  (D) A member of food (E) To the extent practice the resident and their resident reprotopracticable for the resident's care plan.  (F) Other appropriate disciplines as determ or as requested by the	n nurse was interviewed on and reported sometimes the would place the discharge care plan and sometimes he discharge care plan must or days after completion of essessment.  It determines the discharge care plan must or days after completion of essessment.  It days after completion of essessment.  It discharge care plan must or days after completion of essessment.  It days after completion of essessment.	F	556		10/14/24		
	comprehensive and cassessments.	ssment, including both the quarterly review  is not met as evidenced						

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			1	C 12/2024
NAME OF P	ROVIDER OR SUPPLIER	5 11025		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	12/2024
					201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH			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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	e 97	F	657			
	Based on record review, staff interview, and family interview the facility failed to include the				F657		
		care plan to address			What corrective actions will be		
		Resident # 6 and # 17) and			accomplished for those residents found	d to	
	over all medical care	needs (Resident # 16). This sampled residents whose			be affected by the deficient practice?		
		ere interviewed about			Residents #6 and #16 are no longer in	the	
	medical care at the fa	icility. The findings included:			facility.		
	1. Resident # 16 was	admitted to the facility on			Resident #17 has a care plan meeting	is	
	6/17/24. Two of the resident's diagnoses included urinary retention and congestive heart failure.				scheduled to be conducted on		
					10/08/2024. The Facility invited resider		
		40.			#17, and resident #17□s family membe	∍r.	
		16's admission Minimum					
		t, dated 6/20/24, revealed			How will you identify other residents		
	indwelling urinary cat	nitively impaired and had an			having the potential to be affected by the same deficient practice?	ie	
	mawelling unitary can	neter.			same dendem practice?		
		nt's care plan, dated 8/9/24,			100% audit was done on 10/7/2024 of		
		of the urinary catheter or the			residents in the facility to identify if they		
	care of the indwelling				had a care plan meeting held in the las		
	physician orders on 8				30 days. The audit wad completed by t	he	
		he care of the catheter.			facility social worker and/or Assistant		
		entation the responsible			Administrator. Any resident identified	loot	
	meeting.	d and involved in a care plan			without a care plan involvement in the 30 days, will have a care plan meeting	ası	
	Ü	mt # 401- m m - m - ibl - m - mt -			conducted by 10/14/2024.		
		nt # 16's responsible party			What magazras will be put into place o	_	
	, ,	29 PM revealed he had n any type of care plan for			What measures will be put into place o what systemic changes will you make t		
		concerns regarding how the			ensure that the deficient practice does		
		the resident's indwelling			recur?	1101	
		garding the facility staff			10001:		
		and weights related to his			Effective 10/07/2024, the facility social		
	_	s ordered by the physician.			worker will utilize OBRA required MDS		
		ommunication was very			assessment schedule to set up care pla		
		out what needed to be done			meeting monthly. Social worker(s) will		
		nought a care plan session			review the schedule for the upcoming	I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _				C 1 <b>12/2024</b>	
NAME OF PI	ROVIDER OR SUPPLIER	, <b>L</b>		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2024	
				52	01 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH	RALEIGH, NC 27616					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From pag	e 98	F6	657				
1 007	would help but one him to attend.  The facility's care pla 8/30/24 at 9:54 AM a information. The care urinary catheter should plan. He (the care place facility and had start familiar with Resident who had devised his a social worker who was supposed to be families with care place.	an nurse was interviewed on and reported the following e of the resident's indwelling ald be addressed on the care an nurse) was new to the ed in June 2024. He was not at # 16 and he was not sure care plan. There had been was now on leave and who inviting and coordinating ans. He was not sure why ponsible Party had not been		007	month and send care plan invitation let to residents and resident representative solicit the participation of the resident at the resident's representative(s).  Effective 10/07/2024, facility social wor will be in charge of coordinating care preetings that include the participation the resident and the resident's representative(s) if all practical. The facility social worker will document an explanation in a resident sendical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident scare planation.	e to and ker lan of		
	2. Resident #17 was 8/13/2024 with multipincluded blindness in dementia, cancer, ar Documentation on a Set (MDS) assessme Resident #17 as have cognition, range of misides of upper and loincontinence of bladdincontinent of bowel.  Documentation on a 8/14/2024 and revise coordinator on 8/20/2 had a focus area for interventions include movements and refe	admitted to the facility on ple diagnoses some of which in right and left eyes, and Type 2 diabetes.  In Admission Minimum Data ent dated 8/19/2024 coded ring moderately impaired notion impairment on both ower extremity, occasional der, and frequently  I care plan initiated on ed by the MDS/Care Plan 2024, revealed Resident #17 incontinence of bladder. The			Administrator and Assistant Administra will re-educate MDS nurse and social worker on the importance of developing and/or revising comprehensive care plate of OBRA required assessments, and the importance of involving resident and resident representative on care plan development through implementation of care plan meeting process specified above. This education is completed on 10/14/2024 and will be added on the new hire orientation for all new MDS nurses and social workers.  Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:	tor g an ion ne of		
	plan revealed a focus	s area for the resident's rention was for administration			Assistant Administrator, DON and/or ADON will monitor compliance with car	·e		

345529	B. WING		l c		
		B. WING		C <b>09/12/2024</b>	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	03/1/	2/2024	
TWINE OF THOUBER ON OUT FIELD					
UNIVERSAL HEALTH CARE/NORTH RALEIGH		5201 CLARKS FORK DRIVE NW			
		RALEIGH, NC 27616			
(X4) ID SUMMARY STATEMENT OF DEFICIENCI PREFIX (EACH DEFICIENCY MUST BE PRECEDED B TAG REGULATORY OR LSC IDENTIFYING INFORM	Y FULL PREF	· · · · · · · · · · · · · · · · · · ·	HOULD BE	(X5) COMPLETION DATE	
F 657 Continued From page 99	F	657			
of medications as ordered. An additional area on the care plan was for Resident # for falls with one of the interventions bein remind the resident to use their call light of assistance with activities of daily living.  The responsible party (RP) for Resident # interviewed on 8/28/24 at 3:09 PM. Resident 27's RP reported she had multiple concertabout care issues. These were regarding resident being placed in a pull up, medicate being late, and a lack of response to the activities his care, and she did not understance. At that point the RP expressed she just wanted Resident #17 to be moved to another facility.  An interview was conducted with the facility Worker on 8/29/2024 at 2:51 PM. The Soward Worker revealed it was his second week employment at the facility. The Social Worker was currently at the RP for Resident #17's request, but for insurance reasons it was proving difficult alternate placement. The Social Worker scare plan conference could be set up, but for Resident #17 just wanted alternate platernate placement. The Social Worker scare plan conference could be set up, but for Resident #17 just wanted alternate platernate placement. The Social Worker scare plan conference could be set up, but for Resident #17 just wanted alternate platernate platern	focus 17's risk g to to ask g. #17 was lent # rns the ations call bell. ng to and why ust ther  ity Social cial in orker o care t at the aware of r to find stated a t the RP acement  S/Care M. The ocial y of care olanning.	plan involvement by validating of care plan meetings following in plan schedule. This monitoring plan schedule. This monitoring pwill be completed twice weekly for two more week monthly for three months, or untipattern of compliance is establis negative findings will be address. Assistant Administrator promptly monitoring process will be docur a Care plan involvement review monitoring tool located in the factompliance binder.  Effective 10/14/2024, Assistant Administrator and/or social work report findings of this monitoring to the facility Quality Assurance Performance Improvement Comany additional monitoring or modof this plan monthly for three mountil a pattern of compliance is maintained. The QAPI committed modify this plan to ensure the factompliance date 10/14/2024.	che care corocess or two cks, then il the hed. Any sed by the r. This mented on cility  er will process and mittee for diffication onths, or ee can cility		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 09/12/2024		
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		03/12/2024		
(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 CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 657	#17.  3. Resident 6 was a 7/25/24 with diagnor disease. She was on 8/26/24.  Resident #6's admi (MDS) assessment was cognitively inta planning to discharge revealed no mention. There was no docu Responsible Party involved in a care planting to discharged on 8/17. The RP stated she was told the resider on 8/24/24. The RI was very poor at the bedone for the resideron for the residered on the resi	are plan meeting for Resident admitted to the facility on ses including cerebrovascular discharged to the community assion Minimum Data Set dated 7/31/24 revealed she ct. She was coded as ge to the community.  ent's care plan, dated 8/1/24, in of discharge planning. mentation Resident #6, or the (RP) had been invited and	F6	· · · · · · · · · · · · · · · · · · ·				
	8/30/24 at 9:54 AM information. He (the the facility and start familiar with Reside who had devised hi	lan nurse was interviewed on and reported the following e care plan nurse) was new to ed in June 2024. He was not nt # 6, and he was not sure s care plan. There had been o was supposed to be inviting						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345529	B. WING			l	C / <b>12/2024</b>
	ROVIDER OR SUPPLIER	H RALEIGH		520	REET ADDRESS, CITY, STATE, ZIP CODE 01 CLARKS FORK DRIVE NW 1LEIGH, NC 27616	1 09	12/2024
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	not sure why Resider Party had not been in	ilies with care plans. He was nt # 6 or their Responsible volved in the plan of care.		657			10/11/04
F 660 SS=D	§483.21(c)(1) Dischar The facility must devereffective discharge plon the resident's discording fresidents to be actitransition them to postereduction of factors learned fresidents are identified development of a discresident are identified development of a discresident.  (ii) Include regular residentify changes that discharge plan. The coupdated, as needed, (iii) Involve the interdiby §483.21(b)(2)(ii), in developing the discharge in the resident of the resident's or operson(s) capacity and required care, as part discharge needs.  (v) Involve the resident representative in the edischarge plan and in resident representative in the edischarge plan and in resident representative.	rge Planning Process elop and implement an anning process that focuses tharge goals, the preparation we partners and effectively st-discharge care, and the eading to preventable cility's discharge planning sistent with the discharge .15(b) as applicable and- charge needs of each and result in the charge plan for each evaluation of residents to require modification of the discharge plan must be to reflect these changes. sciplinary team, as defined in the ongoing process of arge plan. er/support person availability caregiver's/support and capability to perform and the identification of that and resident development of the form the resident and are of the final plan. ent's goals of care and		660			10/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			D MANO				
		345529	B. WING			09/	12/2024
NAME OF PR	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	TH RAI FIGH	5201 CLARKS FORK DRIVE NW		5201 CLARKS FORK DRIVE NW		
ONIVERSA	AL IILALIII CANL/NONI	MALLIGH			RALEIGH, NC 27616		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	DATE
F 660	Continued From page	e 102	F	660			
	· -	resident has been asked	'				
	about their interest in						
	regarding returning to	_					
		icates an interest in returning					
	· ,	e facility must document any					
	referrals to local conta	-					
	appropriate entities m	•					
	(B) Facilities must up	date a resident's					
		plan and discharge plan, as					
		nse to information received					
		contact agencies or other					
	appropriate entities.						
		e community is determined					
		e facility must document who					
	made the determinati						
		no are transferred to another					
		narged to a HHA, IRF, or					
	LTCH, assist resident						
	T	lecting a post-acute care					
		a that includes, but is not					
		IRF, or LTCH standardized					
	patient assessment d	• •					
		on resource use to the extent The facility must ensure that					
	the post-acute care s						
		ta on quality measures, and					
		is relevant and applicable to					
	the resident's goals o						
	preferences.	die and treatment					
		lete on a timely basis based					
	, ,	ds, and include in the clinical					
		of the resident's discharge					
		plan. The results of the					
	_	iscussed with the resident or					
		tive. All relevant resident					
	information must be in						
		ilitate its implementation and					
		delays in the resident's					
	,	-					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	343323		STREET ADDRESS, CITY, STATE, ZIP CODE	09/12/2024	
NAME OF FI	NOVIDER OR SUFFLIER					
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE NW		
				RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 660	Continued From page	e 103	F 66	0		
	by: Based on record rev	Γ is not met as evidenced iew, staff interview, and		F660		
		e facility failed to implement		What corrective actions will be	4 -	
		e planning process for one		accomplished for those residents fou		
		resident who wished to		be affected by the deficient practice?	I	
	discharge from the fa	Cility.		Resident #7 is no longer in the facility How will you identify other residents	′·	
				having the potential to be affected by	tho	
	The findings included	ŀ		same deficient practice?	uie	
	The findings included			100% audit was done on 10/7/2024 of	of all	
	Posidont #7 was adr	mitted to the facility on		residents admitted in the facility for the	I	
		ole diagnoses some of which		last 30 days to validate each residen	I	
	included Type 2 Diab			a completed discharge planning	. 1105	
		omy status, and chronic		psychosocial assessment in the facili	tv	
	kidney disease stage			electronic health records by the facili		
	Mariey discuse stage	. 0.		social worker and/or Assistant	·y	
	Documentation in the	base line care plan written		Administrator.		
		Set (MDS) /Care plan		Administrator.		
	_	on 8/20/2024 revealed there		100% audit was done on 10/7/2024 o	nf all	
	was no documentation			residents in the facility by the Assista		
		urn to the community.		administrator to ensure that each res	I	
	J 9- F	<b>,</b>		has a comprehensive care plan inclu		
	Documentation on ar	n admission Minimum Data		discharge plan documented on a		
		ent dated 8/25/2024 revealed		discharge care plan. Any resident		
		nitively intact. Resident #7		identified without a discharge care pl	an,	
	_	usly, prior to current illness,		the facility social worker will develop	I	
		t with self-care, mobility,		discharge plan of care based on		
		cognition. Resident #7 was		resident⊡s desires.		
	coded as requiring su	~				
		vities of daily living upon		What measures will be put into place	or	
	admission to the facil	ity, except for eating, for		what systemic changes will you make	e to	
	which he required pa	rtial or moderate assistance.		ensure that the deficient practice doe recur?	s not	
	An interview was con	ducted with Resident #7 on		Effective 10/07/2024, a facility social		
	an initial tour on 8/28	/2024 at 10:24 AM and again		worker and/or assistant social worker	will	
	on 8/29/2024 at 11:08	8 AM for follow-up questions.		complete the discharge psychosocial		
		I the following information.		assessment that include the provision	I	

CENTER	3 FOR MEDICARE &	WEDICAID SERVICES				CIVID IVC	<del>7. 0930-0391</del>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(	
		345529	B. WING _			09/	12/2024
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LININGERO	AL LIEALTH CAREAGO	TH BALFIOLI		52	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	IH RALEIGH		R	ALEIGH, NC 27616		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY 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 660	Continued From pag	e 104	F	660			
	· ·	is greatest desire was to go			discharge planning section that specify	,	
		cknowledged that when he			the discharge location for each residen		
		cility, he required a lot of help			medical equipment arrangements, and		
		. Resident #7 stated that he			home healthcare arrangements. This		
		walk around, catheterize			assessment will be completed on		
		as eating and drinking on			admission/readmission and quarterly		
	his own, and meeting	g his own activity of daily			afterward and with any changes in		
	living needs. Resider	nt #7 stated he found the			discharge planning.		
	food at the facility to			Effective 10/07/2024, the Clinical			
		Resident #7 expressed he			leadership team, which consists of the		
		ne and no longer sit in the			DON, ADON, Minimum Data set (MDS	, .	
		vision. Resident #7 revealed			Social worker, Unit coordinators (#1, #2		
		er a couple of days ago he			and/or wound nurse, modified the revie		
	_	out heard nothing back.			process for new admission/readmission		
		obody listened when he told			ensure that the review include validation		
	them he wanted to g	o nome now.			that discharge psychosocial assessme is completed, and discharge care plan		
		occupational therapist note			developed for all residents who were		
		tten by the Rehabilitation			admitted to the facility in the last 24 ho	urs	
		evealed, "[Resident #7] in			or from the last clinical meeting. This		
		s arrival in room. [Resident			process will be incorporated into the da		
		r that [Medical Director] told			clinical meeting. Any negative findings		
		ursing to remove catheter. ed on plan of [treatment] and			be addressed promptly and documente on the daily clinical meeting form and	ea	
	-	n] made aware of [Resident			maintained in the daily clinical meeting		
	#7] requesting a [disc	= -			binder.		
	#1] requesting a false	onargej care plan.			Assistant Administrator will re-educate		
	An interview was cor	nducted with the			social worker on the importance of		
		es Manager on 8/29/2024 at			completing discharge planning		
		bilitation Services Manager			psychosocial assessment and implement	ent	
		24 she discussed the			the discharge planning process that		
	-	#7 to go home with the			focuses on the resident⊡s discharge		
	interdisciplinary team	-			goals, with the resident as the active		
		ilitation Services Manager			partners for effectively transition to the		
	explained that home	health services and therapy			discharge location. The education also		
		to be set up for Resident #7			emphasized that; discharge care plan		
		facility Social Worker was			must be developed on admission base		
		eeting on 8/28/2024 for her			on resident⊡s desires. This education	is	
	to let him know of the	e request to go home of			completed on 10/14/2024 and will be		

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 1 <b>12/2024</b>	
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2024	
					5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH			RALEIGH, NC 27616			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 660	Continued From page	e 105	F 6	660				
	Resident #7. The Rel	nabilitation Services			added on the new hire orientation for a	.II		
	Manager stated she	did discuss with the therapy			new social worker.			
	services team what the	ne needs of Resident #7			Monitoring of corrective actions to ensu	ıre		
	would be if he were to	o go home. The			that the deficient practice is being			
		es Manager indicated it was			corrected and will not recur:			
		rker who would have to set						
	up discharge plannin	g for Resident #7 and she			Effective 10/7/2024, Assistant			
	indicated she would g	go directly to the Social			Administrator and Social Worker will			
	Worker to let him kno	w of the request for			monitor compliance with discharge			
	Resident #7 to go home.				planning. This monitoring process will I			
					accomplished by reviewing the comple	tion		
		ducted with the facility Social			of discharge planning psychosocial			
		at 2:51 PM. The Social			assessment for all new			
		as his second week in			admission/readmission and quarterly.	∖ny		
		cility. The Social Worker			issues identified during this monitoring			
	stated he immediatel				process will be addressed promptly. T			
	1	dent #7 that day (8/29/2024)			monitoring process will be conducted of	-		
	since it was brought t				Monday to Friday for two weeks, week	i <b>y</b>		
		es Manager of his desire to			for two more weeks, then monthly for			
		. The Social Worker stated			three months or until a pattern of			
	_	g up home health services			compliance is maintained.			
		equipment delivery for			Effective 10/14/2024, Assistant			
		lay (8/29/2024). The Social			Administrator and/or social worker will			
	Worker stated the fac	and revealed Resident #7			report findings of this monitoring proce	SS		
		when he found out he was			to the facility Quality Assurance and Performance Improvement Committee	for		
	able to go home.	i when he lound out he was			any additional monitoring or modification			
	able to go nome.				of this plan monthly for three months, or			
	Δn interview was con	ducted with the MDS/Care			until a pattern of compliance is	<i>n</i>		
		3/30/2024 at 9:53 AM. The			maintained. The QAPI committee can			
		dinator stated it was the role			modify this plan to ensure the facility			
	of the Social Worker				remains in substantial compliance.			
	planning.	,9-			Compliance date 10/14/2024.			
F 677	· <del>-</del>	or Dependent Residents	F	677			10/14/24	
SS=D	CFR(s): 483.24(a)(2)			J. 1				
	§483.24(a)(2) A resid	ent who is unable to carry						
		living receives the necessary						
		•						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY PLETED
		345529	B. WING			C 1 <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	12/2024
				5201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 677	Continued From page	e 106	F 67	7		
	personal and oral hyg This REQUIREMENT by: Based on record rev resident, family, and	good nutrition, grooming, and giene; is not met as evidenced iew, and interviews with staff the facility failed to seived assistance with		F677 What corrective actions will be accomplished for those residents for	ound to	
	of four residents revienceds being met. The	-		be affected by the deficient practice Resident #2 was assessed by the U Coordinator #1 on 10/7/2024 for an or symptoms of distress for missing	Jnit ly signs J	
	Record review revealed Resident # 2 was admitted to the facility on 10/27/23. The resident's diagnoses included in part a history of congestive heart failure, a history of spinal stenosis and stroke.			assistance for activities of daily livir care). No signs or symptoms of distincted for resident #2 Identification of other residents hav potential to be affected by the same deficient practice:	tress	
	Set assessment, date resident as moderate resident was also ass dependent on staff to needs, toileting need	cant change Minium Data ed 8/22/24, coded the ely cognitively impaired. The sessed to be totally or bed mobility, hygiene s, and bathing needs. He frequently incontinent of		100% observation of residents in the facility completed on 10/07/2024 by ADON, Unit coordinator #1, #2 and scheduler to validate all residents reassistance of daily living care included incontinent care. This audit is document to ADL audit tool located in a facility compliance binder  Measures/systemic changes will be	/ DON, /or eceives ding mented	
	had been updated or resident required ass daily living due to cor chronic medical cond noted the resident wa	t 2's care plan revealed it 7/18/24 to include that the istance with his activities of ngestive heart failure and litions. The care plan also as incontinent of bladder and e directed on the care plan to th care.		into place to ensure that the deficie practice does not recur:  Effective 10/07/2024 facility will ensure that any resident who is unable to out activities of daily living receives necessary services to maintain good nutrition, grooming, and personal, a oral hygiene. These systemic change.	sure carry the od and ges will	
	PM and reported the often had to wait to b	erviewed on 8/28/24 at 3:50 following information. He e changed when he was id been a recent incident		be accomplished by implementing to following measures:  Effective 10/07/2024, facility scheduler.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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		345529	B. WING _		0	9/12/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LIMIVEDO	NI HEALTH CARE/NOR	TH DAI EICH		5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	TH KALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From pag	e 107	F 6	77			
	himself with both urin called his sister to le requested help and a	ed for hours and had soiled ne and stool. He routinely t her know when he had any problems getting help.		ensure adequate staffing neces assure each resident in need o assistance to maintain good nu grooming, personal, and oral h receive such services in a time	f ADL itrition, ygiene		
	8/28/24 at 1:43 PM a information. Resident changed. He would do and she would take incident on 8/18/24 varound 8:30 AM lettit to be changed. He had the her that same day at that they had just changed had not had enough Consultant reported 300/400 halls was 600 Nurse Aide # 8 was 1 PM and reported the 8/18/24 there were consultant was 600 PM and reported the 8/18/24 there were consultant reported the 8/18/24 t	If the facility corporate Nurse that the census on the 6 on the date of 8/18/24.  Interviewed on 9/3/24 at 7:20 of following information. On only two Nurse Aides for the		All nurses and CNAS will be ed the DON, ADON, Unit Coordina #2) on answering call bells in a manner, and provide necessary to maintain good nutrition, groupersonal and oral hygiene, as wincontinent care for all resident unable to carry out activities of This education will be complete 10/14/2024. Any licensed staff educated by 10/14/2024, will not allowed to work until educated. Monitoring of corrective actions that the deficient practice is beicorrected and will not recur: Effective 10/14/2024, the medic coordinator will audit, and interresidents chosen from each un	ducated by ator (#1, timely y services oming, and well as s who are daily living. ed by not be s to ensure ing cal records view 3 it, twice		
	been assigned to Re reported regarding n was true. The Nurse were so many reside care that it was just i # 2 sooner than she rounds for hygiene a Nurse Aides had to presidents for the breather with the co 8/31/24 at 12:00 PM currently working on	hall and 400 hall. She had esident # 2 and what he of receiving incontinent care. Aide reported that there ents for whom they had to impossible to get to Resident did. In addition to making and incontinent care, the two bass out trays and feed akfast and lunch meal.  The porate Nurse Consultant on revealed the facility was staffing and trying to hire for the red in the standard		weekly, and ask them if they had their call bells answered in a tirmanner and received ADL care incontinent care if applicable. To done for two weeks, weekly for weeks, then monthly for three runtil a pattern of compliance is maintained.  Effective 10/14/2024, Director of will report findings of this monit process to the facility Quality A and Performance Improvement Committee for any additional mor modification of this plan mor three months, or until a pattern	mely to include This will be two months or  of Nursing oring ssurance t nonitoring othly for		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345529	B. WING _				C <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	IL/LULT
				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	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	e 108	F6	677			
	multiple administrativ weeks.	e staff members in recent			compliance is maintained. The QAPI committee can modify this plan to ensuthe facility remains in substantial compliance.  Compliance date: 10/14/2024	ıre	
F 684 SS=K	Quality of Care CFR(s): 483.25		F 6	84			10/14/24
	applies to all treatment facility residents. Bas assessment of a resident residents received accordance with professor practice, the comprehessor plan, and the resident resid	ndamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of inensive person-centered sidents' choices.  This is not met as evidenced siew, staff interviews, services (EMS) interview, physician interviews, the facility staff were made and a blood glucose level of the (Glucagon is a manmade made by the pancreas that levels) per standing orders; ly respond to a medical ended glucose level of 38 and the hospital records indicated of oundly hypoglycemic. Interview in the level falls too low for bodily Severe hypoglycemia may			F684 Corrective actions accomplished for the residents found to be affected by the deficient practice:  1. Resident #16 no longer in the facil no other actions taken for resident #16 2. Resident #21 was assessed by the Assistant Director of Nursing on 09/06/2024 for any clinical signs of hypoglycemia. No signs of hypoglycemwere noted. 3. Resident #22 is no longer in the facility. No other actions taken for resident #22.  Identification of other residents having potential to be affected by the same deficient practice: Clinical assessments of all current	ity, e nia lent	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 50.25	_	<del></del>	(	
		345529	B. WING				12/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
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F 684	Continued From page	e 109	F	684			
		400 mg/dL over two days;			residents in the facility were completed	on	
		ssess and monitor the			09/07/24 by the Director of Nursing,	•	
	-	a physician who oversaw			Assistant Director of Nursing, and/or U	nit	
		accurately appraised of her			coordinator (#1 or #2) to identify any of		
		he facility failed to effectively			resident with the change condition that		
		emergency when Resident			require medical attention. The clinical		
	#22 was found to be	nonresponsive by a physical			assessment focused on resident⊡s vita	al	
	therapy staff member	hours before EMS was			signs to include, blood pressure readin	g,	
	called. Resident #22	was found with an elevated			pulse, respiration rate, temperature,		
	heart rate of 140 bear	ts per minute (bpm) (a			and/or presence of pain. The assessm	ent	
		ate for adults is between 60			also includes measuring blood glucose		
		ations in the 40s breaths per			the residents with diagnosis of diabetes		
	,	piratory rate is between 12			with orders for blood glucose check. The		
		ninute), and with a continued			attending physician will be informed by		
		ucose level more than 400			Director of Nursing, Assistant Director		
	_	sport by EMS. At the time of			Nursing and/or Unit Coordinator #1 or		
	ED (emergency depa				on any identified findings of a change i		
		nt # 22 was diagnosed with			condition and appropriate measures to		
		emia. (Hyperglycemia is a			include, but not limited to activating	al	
		which the body's blood			emergency medical services if indicate 100% audit of all current resident⊡s ble		
		er than normal. High blood en the body has too little			glucose reading documented from	Jou	
	insulin or when the bo				6/28/2024 to 09/07/2024 completed on		
	properly.) The facility				09/07/2024 to 09/07/2024 completed on 09/07/2024 and 09/08/2024, by the		
		poratory tests and obtain			Director of Nursing, Assistant Director	of	
		ss Resident #16's medical			Nursing, and/or Unit Coordinator (#1 or		
		or three (Resident #21, #22,			#2) to identify any other documentation		
		ents reviewed for a change			a resident with episodes of hypoglycei		
	in medical condition.	ű			and/or hyperglycemia that was not		
					addressed appropriately in accordance		
	Immediate jeopardy b	pegan on 6/28/2024 when			with professional standards of practice		
		entified as having a blood			the comprehensive person-centered ca		
		B mg/dL and the facility failed			plan, and the residents□ choices. Any		
		on per physician standing			resident(s) identified with a change in		
	orders. Immediate jed	opardy began on 7/10/2024			condition, the Director of nursing will		
		vas identified as having a			inform the physician for appropriate		
	blood glucose reading	g of over 400 mg/dL and the			measures and or interventions and		
	facility failed to effect	ively assess and implement			implement the interventions as ordered	l.	
	interventions. Immed	iate Jeopardy was removed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	. ,	OATE SURVEY OMPLETED
		345529	B. WING _			C 09/12/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	03/12/2024
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UNIVERSA	AL HEALTH CARE/NOR	ΓΗ RALEIGH			•	
				RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE ) TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 684	Continued From pag	e 110	F 6	84		
F 684	on 9/9/2024 when the acceptable credible a jeopardy removal. The compliance at a lower ensure education is consistent with a systems put in place for Resident #16 will and severity level of the same assessment dated 6/#22 was readmitted to a hospitalization for the truinary tract infection (Hydronephrosis is a characterized by exceptockage in the tube the bladder.)  Documentation on a assessment dated 6/#22 was assessed as and vision with clear the same assessment was usually understand coded as having the mellitus and received of the assessment per documentation on the documentation on the pocumentation on the	e facility implemented an allegation of immediate are facility will remain out of a scope and severity D to completed and monitoring are effective. Example #3 be cited at a lower scope D.  originally admitted to the with multiple diagnoses some mentia, type 2 diabetes ive disorder, major and hypertension. Resident to the facility on 6/21/24 after the diagnoses of sepsis, and hydronephrosis. medical condition ess fluid in a kidney due to that connects the kidney to that connects the kidney to a quarterly Minimum Data Set 24/2024 revealed Resident as having adequate hearing speech. Documentation on the indicated Resident #22 tood and usually had the others. Resident #22 was diagnosis of type 2 diabetes I insulin injections for 7 days eriod.	F 6	100% audit of all curre orders for daily weights 10/08/2024, by the Dire Assistant Director of N Coordinator (#1 or #2) other resident who mist the last seven days to weight was obtained as resident(s) identified weight, the Director of the physician for approand or interventions an interventions as ordered.  Measures/systemic chainto place to ensure the practice does not recurred to include assession addressing a change in the seriousness of a chand recognize the needenergency medical seacordance with profession-centered care presidents choices. The modification will be accomplementing the follow Effective 09/07/2024, li oversee care and services at the beginning through the daily schedules.	s completed on ector of Nursing, ursing, and/or Unit to identify any used daily weights in validate daily sordered. Any ith missing daily nursing will inform opriate measures and implement the ed.  anges will be put at the deficient resolution, identify nange in condition, identify nange in condition, do to initiate revices in sesional standards of ensive complished by wing measures: idensed nurses will ides for each The Nurse will be ing of the shift, dule, of his/her	
	6/22/2024 revealed a Resident #22's risk fo	care plan description of or hypo/hyperglycemia and a retinopathy relative to a		responsibility to overse medication aide(s) if ar	ee certified	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345529	B. WING			1	/12/2024
NAME OF PI	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)
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F 684	Continued From page	e 111	F	684			
	diagnosis of diabetes	mellitus. One of the			Effective 09/07/24, Director of Nursing,		
		observe signs and symptoms			Assistant Director of Nursing, Unit		
		ia such as sweating, tremor,			Coordinator (#1 or #2), Weekend		
	pallor, nervousness,	headache, double vision,			Supervisor, and/or Scheduling		
	confusion, and or lac	k of coordination. Additional			Coordinator will be responsible to upda	ıte	
	interventions were to	perform blood glucose			daily schedule for nursing staff (license	ed:	
	monitoring and medic	cation/insulin as ordered.			nurses, medication aides, and certified		
					nursing aides). The daily schedule will		
	Documentation in a p				inform each nursing staff of their		
		Resident #22 was ordered to			assignment and responsibilities to inclu	ıde	
		lin solution to be injected			responsibility for licensed nurses to		
		lied under the skin) three			oversee medication aides (if any).		
		l, 12:00 PM, and 4:00 PM					
	per the following slidi	-			The Facility Administrator will educate		
	_	1 to 250 administer 4 units;			Director of Nursing, Assistant Director	of	
	251 to 300 administe				Nursing, Weekend Supervisor, Unit		
		51 to 400 administer 10 units;			Coordinator #1/or #2 and Scheduling		
		the physician. Novolog is a			Coordinator. The education focused or		
	fast-acting insulin use				the importance of ensuring a daily nurs	-	
	glucose for people wi	in diabetes.			schedule is completed and indicate the		
	Documentation in a p	bysisian arder dated			responsibility of each nursing staff to		
		Resident #22 was ordered to			include the responsibilities of the licens nurse to oversee the medication aides.		
	0,22,202 : :0:00.00	nglee insulin solution to be			This education will be completed by		
		isly one time a day at 8:00			9/8/2024. Any licensed nurses and/or		
	· ·	a. Semglee is a long-acting			medication aide not educated by 09/08	/24	
	, ,, ,,	nigh blood glucose levels for			will not be allowed to work until educate		
	people with diabetes.				The Director of Nursing will complete the		
	poopio with diabotoo.	•			education for any newly hired, Assistar		
	Documentation on the	e July Medication			Director of Nursing, Weekend Supervis		
		d (MAR) for Resident #22			Unit Coordinator #1/or #2 and Schedul		
		the blood glucose level was			Coordinator during the orientation proc	•	
	399 and Medication A				effective 9/8/2024.		
		s of insulin at 6:22 PM.					
					Effective 09/07/2024 the assigned		
	Med Aide #5, an age	ncy employee, was			licensed nurse will be responsible to		
		024 at 1:08 PM and revealed			provide necessary care to include		
	the following informat	tion. Med Aide #5 confirmed			assessing, monitoring, addressing a		
	_	d alucose reading of 399 on			change in condition, identifying the		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345529	B. WING			1	12/2024
NAME OF P	ROVIDER OR SUPPLIER	0.0020	<del> </del>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	09/	12/2024
TO UNIC OF T	TO VIDER OR GOLF EIER				01 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH					
				RA	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 112	F 6	84			
F 684	7/9/2024 and that she Resident #22. Med A licensed nurse was w perform medication a her scope of practice explained when she preading into the elect administration of the go under her name. It had to trust that the lireported the blood gliwould administer the document the adminiphysician of any condition. Documentation on the #4 administered Sem Resident #22 on 7/9/2. There was no docum Resident #22 had a breceived Novolog inson 7/10/2024.  Med Aide #4, an agel interviewed on 9/6/20 revealed the following morning of 7/10/24 sl AM to 7:00 PM shift to Resident #22 resided Nurse #4 took care of for several people du shift ending on 7/10/2 of those people who she had already administred saw was a serior several people who she had already administred was was a serior several people who she had already administred was was a serior several people who she had already administred was was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior several people who she had already administred was a serior sever	e did not administer insulin to ide #5 did not recall who the who was assigned to help her administration tasks out of on 7/9/2024. Med Aide #5 but the blood glucose ronic MAR, the insulin would also incorrectly Med Aide #5 indicated she censed nurse, to whom she ucose level of Resident #22, correct insulin dose, stration, and notify a cerns if needed.  e July MAR revealed Nurse aglee insulin as ordered to 2024 at 8: 24 PM.  entation on the July MAR blood glucose level taken or ulin as ordered at 8:00 AM  ncy employee, was 024 at 1:54 PM. Med Aide #4 g information. On the ne was assigned for the 7:00 of the hallway which in Med Aide #4 was told f administering medications ring the 7:00 PM to 7:00 AM 2024. Resident #22 was one Nurse #4 told Med Aide #4	F 6	684	seriousness of a change in condition, a recognizing the need to initiate emerge medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices for the assigned residents, and/or those assig to the medication aide under the nurse supervision.  Effective 09/07/2024, for residents with orders for blood glucose check; certified medication aides will obtain and document blood glucose reading in each resident smedical records, and informative immediately, on any blood glucose level less than 60, greater than 200 or based on the physician order. Facility licensed nurses on duty will assess the resident blood glucose level and provide appropriate intervention including assessing, monitoring, addressing a change in condition, identifying the seriousness of a change in condition, a recognizing the need to initiate emergent medical services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices.  Effective 09/07/2024, facility licensed nurses on duty will administer medication related to hypoglycemia and/or hyperglycemia, including glucagon for blood sugar, and/or insulin for high bloog glucose, based on physician orders and	eir ned se d d ch a se de nocy	
		nt on the MAR the told had already been xplanation for why there was			document the administration of such medication in each resident □s clinical record.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER	1 2 1 2 2 2	<del>-</del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	12/2024
NAME OF T	TOVIDER OR GOLT EIER				201 CLARKS FORK DRIVE NW		
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				R	ALEIGH, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From pag	e 113	F6	84			
	no documentation of	the Novolog insulin for			Effective 09/07/2024, facility Medical		
	Resident #22 at 8:00	_			Director approved the protocol for low	and	
		7 6 7, 16, 262			high blood sugar. The protocol include:		
	Documentation on th	e July MAR revealed Med			(in part), residents who are unresponsi		
		glucose level of 400 mg/dL			and with low blood glucose (less than 6		
		units of Novolog insulin on			will receive glucagon injection,	,	
		If to Resident #22, one hour			administered by a licensed nurse, bloo	d	
	and 43 minutes after				sugar will be rechecked within ten		
	administration time.				minutes, if blood sugar remain less tha	n	
					60, and/or resident remain unconsciou	S	
	There was no docum	entation on the July MAR			facility staff will call 911. This protocol i	s	
	Resident #22 had a l	olood glucose level taken or			implemented effective 09/07/2024.		
	was administered No	volog insulin as ordered at			Effective 09/07/2024, residents with bloom		
	4:00 PM on 7/10/202	24.			glucose over 400 will receive 10 units of	of	
					fast acting insulin, (Humalog or Novolo		
	Med Aide #4, an age				blood glucose will be rechecked within		
		024 at 1:54 PM. Med Aide #4			minutes, or per physician order, after th		
		information. Med Aide #4			administration of insulin, if blood glucos		
	-	ould not remember which			remains over 400, resident⊡s physicia	า	
		assisting her on 7/10/2024			will be notified for further evaluation		
		id not administer Novolog			and/or treatment. This protocol is		
		22 on 7/10/2024 at 1:43 PM.			implemented effective 09/07/2024.		
	•	the licensed nurse, assisting			Effective 09/07/2024, facility employee		
		Unit Manager #2. On glucose level for Resident			including medication aides on duty, wil utilize phone intercom communication		
		bove 400 on the glucose			method and announce code blue for a	21/	
		of "HI" on a glucometer			medical emergency to include but not	ıy	
	, ,	above the level readable by			limited to resident change in condition	that	
		licensed nurse who was			require clinical support.	ıııaı	
		4 was told the blood glucose			Effective 09/07/2024, facility clinical sta	aff	
		above 400 and the physician			to include licensed nurses, certified	,	
		The licensed nurse told Med			medication aides, certified nursing aide	s.	
		n ordered 12 units of Novolog			and any other medical/clinical trained	,	
		tered to Resident #22 and to			professionals will respond to the code		
		ood glucose level every			blue announcement and go to the		
		ept checking the blood			specified location for assistance. Licen	sed	
		nour and reported to the			nurse will aid including assessing,		
		ading was still registering as			monitoring, addressing a change in		
		ed Aide #4 thought the			condition, identifying the seriousness of	fa	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		345529	B. WING _			C <b>9/12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	0/12/2024
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UNIVERSA	AL HEALTH CARE/NOR	ΓΗ RALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From page	e 114	F 6	84		
	and take care of the	oing to document everything 4:00 PM scheduled Novolog on 7/10/2024 because of		change in condition, and reco need to initiate emergency m services in accordance with	nedical	
		adings that were over 400		standards of practice, the col		
	_	nysician to be involved.		person-centered care plan, a	•	
	g,	,,		residents□ choices.		
	Unit Manager #2 was	s interviewed on 9/10/2024 at				
		er #2 revealed the following		Effective 09/07/2024, a licens	sed nurse will	
	information. Unit Mar	nager #2 did recall Med Aide		remain with a resident with a		
	#4 contacting her abo	out an elevated glucose level		condition that requires emerg	gency	
	for Resident #22 on 7	7/10/2024. Unit Manager #2		medical attention until the em	nergency	
	revealed she assess	ed Resident #22 and thought		medical services (EMS) team	າ arrived for	
		but was arousable and able		proper monitoring and asses	sment of the	
		anager #2 stated she was		resident.		
		, in addition to being the unit		Effective 10/08/2024, license		
	manager, the only re			duty will obtain daily weight p		
	building, doing wound			order and document in each		
	-	aving her with little time for		electronic health record as or		
		of the Med Aides in the		Effective 10/08/2024, revised	•	
	-	er #2 revealed she thought		tracking tool implemented to		
		physician for Resident #22		ordered laboratory is comple		
	_	elevated blood glucose		orders. Unit manager will rev		
		Unit Manager #2 stated she It of Med Aide #4 and felt she		laboratory tracking log in a da meeting to validate all ordere	•	
		ively if she needed any		obtained per order.	d labs ale	
		ager #2 could not recall		100% education of all license	ad nurses and	
		rventions were put in place		Medication aides, to include		
		nan administration of insulin		time, and as needed nursing		
		trust the recollections of Med		will be completed by the Dire		
		er #2 revealed she kept a		Nursing, Assistant Director of		
	_	notes on which residents she		and/or Unit Coordinators (#1	•	
		omplete documentation on		emphasis of this education in	•	
		Manager #2 thought perhaps		not limited to:		
		elevated blood sugars was		The importance of admir	nistering	
		s and she forgot to go back		medication to include insulin,	-	
	and document.			and other medications per ph	nysician	
				order.		
	Documentation on th	e July MAR revealed Nurse		The importance of ensure	ring each	
	#4 administered Sem	nglee insulin as ordered to		resident is assigned to a lice	nsed nurse to	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2024
					201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH			RALEIGH, NC 27616		
(VA) ID	STIMMADA	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		COMPLETION DATE
F 684	Continued From pag	ge 115	F 6	684			
	Resident #22 on 7/1	0/2024 at 10:56 PM.			oversee his/her care including provisio	n	
					for assessing, monitoring, addressing	a	
	There was no docum	nentation in the electronic			change in condition, identifying the		
	medical record of Re	esident #22 that any			seriousness of a change in condition, a	and	
	additional intervention	ons were taken for the			recognizing the need to initiate emerge	ncy	
	elevated blood gluco	ose reading on 7/10/2024.			medical services in accordance with		
					professional standards of practice, the		
		nentation on the July MAR			comprehensive person-centered care		
		blood glucose level taken or			plan, and the residents choices.		
		ovolog insulin as ordered at			3. The importance for each medication	on l	
	8:00 AM on 7/11/202	24.			aide to be aware of their assigned	_	
	The facility pureing a	schodule dated 7/11/2024			licensed nurse at the beginning of their		
		schedule dated 7/11/2024 was assigned to the hallway			shift (through the daily schedule that w indicate the nurse who is responsible t		
		\$22 resided for the 12 hour			oversee them)	J	
	"day shift (7:00 AM t				4. The use of code blue for all medic	al	
		,.			emergencies through telephone interco		
	Nurse #7 was interv	iewed on 9/5/2024 at 2:37			system		
	PM. Nurse #7 stated	d she was an agency nurse			5. The implementation of hypoglycer	nia	
	who only worked at	the facility on one occasion			protocol for unresponsive residents us	ng	
	and that was 7/11/20	024. Nurse #7 stated she did			glucagon for low blood sugar.		
	not recall what hall s	she was assigned to. Nurse			6. The implementation of hyperglyce		
		arrived at 7:00 AM on			protocol includes administration of fast		
		duler handed her a stack of			acting insulin and rechecking blood su	_	
		d her to go to the hall to begin			within 30 minutes and notifying physici	an	
	-	. Nurse #7 explained she was			for any other orders.		
		ave access to the electronic			7. The importance of calling 911 for	:!	
		em. Nurse #7 revealed it was yed. Nurse #7 further			medical emergencies that require med attention at the acute care center. (The		
		30 PM she was approached			education emphasized that any staff	;	
		or of Nursing (DON) with the			member can call 911 when indicated.)		
	electronic medical re	<b>.</b> ,			8. Importance for a licensed nurse to	,	
		ded and another stack of			remain with a resident until emergency		
		mission she was expected to			medical services (EMS) arrived.		
		aid she handed the new			9. The importance of documenting b	ood	
	-	k back to the Interim DON			glucose findings in resident□s medical		
		sn't doing it. Nurse #7			records.		
	revealed she had ne	ever returned to the facility.			10. For medication aides, the education		
					also covered the importance to report	.0	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
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				52	01 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/N	ORTH RALEIGH		R/	ALEIGH, NC 27616		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 684	Continued From p	page 116	F	684			
	Med Aide #4 was	interviewed on 9/6/2024 at 1:54			the charge nurse immediately any bloc	od	
	PM. Med Aide #4	stated she was assigned on			glucose level less than 60, greater that	n	
	7/11/2024 for the	7:00 AM to 7:00 PM shift to			200 or based on the physician order.		
	another hall next t	to the hall which Resident #22			11. The education also covered on the	е	
	resided. Med Aide	e #4 revealed everything was "a			importance of obtaining daily weights a	and	
		way which Resident #22 resided			laboratory tests as ordered.		
		s an agency nurse (Nurse #7)			This education will be completed by		
		figure out the paper MAR and			10/14/2024. Any licensed nurses and/o		
		g medications. Med Aide #4			medication aide not educated by 10/14		
		ncy nurse (Nurse #7) left and			will not be allowed to work until educat		
	was put on the do	not return list.			Director of Nursing, Assistant Director Nursing, and/or Unit Coordinators (#1,		
	Documentation or	n the July MAR revealed Med			will monitor and track the completion o	ıf	
	Aide #4 obtained	a blood glucose level of 400			this education and will complete this		
	mg/dL and admini	stered ten units of Novolog			education for any newly hired licensed		
	insulin on 7/11/20	24 at 11:47AM to Resident #22.			nurses and/or medication aides during new hire orientation.	the	
	Documentation or	n a physical therapy treatment					
		r Resident #22 written by			Monitoring of corrective actions to ens	ure	
		Assistant (PTA) #1 on			that the deficient practice is being		
		PM revealed, "PTA facilitated 2] get [out of bed] for the			corrected and will not recur:		
	purpose of attemp	oting goals. [Resident #22]			Effective 10/7/2024, the Director of		
	responded [by de	monstrating] extreme lethargy,			Nursing, Assistant Director of Nursing,		
	incoherent mumb	ling, [nonresponsive] pupils/eye			and/or Unit Coordinators (#1, #2) will		
	movement to brigi	ht light. PTA attempted to have			complete the monitoring process to		
	[Resident #22] sit	[on edge of bed] with [Resident			ensure residents received necessary of	are	
	#22 [demonstrating	ng] inability to arise from			to include assessing, monitoring,		
		hold head. Nursing [Med Aide			addressing a change in condition, iden		
		al Therapist/Occupational			the seriousness of a change in condition	on,	
		l regarding [Resident #22's]			and recognize the need to initiate		
	decrease in status	s. Continue [with plan of care.]"			emergency medical services in		
					accordance with professional standard	s of	
		conducted with PTA #1 on			practice, the comprehensive		
		PM. PTA #1 revealed the			person-centered care plan, and the		
	_	ion. PTA #1 stated she did not			residents□ choices. This monitoring		
		ne she went to see Resident			process will be accomplished by		
		. PTA #1 confirmed she found			implementing the following measures:		
	Resident #22 in a	nonresponsive condition on		- 1	Effective 10/08/2024, the Director of		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345529	B. WING _			09/	12/2024
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UNIVERSA	AL HEALTH CARE/NO	JRTH KALEIGH		R	ALEIGH, NC 27616		
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F 684	Continued From page	age 117	F 6	684			
F 684	that day, so she we the interim DON, to Occupational thera concern for Reside Documentation on Aide #4 took a bloom and administered to 7/11/2024 at 4:51 Med Aide #4 was in PM. Med Aide #4 took and administered to glucose readings for at 11:47 AM and 4 that some of the bloom Resident #22 were over 400 mg/dL which was administered actually 400 mg/dL MAR did not allow off as administered entered into the M reading. Med Aide mg/dL although the 400 mg/dL. Med A licensed nurse who 7/11/2024 for the administration time the blood glucose Med Aide #4 explain going into the MAF blood glucose read credentials to documentation to documentation time the blood glucose read credentials to documentation to the MAF blood glucose read credentials to documentation to the MAF blood glucose read credentials to documentation and the state of the	the Physical Therapist, and apist to let them know of her ent #22.  the July MAR revealed Med od glucose level of 400 mg/dL ten units of Novolog insulin on PM.  Interviewed on 9/6/2024 at 1:54 confirmed she took the blood for Resident #22 on 7/11/2024 :51 PM. Med Aide #4 revealed lood glucose readings for a catually registering as HI or nile at least one of the readings on the MAR on 7/11/2024 was L. Med Aide #4 revealed the Novolog insulin to be checked drunless an actual number was AR for the blood glucose #4 stated she had to put in 400 the reading may have been over ide #4 confirmed she told the owas assisting her on 12:00 PM and 4:00 PM the for the Novolog insulin, that levels were continuously HI. Lined the licensed nurses were Reafter she documented the ding and using her login ument the administration of	F	384	Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the monitoring process to ensure residents with orders for daily weights and laboratory test orders are completed as ordered, by reviewing the MAR for completion of daily weights an laboratory tracking tool for ordered laboratory tracking tool for ordered laboratined in the last 24 hours or from the last clinical meeting. This monitoring process will be completed daily (Mondathrough Friday) for two weeks, weekly two more weeks, then monthly for three months, or until the pattern of compliar is established. Any negative findings we addressed by the DON, ADON and Unit Coordinator #1 or #2 promptly. Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review daily nursing schedule to validate that a licensed nurses was designated oversee care and services for each resident in the facility, and validate the daily schedule indicate a name of a nuresponsibility to oversee certified medication aide(s) if any. This monitor process will be completed daily (Mondathrough Friday) for two weeks, weekly two more weeks, then monthly for thre months, or until the pattern of compliar is established. Any negative findings we be addressed by the DON, ADON and	e and some ay for e ance vill /or	
	nurse on 7/11/202- contacted and ord monitored. Med Ai licensed nurse was	#4 was told by the licensed #4 the physician had been ered for Resident #22 to be de #4 did not recall who the #5. Med Aide #4 confirmed PTA #5 concerns of the lack of			Unit Coordinator #1 or #2 promptly. The monitoring process will be documented a blood glucose monitoring tool located the facility compliance binder.  Effective 10/07/2024 the Director of Nursing, Assistant Director of Nursing,	d on d in	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ ' '	PLE CONSTRUCTION  G		E SURVEY PLETED
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		345529	B. WING _			/12/2024
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F 684	Continued From pag	ge 118	F 68	34		
F 684	response from Resides he did tell the license said. Med Aide #4 st Manager #2 and ser interim DON about to readings of over 400 Med Aide #4 stated from the interim DOI of it." Med Aide #4 so fher shift on 7/10/2 #4 know Resident #2 blood glucose reading Aide #4 indicated Not telling her that on the when Nurse #4 work readings for Resider mg/dL. Med Aide #4 any sense to me but doctor."  An interview was coparty (RP) for Resid PM and the following On 7/8/2024 the RP before going out of t RP heard nothing all	dent #22. Med Aide #4 stated sed nurse of what PTA #1 had tated she informed Unit at a text message to the he continued blood glucose of mg/dL for Resident #22. She got a text message back of the he would take care tated that in report at the end that and 7/11/24 she let Nurse 22 was continually having angs of over 400 mg/dL. Med tarse #4 did not seem to care, the shift, 7:00 PM to 7:00 AM, and the blood glucose and #22 were in the 200's stated, "It just didn't make to only the nurses can call the enducted with the responsible tent #22 on 9/3/2024 at 3:42 grinformation was provided. The levek from the facility. On	F 68	and/or Unit Coordinators (#1, review medication administrator all residents with orders for all residents with orders for all residents with orders for glucose, all residents with ordered, reviging the physiciar parameters and provide neces include assessing, monitoring a change in condition, identifications are cognizing the need to initiate medical services in accordant professional standards of pracomprehensive person-center plan, and the residents chotoassigned residents, and/or the tothe medication aide under supervision. This monitoring be completed daily (Monday Friday) for two weeks, weekly more weeks, then monthly for months, or until the pattern of is established. Any negative to be addressed by the DON, A Unit Coordinator #1 or #2 professional residents with the pattern of the professional standards of the pattern of the p	tion records or blood ders for daily reses obtained iewed blood in ordered essary care to g, addressing ying the condition, and the emergency ce with ctice, the red care ices for their ose assigned the nurse sprocess will through y for two rethree from pliance findings will DON and/or imptly. This	
	had several missed picked up on the next number. The person themselves but told now and check on yemergency. She need id not know what we facility did not notify sick. The RP called was local to the facilifacility to see Reside	PM to 8:00 PM she saw she calls on her phone. She then at one. It was from a private on the phone did not identify the RP, " You need to come our mother. It is an eds to be sent out." The RP was going on because the her that Resident #22 was another family member who ity and asked him to go to the ent #22. The family member around 8:30 to 8:45 PM to		monitoring process will be do a blood glucose monitoring to the facility compliance binder Effective 10/07/2024, the Dire Nursing, Assistant Director of and/or Unit Coordinators (#1, review any occurred medical that happened in the last 24 lithe last held clinical meeting employees followed the propinclude utilizing phone intercommunication method and a code blue for any medical em	pool located in ector of f Nursing, #2) will emergency nours or from to validate er protocol to om announce	

PRINTED: 10/22/2024 FORM APPROVED OMB NO. 0938-0391

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID IVC	7. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345529	B. WING			09/	12/2024
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH			201 CLARKS FORK DRIVE NW		
				R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 684	Continued From page	e 119	F	684			
	find Resident #22 wa	s not responding. Nurse #4			include but not limited to resident chan	ge	
	walked into the room	with a blood glucose			in condition that require clinical support	t,	
		doctor ordered Resident #22			and validate clinical staff, to include		
		monitor her blood glucose			licensed nurses, certified medication		
		ctor back in two hours. Since			aides, certified nursing aides, and any		
		t responding the family			other medical/clinical trained	1-	
		Resident #22 be sent to the			professionals will responded to the cod	ie	
		I finally Nurse #4 called services (EMS). Later that			blue announcement and go to the specified location for assistance, and a	2	
		I called the RP wanting to			licensed nurse will remain with a reside		
	_	her from the facility to let			with a change in condition that requires		
		22 was not well. The RP			emergency medical attention until the		
		ow who the anonymous			emergency medical services (EMS) tea	am	
		t she was grateful she was			arrived for proper monitoring and		
	contacted as it may h	nave saved the life of			assessment of the resident. This		
	Resident #22. The RI	P talked to the (former)			monitoring process will be completed d	aily	
	Administrator about h	ner concerns and the			(Monday through Friday) for two weeks	<b>3</b> ,	
	` '	or informed the RP that the			weekly for two more weeks, then month	•	
	-	nat a physical therapy staff			for three months, or until the pattern of		
		change in the resident			compliance is established. Any negativ		
		(former) Administrator			findings will be addressed by the DON,		
	-	did not have to let the family			ADON and/or Unit Coordinator #1 or #2		
		had elevated blood glucose make sense to her. If she			promptly. This monitoring process will be documented on a F684 monitoring tool		
	,	dent #22's blood glucose			located in the facility compliance binder		
		high for several days she			Effective 10/07/2024, Director of Nursir		
		er sent to the hospital to be			will report findings of this monitoring	'9	
	checked.	,			process to the facility Quality Assuranc	е	
					and Performance Improvement		
	Documentation in the	physician orders revealed			Committee for any additional monitorin	g	
	an order dated 7/11/2	2024 at 7:00 PM for Resident			or modification of this plan monthly for		
		ed ten units of Humalog			three months, or until a pattern of		
		injected subcutaneously one			compliance is maintained. The QAPI		
	_	glucose exceeding 400			committee can modify this plan to ensu	ire	
		e physician in two hours.			the facility remains in substantial		
		fast-acting insulin which is			compliance.		
	-	I starts working in about 15			Compliance date: 10/14/2024		
	⊢minutes atter iniectioi	n to lower blood alucose					

levels.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	, ,	DATE SURVEY COMPLETED
		345529	B. WING _			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	l	09/12/2024
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F 684	Continued From pag	ne 120	F 6	84		
	There was no documentation on the standard stand	nentation on the July MAR malog insulin was ident #22 on 7/11/2024 after the July MAR revealed Nurse inglee insulin to Resident #4 is PM.  The physician orders revealed 2024 at 9:00 PM for Resident red ten units of Novolog utaneously one time for blood and mg/dL and contact the res.  The inentation on the July MAR der for Novolog insulin was a Resident #22 on 7/11/2024 documentation in the ecord of any vital signs taken				
	made aware of result requested for reside room] for evaluation	its. Family arrived and RP int to be sent to [emergency in Physician made aware and ind resident to [emergency				

STATEMENT OF DEFICIENCIES (X 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				12/2024
NAME OF P	ROVIDER OR SUPPLIER	1 2 3 2 2 2			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2024
TO WILL OF T	NOVIBER OR OUT FIER				201 CLARKS FORK DRIVE NW		
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F 684	Continued From pag	e 121	F	684			
	9/5/2024 at 6:04 PM following information Resident #22 on the #4 started her 7:00 FPM on 7/11/2024. No information in a nurs that the blood glucose above 400 mg/dL on pass. Nurse #4 denie the blood glucose lev or above 400 mg/dL stated she assessed vital signs at the star revealed the blood g was registering as H glucometer, a device levels. Nurse #4 reverseident #22 were fiphysician. Nurse #4 from the physician to acting insulin to Resiphysician back in two went back to check of 9:00 PM and all her resident #22 did not elevated blood press rate. Nurse #4 stated still registering as HI glucometer. Nurse #4 was fine and was resithat when she pricked with the lancet, the received a phone call	ing report from Med Aide #4 se level of Resident #22 was the 4:00 PM medication ed she had any knowledge of vel of Resident #22 being at for several shifts. Nurse #4 Resident #22 and took her t of her shift. Nurse #4 lucose level of Resident #22 I or over 400 mg/dL on the to measure blood glucose ealed the vital signs of ne, so she called the on-call stated she received an order of administer 10 units of fast dent #22 and call the of hours. Nurse #4 stated she on Resident #22 again at					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION  NG	, ,	DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	<b>I</b>	09/12/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF	CTION SHOULD BE COI O THE APPROPRIATE	
F 684	Resident #22 and de emergency room. Nu know who called the and vital signs for Re Nurse #4 reported sh physician because of reading, so she called physician agreed Resper the family wishes did all her documenta end of her shift so that for each resident cou explanation for why h #22 was dated 7/12/2 #22 discharged from  An interview was con on 9/5/2024 at 1:58 F she was not made aven the blood glucose leven RP called her on the approximately 8:00 PDON was told by the received from a faciliting Resident #22 was vento the hospital. The incalled Nurse #4 and we still at the facility and further revealed Nurse following intervention assessment had been revealing an elevated lethargy, vital signs we called for orders, and responsive. The interthe blood glucose leven the moment on the	Resident #22 looked at manded she be sent to the rse #4 stated she did not family because the breathing sident #22 were normal. e was about ready to call the the elevated blood glucose d the physician, and the sident #22 could be sent out. Nurse #4 relayed that she at all the events of the shift ld be documented, for an iter nursing note for Resident 2024, the day after Resident the facility.  ducted with the interim DON PM. The interim DON stated ware of any concerns with rels of Resident #22 until the evening of 7/11/2024 at PM or 8:30 PM. The interim RP of a phone call she that she was told Resident #22 was was fine. The interim DON is #4 had explained the server fine, the physician was	F 6	684		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
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				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		RALEIGH, NC 27616			
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F 684	physician for Resider PM. MD #2 stated he notified of the elevater Resident #22 on 7/9/27/11/2024. MD #2 exprotified of elevated by Resident #22 during would have ordered a fast-acting insulin to be requested a call back after continuous mon #2 indicated that if the 7/10/2024 or 7/11/2024 was likely he was not did not recall receiving evening of 7/11/2024 received phone calls it difficult to recall a stype for a resident. M glucose level of 400 m having a blood glucosisolated event for this underlying medical control which he would have been been possible by the services (EMS) report 911 was called at 9:1 Resident #22 at 9:37 information was reveau Upon arriving at the services (EMS) and the services underlying at the services the services of the services of the services underlying at the services are resident #22 at 9:37 information was reveau.	ducted with MD #2, the at #22, on 9/9/2024 at 1:12 could not recall if he was ad blood glucose levels of 2024, 7/10/2024, or plained that if he had been could glucose levels for normal business hours, he a change in the amount of the administered and if there was no change itoring of the resident. MD cose orders did not exist on 24 during the day shift then it notified. MD #2 stated he g a phone call on the from Nurse #4, but he of that type routinely making pecific phone call of that D #2 stated that a blood mg/dL was "not good," but see level of 400 mg/dL was an resident making it likely an ondition was occurring for had to figure out.  I Emergency Medical that and arrived at room of	F6		Υ)		
	glucose level all day a acting like herself. Th they had been giving	and had been alert but not e facility staff also told EMS Resident #22 insulin as dent's physician with no					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG	' '	(X3) DATE SURVEY COMPLETED		
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F 684	monitor. EMS noted reading of HI on the EMS documented R	Ing level of HI on the glucose I Resident #22 had a glucose Ir glucose monitor as well. Resident #22 as having a heart Dirations in the 40s. Once in	F 6	84			
	7/11/2024 admission diagnosed with seps mental status, acute and a urinary tract in room. Resident #22 hospital on 7/24/202 home health services	a hospital record dated for a n revealed Resident #22 was sis, hyperglycemia, altered e renal failure, dehydration, infection in the emergency was discharged from the 24 into the care of the RP with es, per the RP's request.					
	facility on 2/8/21. The included in part a dis	ne resident's diagnoses					
	Minimum Data Set a resident was cogniti clearly speak and m was also able to eat resident was also co	# 21's 4/12/24 quarterly assessment revealed the vely impaired. He was able to take himself understood. He with supervision only. The oded to be a diabetic and had seven days in the assessment					
		4 monthly orders and the edication administration e following:					
	3/25/23, for Humalo	an order, which originated on g 100 units/ml give 5 units breakfast. (Humalog is a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOF	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			
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F 684 Continued From page 125		ge 125	F 6	584			
	11/16/23, for Humal under the skin every Resident # 21 had a 11/16/23, for Humal under the skin every Resident # 21 had a 4/18/24, for Levemir (Levemir is a long a Additionally Resider glucose checks and with Humalog Insulin sliding scale insulin follows: 201-250 4 to 301-350 8 units; 35 greater than 400. At MAR the blood gluc for 6:00 AM; 11:30 AT The resident's MAR 6/28/24 at 6:00 AM.  Resident # 21 also be standing orders.  Review of standing measures would be immediately when eaway) CBG (capillar hypoglycemia (low borders further direct than 60 the following resident had no renewall.	an order, which originated on og 100 units/ml give 7 units y day at 4:30 PM.  an order, which originated on 70 units every hour of sleep. cting insulin).  at # 21 had orders for blood sliding scale insulin coverage in four times per day. The dosage was noted be as units; 251-300 6 units; 1 to 400 10 units; call MD for ccording to the June 2024 ose checks were scheduled AM; 4:30 PM; and 9:00 PM. was blank for the reading on					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	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 684	given protein (4 ound peanut butter) and car graham crackers). The checked again in response was inaded be repeated.  On 6/28/24 at 9:54 Athe following entry. "I responding normally of sleep). Resident was igns measured. Restemperature of 99.8. needed) Tylenol with during follow up reside to 98.8. At 0600 (6:0 remained within normal companies of the following following following the following the following the following the following following the following the following the following fo	empule) Glucagon IM en the resident was to be ces of milk or 1 tablespoon of arbohydrate (6 saltines or 3 ne blood glucose was to then 15 minutes and if the quate the treatment was to  M Nurse # 4 documented Resident was alert and per his baseline at HS (hour vas hot to the touch and vital sident noted to have Resident received PRN (as a scheduled medications and dent's temperature had fallen 0 AM) resident's temperature nal ranges."	F	584			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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F 684	4 documented the forwriter was made aw glucose was measured uty. Upon entering to be pale and lethat orange juice at that mixed in applesauch measured again and on duty arrived to rearrived 9:06 AM and Unit Manager on duty arrived 9:06 AM and Unit Manager on duty arrived 9:05 AM, and at I AM. At 9:11 AM the resident was unresphe had a blood gluc with dextrose was balert and talking. The temperature reading transferred to the hold to be profoun glucose reading of 3 noted the resident was cidosis related poshypoglycemia. (Lacilactate acid in the bemetabolized and call dysfunction). Follow	bollowing nursing entry. "This are that residents blood red at 33 by med aides on the room, resident was noted rgic. Resident unable to drink time but tolerated sugar e. Resident blood glucose d read 56. RN Unit Manager from to assess resident. EMS d was received report from RN ty."  Itergency medical system) e following information. EMS 24 at 8:56 AM, on the scene Resident # 21's side at 9:07 EMS records showed the consive upon their arrival and ose level of 38. Once an IV egun the resident became ey were unable to obtain his	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345529	B. WING				12/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
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F 684	was interviewed and 6/28/24 she arrived a MA # 4 had asked for coming on duty. MA assigned Nurse Aide that Resident # 21 wand she needed help immediately, and she blood glucose. It was (Assistant Director of 911. As a medication not call 911. Therefor who was the night she She told Nurse # 4 that time Nurse # 4 wroom. Nurse # 4 did she ran to tell another then went back to the the resident some sun his tongue. She had some Glucagon, but before EMS arrived. # 3) was the only state the resident and he will manager # 2 came in arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. When the Ur that she had come before EMS arrived. The EMS arrived arrived and the EMS arrived arrived and the EMS arrived arrived arrived and the EMS arrived	M MA (Medication Aide) # 3 reported the following. On at work during the morning. r help as she (MA # 3) was # 4 informed her that the had let her (MA # 4) know as "gurgling and everything" b. She (MA # 3) went c checked the resident's f. 33. She called the ADON f. Nursing) who told her to call aide, she thought she could re, she ran to get Nurse # 4, ift nurse and still at work. that she needed to call 911. At was still in the medication mot move to do anything, so for nurse (Nurse # 5). She for room and started to give gar and orange juice under also asked Nurse # 4 to get she never came to help When EMS arrived, she (MA ff member in the room with was not responding. Unit to the room after EMS hit Manager arrived, she said fecause the ADON had texted inderstand why the ADON of needed help from the fince EMS came to the room,	F	684			

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 <b>9/12/2024</b>
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F 684	Continued From page 129		F	684		
	and reported the fibreakfast time per NA (Nurse Aide) is resident was not at the NA. At the be been told who the conduct assessme complete as a MA room and checked. She did not recall there and tried to 4 was still there from Nurse # 4 if there be given to Reside Nurse # 4 did not and she did not reafter EMS got the did come, Nurse # resident or assess as she and MA # sugar with apples swallow. She recacome to the room it was after EMS awhen EMS arrived person in the roor that she recalled to the revealed she had time. She had been glucose was low, worked together as getting a phone can MA #3 to call 911. glucagon on the call she had together as getting a phone can MA #3 to call 911. glucagon on the call she had together as getting a phone can MA #3 to call 911. glucagon on the call she had together as getting a phone can MA #3 to call 911. glucagon on the call she had together as getting a phone can MA #3 to call 911. glucagon on the call she had together as getting a phone can MA #3 to call 911. glucagon on the call she had together as getting a phone can MA #3 to call 911.	iewed on 9/5/24 at 12:06 PM following. On 6/28/24 during the find Resident # 21's assigned and let her know that the acting right and would not talk to ginning of the shift, she had not nurse was covering her to ents and things she could not a. She went into Resident # 21's dis blood glucose. It was low. The exact number. MA # 3 was help her. They saw that Nurse # form night shift. They asked was some glucose that could ent # 21 and there was none. It was before EMS or the that she did come. When she is a him. She stood and watched as were trying to give him some auce, but he was not able to alled that Unit Manager # 2 did at some point, but she thought entired. She was at the door of the let them in and the only in with the resident was MA # 3 when the EMS team arrived.  ADON on 9/5/24 at 1:18 PM been the acting DON at the en aware the resident's blood but she thought the staff had as a team. She did not recall all from MA # 3 or that she told. There was supposed to be rash carts for emergencies and dication supply from the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 09/12/2024	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			12/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	MA # 4 try to give Re and applesauce (a mapplesauce) while Ur glucagon. She did know problem with them not she thought it was been emergency in a while The glucagon had been she was not aware the had tried to tell some was not right or that had tried to tell some was not right or that had tried to tell some was not right or that had tried to tell some was not right or that had tried to tell some was not right or that had tried to tell some was not right or that had tried to tell some was not right or that had tried to tell some was confused at time #21's roommate could seen was confused at time #21's roommate's Minassessments, dated revealed Resident # cognitively impaired.)  Nurse # 4 was interviand reported the following already counted off in # 4 and finished her in the medication room to get her and let her	ght that Nurse # 4 helped sident # 21 a paste of sugar in hit Manager # 2 went to find ow that there had been a ot finding the glucagon, but ecause they had not had an and just had not found it. Hen present in the facility. In the roommate alleged he one earlier that the resident both MA # 3 and MA # 4 urse # 4 did not come right alked to MA # 4 about the know she had been involved. In the thin the was alert, but he is. (A review of Resident himm Data Set 5/25/24 and 8/25/24, 21's roommate was sill in documenting. MA # 4 came know that Resident # 21	F	684	DEFICIENCY)		
	Resident # 21's blood did not recall the valuable what glucagon looked her to get it for her. In glucagon on the med Unit Manager # 2 car in and out of the room resident alone with the	ent with MA # 4 to check d glucose. It was low. She le. She described to MA # 4 d like on the cart and asked MA # 4 could not find ication cart. At some point ne also and they were both n. They did not leave the le medication aides. She by medication supply which					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR			STREET ADDRESS, CITY, STATE, ZIP COD 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		99/12/2024
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	Station # 1. (Resider 2). When she return she found in the emergement of the found that the first rewere in the room and for the low blood glu give the glucagon shouther reported Resthe night before the She had checked his time of 6:00 AM and had been called by Nobeen finishing her deforgotten to chart it. 21's roommate spead been trying to tell so something wrong wit time.	apposite side of the building at the first # 21 resided on Station # and with the glucagon, which be regency supply, she then be sponders and paramedics and giving other interventions cose. Therefore, she did not the had obtained. Nurse # 4 aident # 21 had slept during incident of low blood glucose. It was above 100. When she was above 100 when she was above	F6	84		
	arrived to Resident # because she got a to needed assistance. facility at the time sh Manager) to go to th barely responding be arrived. He could no eyes. He was diaphorally to the resident a 2. She thought MA sher role as what she aide. There had bee desk that the MAs why she thought MA than activating some	ed the following. She had # 21's room on 6/28/24 ext from the ADON that they The ADON was not in the e texted for her (the Unit e room. The resident was ut was breathing when she t talk and could not open his pretic (sweating heavily). gon in the entire facility to according to Unit Manager # # 3 had been confused about could do as a medication in directions at the nursing ere to call the ADON. That is in # 3 called the ADON rather e sort of emergency system in the arrived in the room after the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTI NG	ON	(X3) DATE COMP	SURVEY LETED
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRE	SS, CITY, STATE, ZIP CODE	1 03/	12/2024
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F 684	Continued From pag	e 132	F	884			
1 004	paramedics got to the started asking questi 21's blood glucose had been. Reside up and said he had to resident was not actinight. She Unit Manaminutes before the fin paramedic team. The signs, but she though happened that a code the staff to get help. The reported she no long to the staff to get help. The reported she no long to the staff to get help. The reported she no long to the staff to get help. The reported she no long to the staff to get help. The reported she no long to the staff to get help. The reported she no long to the glucose was in the relation of the staff to get help. The rehabilitation room dock the phone her sliding medication room dock came down to the relation of the she (Nurse # 5) to call 91 to the she (Nurse # 5) then rehabilitation hall to the she (Nurse # 4 standing Resident # 21's room she did not go to the did not ever see them.	er room. The EMS crew ons about what Resident # ad been previously and how in # 21's roommate spoke ried to tell someone that the ing like himself during the inger # 2) arrived a couple re department and it in a case such as what it is in a case such as couple free department and each of the case such as what is in a case such as couple for a case such as couple free department and each of the case such as what is in a case such as couple for a case such		84			
	She did not go to the did not ever see then An attempt was made	room at that time, and she n actually in the room.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		345529	B. WING _	<del>-</del>		09/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE		
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		RALEIGH, NC 27616			
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F 684	Continued From page	e 133	F 6	684			
	6/28/24. The Nurse A An attempt was made talk to the Nurse Aide	transferred to the hospital on hide could not be reached. e on 9/5/24 at 2:43 PM to e who had been assigned on ent # 21 on 6/28/24. The					
	and reported the follo been summoned becoming glucose was 30. When not a licensed nurse in and it "took a hot min was a Medication Aid had been trying to gehim. The paramedic of specialized efforts hat arrived. One of the nurse supervisor" (Lalked like she knew was resident, "but her wor because she comment why the staff had not concerned him that she that the problem was glucose being low an arrived, the resident was that the problem was glucose being low an arrived, the resident was that the problem was glucose being low an arrived, the resident was that the problem was glucose being low an arrived, the resident was that the problem was glucose being low an arrived, the resident was attent that point, but have led to cardiac an work starting an IV in to rise. Once they go also found that there temperature reading, transported him to the	cs who responded on wed on 9/5/24 at 10:52 AM owing information. EMS had ause the resident's blood en they arrived, there was in the room with the resident ute for one to arrive." There is ewith the resident, and she it orange juice and sugar to did not know what other id been made before they urses that arrived in the here identified herself as the Unit Manager # 2). She what was going on with the reds indicated otherwise" inted that she did not know given him his insulin. That he did not seem to realize with the resident's blood in thigh. When they was not at a life threatening this low blood sugar could in the sugar of this blood glucose up, they was a problem with his. They went ahead and the hospital. He did recall ussion in the room about					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	H RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		03/12/2024	
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F 684	not paid a lot of attent focused on getting Re up, and he did not kno	e 134 It he (the paramedic) had cion because they were esident # 21's blood glucose ow if the roommate was know what he was talking	F6	584			
	on 9/5/24 at 4:15 PM information. It was a sto page for help when emergency situation smembers could arrive to be totally without sicalled. According to the Consultant a licensed assessed the residen	so that multiple staff  The resident did not have gns of life for a code to be ne Corporate Nurse nurse should have t prior to EMS arrival and when the resident was not					
	on 9/6/24 at 11:28 AM. The facility has both to also glucagon in a geometric emergency medication records showed the gomedication emergence 6/28/24 and had not ropharmacy. There was signed out for Reside other resident. The fill emergency medication	n supply. The pharmacy lucagon was in the y supply on the date of needed to be refilled by the no glucagon that had been in # 21 on 6/28/24 or any rest access to the entire in supply system was on by the ADON. At that time,					
	interviewed and repor	AM Pharmacist # 2 was also ted she could access d whether the drawer of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		OATE SURVEY OMPLETED
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F 684	actually opened in a glucagon. This was into the computer symedications before the medication they nurse logged into the for all the medication logged into the eme access the drawers medication prior to taystem on 6/28/24.  The facility's medical 9/9/24 at 4:19 PM a reported they had rehypoglycemic episowith the medical directored no one had him about the incide of any failures on the On 9/6/24 at 5:44 P and Corporate Nurs Immediate Jeopardy Resident # 21 and F	on supply with glucagon was in attempt to remove the because nurses had to log stem for the emergency they could tell which drawer needed was located. Once a se system, not all the drawers insopened. No one had regency medication supply to and remove any type of the ADON logging into the and details of how the staff seponded to Resident # 21's de on 6/28/24 were discussed ector. The medical director a shared any problems with int and he had been unaware to facility's part to respond.  What the facility Administrator is a consultant were notified of a based on findings related to desident # 22.  What provided the following removal plan:	F	584		
	03/06/2021 and read Between the originathe was discharged to The most recent read	admitted to the facility on dmitted on 07/05/2024. I admission and readmission, o the hospital on 06/28/2024. dmission, he was readmitted included: Major depressive				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		345529	B. WING		C <b>09/12/2024</b>		
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	09/12/2024		
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F 684	cirrhosis of liver, and anemia, old myocard heart disease of nati angina pectoris (a codiscomfort that happ heart doesn't get end spastic diplegic cere disorder that causes and metabolic encept that occurs when an a chemical imbalance brain).  Review of Resident and brain).  Review of Resident #21 has Status (BIMS) assered (MDS) assered	petes with hyperglycemia, ciety disorder, dementia, dial infarction, atherosclerotic ve coronary artery without ondition of chest pain or ens when some part of the bugh blood and/or oxygen), bral palsy (a neurological muscles to be overly toned), chalopathy (a brain disorder underlying condition causes e in the blood that affects the #21's quarterly Minimum essment with Assessment D) of 04/12/2024 indicated and a Brief Interview of Mental of six which suggests severe	F 6	84			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			l '	12/2024		
NAME OF P	ROVIDER OR SUPPLIER	1	1	STREET ADDRESS, CITY, STATE, ZIP	CODE				
		TU DAI 51011		5201 CLARKS FORK DRIVE NW					
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616					
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F 684	works with other horn	gon (synthetic hormone that mones and bodily functions ose level), to Resident #21	F 6	84					
	Phone interview was Director of Nursing or reported the following indicated she docum 6/29/2024 as a late of happened on 6/28/2024 recalled being notifie blood glucose at app 6/28/2024, (initial repapproximately three entered Resident #2 noted to be pale and Nurse #4 rechecked glucose approximate report, blood glucose Unit Manager #2 arri approximately fifteen report to assess Res Nurse # 5 contacted services (EMS) at an at approximately 9:00 in the room at the time EMS arrival on 6/28/2 glucose reading was nonresponsive at the hospital records indic profoundly hypoglyce Resident #21 was re 07/05/2024. Resident Assistant Director of any clinical signs of hypoglycemia were resident were residen	conducted by the Assistant in 09/07/2024, Nurse #4 g information: Nurse #4 ented the event on entry for an event that 4, She also added that, she d of Resident #21's low roximate 8:30am on corted time). After minutes of being notified, she 1's room, Resident #21 was lethargic, Nurse #4 added. Resident #21's blood ly ten minutes after the initial e read 56. Nurse #4 added, wed in the room minutes after the initial ident #21. Nurse #4 added, the Emergency medical bound 8:56 AM. EMS arrived 55am. Medication Aide #3 was ne when EMS arrived. Upon 24 Resident #21's blood 38, Resident #21 was still the time EMS arrived. The cated the resident was emic. admitted to the facility on the typoglycemia. No signs of							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	1 00.		
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH		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	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BI		(X5) COMPLETION DATE	
F 684	Between the original she was readmitted or recent readmission, sidiagnoses that includ diabetic retinopathy word complication of diabetics and blindness), sidementia, chronic emwhere one or more blipulmonary arteries), allower extremity (a blowithin the deep veins occur in the arms).  Review of Resident #Administration Record 7/10/24 at 1:43pm the notified Unit Manager blood glucose levels in Resident #22's MAR received 10 units of Neutral Further review of Resident 7/11/2024, at 11:4	larged on 07/11/2024.  admission and discharge, on 06/21/2024. The most whe was readmitted with ed: Type 2 diabetes with without macular edema (a tes that can cause vision schizoaffective disorder, abolism (long-term condition ood clots block the and thrombosis of distalled clot condition that forms a usually of the leg, but can be medication aide (MA #4) are gistering over 400.  are 22's Medication des (MAR), indicates; on the medication aide (MA #4) are gistering over 400.  are 22's MAR indicates; on the medicates that Resident #22 lovolog insulin at 1:43pm.  be 32's MAR indicates; on the medicates that Resident #22's blood and 10 units	F6	584	Υ)			
	Nursing was notified. actions taken. The Di informed is no longer  On 7/11/24 at 4:51pm by MA #4 to be 400.	11/24 at 3:38 PM the ponsive, and the Director of No documentation of rector of Nursing who was working at the facility.  In blood glucose documented The MAR indicates Resident of Novolog insulin. No						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
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	DOLUMED OF SURENIES	345529	D. WING _		005	09/	12/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
UNIVERSA	AL HEALTH CARE/NORT	'H RALEIGH		5201 CLARKS FORK DRIVE NW				
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F 684	Continued From page	e 139	F 6	884				
	Review of progress n 7/12/2024 (late entry #22's medical records contacted physician of glucose exceeding 40 from the physician to Humalog or Novolog hours. After two hours reading still exceeded aware of results, the family arrived and records be sent to the hospital physician made awar send resident to hospital physician order to a Humalog or Novolog hours. Nurse #4 indic Administering 10units per physician order. Nat approximately 9:00 Resident #22's blood exceeded 400. She a made aware of the re 9:03pm. Per Nurse #4	otes documented on for 7/11/2024), in Resident is indicate (in part); Nurse #4 due to Resident #22 blood 00. An order was received administer ten units of and report back after 2 is, resident #22 blood sugar id 400 and physician made note added. Resident #22's quested that Resident #22 to all for evaluation. The idea is conducted on 09/07/2024						
	for Resident #22 be s physician was made approximately 9:10pr received to send the 4 contacted EMS at 9	ely 9:05pm and requested sent to the hospital. The aware of the request at n, and the order was resident to hospital, Nurse # 0:17pm, interview concluded.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZI 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	P CODE	30/12/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIA	
F 684	EMS report, Resider elevated heart rate of and with a continued excess of 400 at time was sent to the hosp treatment, Resident approximately 9:53p in the facility. No other than the facility of the facility Director of Clinical Solution Nursing conducted the 109/06/2024, to identify alleged noncompliant appropriate measure reoccurrences.  For Resident #21, the (RCA) identified the resulted from the failure of the facility of follow the profession managing hypoglyce was non-responsive further identified that announce "code blue emergency to solicit employees in the facility employees in the facility of the facility	sive when EMS arrived. Per at #22 was found with an f 140, respirations in the 40s, reading of a blood sugar in the of transport. Resident #22 ital for further evaluation and #22 left the facility at the m. Resident #22 is no longer the ractions taken.  Iled by the Vice President of the y Administrator, Regional the ervices, and Director of the root cause analysis on the first the facility at the causative factor for this cause and implemented the sto correct and prevent the the ervices and prevent the the ervices and implemented the sto correct and prevent the the ervices and implemented the sto correct and prevent the ervices and implemented the sto correct and prevent the ervices and implemented the sto correct and prevent the ervices and implemented the sto correct and prevent the ervices and implemented the sto correct and prevent the ervices and implemented the sto correct and prevent the ervices and implemented the sto correct and prevent the ervices and implemented the storage of the stor	F	584		

NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/NORTH RALEIGH    SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/NORTH RALEIGH    CAJ ID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS   PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    F 684   Continued From page 141 resulted from the faillure of the facility employee (Nurse # 4) to follow the professional standard of practice on managing repeated episodes of hyperglycemia for Resident #22 who was non-responsive on 7/11/2024. The RCA further identified that the facility failed to have a system in place medication aides to be informed of the licensed nurse responsible to oversee them while on duty.  The governing body put forth the following plan for identification for those residents who are likely to suffer a serious adverse outcome as a result of the alleged noncompliance and implemented the measures below to alter the process to prevent a serious adverse outcome from occurring.  Clinical assessments of all current residents in the facility were completed on 09/07/24 by the Director of Nursing, Assistant Director of Nursing, and/or Unit coordinator (#1 or #2) to identify any other resident with the change condition that require medical attention. The clinical assessment focused on resident's vital signs to include, blood pressure reading, pulse,			345529	B. WING _			1		
(X4) ID PREFIX (EACH DETCIENCY MIST BE PRECIDED BY FULL TAG WITH THE PREFIX (EACH DETCIENCY MIST BE PRECIDED BY FULL TAG)  F 684  Continued From page 141  resulted from the failure of the facility employee (Nurse # 4) to follow the professional standard of practice on managing repeated episodes of hyperglycemia for Resident #22 who was non-responsive on 7/11/2024. The RCA further identified that the facility failed to have a system in place medication aides to be informed of the licensed nurse responsible to oversee them while on duty.  The governing body put forth the following plan for identification for those residents who are likely to suffer a serious adverse outcome as a result of the alleged noncompliance and implemented the measures below to alter the process to prevent a serious adverse outcome from occurring.  Clinical assessments of all current residents in the facility were completed on 09/07/24 by the Director of Nursing, Assistant Director of Rursing, and/or Unit coordinator (#1 or #2) to identify any other resident with the change condition that require medical attention. The clinical assessment focused on resident's vital signs to include, blood pressure reading, pulse,	NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2027	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 684  Continued From page 141 resulted from the failure of the facility employee (Nurse # 4) to follow the professional standard of practice on managing repeated episodes of hyperglycemia for Resident #22 who was non-responsive on 7/11/2024. The RCA further identified that the facility failed to have a system in place medication aides to be informed of the licensed nurse responsible to oversee them while on duty.  The governing body put forth the following plan for identification for those residents who are likely to suffer a serious adverse outcome as a result of the alleged noncompliance and implemented the measures below to alter the process to prevent a serious adverse outcome from occurring.  Clinical assessments of all current residents in the facility were completed on 09/07/24 by the Director of Nursing, Assistant Director of Nursing, and/or Unit coordinator (#1 or #2) to identify any other resident with the change condition that require medical attention. The clinical assessment focused on resident's vital signs to include, blood pressure reading, pulse,					5201	CLARKS FORK DRIVE NW			
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respiration rate, temperature, and/or presence of pain. The assessment also includes measuring blood glucose for the residents with diagnosis of diabetes with orders for blood glucose check. The attending physician will be informed by the Director of Nursing, Assistant Director of Nursing and/or Unit Coordinator #1 or #2) on any identified findings of a change in condition and appropriate measures to include, but not limited to activating emergency medical services if indicated.  100% audit of all current resident's blood glucose reading documented from 6/28/2024 to	F 684	resulted from the failure of the facility et follow the professions managing repeated of the facility failed to Resident #22 who 7/11/2024. The RCA facility failed to have aides to be informed responsible to overse. The governing body if for identification for the suffer a serious and the alleged noncomp measures below to a serious adverse outcompound the facility were compounded in the facility of the facility were compounded in the facility of the facility of the facility of the facility of the facility facility of the facility of the facility of the facility facility of the facility facility of the facility facility of the facility facility of the facility fa	employee (Nurse # 4) to all standard of practice on episodes of hyperglycemia of was non-responsive on further identified that the a system in place medication of the licensed nurse see them while on duty.  But forth the following plan mose residents who are likely verse outcome as a result of liance and implemented the liter the process to prevent a some from occurring.  For all current residents in coleted on 09/07/24 by the assistant Director of Nursing, or (#1 or #2) to identify any e change condition that tion. The clinical on resident's vital signs to are reading, pulse, perature, and/or presence of that also includes measuring residents with diagnosis of for blood glucose check. The will be informed by the assistant Director of Nursing tor #1 or #2) on any a change in condition and as to include, but not limited now medical services if	F	584				

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F 684	Director of Nursing, a or #2) to identify any resident with episode hyperglycemia that w appropriately in accordance choices. Any resident in condition, the Directory physician for approprinterventions and impordered.  Specify the action the process or system fair adverse outcome from when the action will be active to 9/07/2024, ensure residents received assessing, machange in condition, in change in condition, initiate emergency maccordance with profession practice, the compression care plan, and the resistency modification implementing the followersee care and ser the facility. A Nurse # beginning of the shift.	d on 09/07/2024 and irector of Nursing, Assistant nd/or Unit Coordinator (#1 other documentation of a s of hypoglycemia and/or as not addressed rdance with professional the comprehensive plan, and the residents' ((s) identified with a change ctor of nursing will inform the late measures and or element the interventions as the entity will take to alter the lure to prevent a serious in occurring or recurring, and the complete:  facility employees will eleved necessary care to conitoring, addressing a dentify the seriousness of a land recognize the need to electical services in lessional standards of the ensive person-centered sidents' choices. This is will be accomplished by cowing measures:  licensed nurses will vices for each resident in 4 will be informed at the through the daily schedule, ty to oversee certified	F	884			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP COI 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	DE	3371272	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) IPLETION DATE
F 684	Director of Nursing, Weekend Supervisor Coordinator will be responsibility for lice medication aides (if a The Facility Administ Nursing, Assistant D Supervisor, Unit Coordinator the importance of scheduling Coordinator the importance of schedule is completed responsibilities of the medication aides completed by 9/8/20, and/or medicat	pirector of Nursing, Assistant Unit Coordinator (#1 or #2), r., and/or Scheduling esponsible to update daily staff (licensed nurses, d certified nursing aides). Vill inform each nursing staff and responsibilities to include insed nurses to oversee any).  Verator will educate Director of irector of Nursing, Weekend ordinator #1/or #2 and ator. The education focused ensuring a daily nursing ed and indicate the include the elicensed nurse to oversee. This education will be 24. Any licensed nurses de not educated by 09/08/24 owork until educated. The vill complete this education Assistant Director of Nursing, r., Unit Coordinator #1/or #2 redinator during the orientation of the assigned licensed nurse to provide necessary care to ionitoring, addressing a identifying the seriousness of in, and recognizing the need	F	584			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616			12/2027	
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F 684	Effective 09/07/2024 blood glucose check; will obtain and docun each resident's mediately, or less than 60, greater physician order. Faci will assess the reside provide appropriate in assessing, monitoring condition, identifying in condition, and recomprehensive personal standard comprehensive personal effective 09/07/2024 duty will administer in hypoglycemia and/or glucagon for low blood high blood glucose, but and document the admedication in each residents. Effective 09/07/2024 approved the protocol in who are unresponsive (less than 60) will recompanie than 60) will recompanie than 60, unconscious facility services will obtain the service of the protocol in the service administered by a lice of the protocol in the service administered by a lice of the protocol in the service administered by a lice of the protocol in the service administered by a lice of the protocol in the service administered by a lice of the protocol in the service administered by a lice of the protocol in the service administered by a lice of the protocol in the service administered by a lice of the protocol in the service administered by a lice of the protocol in the service administered by a lice of the protocol in the service administered by a lice of the protocol in the service and the service an	for residents with orders for certified medication aides nent blood glucose reading in cal records, and inform a in any blood glucose level than 200 or based on the lity licensed nurses on duty and blood glucose level and intervention including g, addressing a change in the seriousness of a change agrizing the need to initiate services in accordance with als of practice, the in-centered care plan, and is.  If acility licensed nurses on inedication related to hyperglycemia, including and sugar, and/or insulin for assed on physician orders ininistration of such asident's clinical record.  If acility Medical Director of for low and high blood includes, (in part), residents and with low blood glucose serve glucagon injection, and/or resident remain and	F	584				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUF UNIVERSAL HEALTH CA		TH RALEIGH		5	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	1 03/	12/2027
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acting insuling glucose will per physicial insulin, if bloor resident's phevaluation a implemented.  Effective 09/medication a intercom con "code blue" but not limited require clinical companion of the "code specified local will provide a monitoring, a identifying the condition, are mergency in professional comprehensional comprehensional comprehension of the "code specified local will provide a monitoring, and identifying the condition, are mergency in professional comprehensional compreh	r 400 will now, (Human be rechen order, a lood glucon sysician will now indoor treat of effective for 2024, aides on order any med to residual support of a look of the second for any medical support of the second recognization for a sysistance addressing the second recognization for a look of the second recognization of all look of the second recognization of the second r	receive 10 units of fast log or Novolog), blood cked within 30 minutes, or after the administration of se remains over 400, will be notified for further atment. This protocol is e 09/07/2024.  facility employees, including duty, will utilize phone tion method and announce redical emergency to include dent change in condition that rt.  facility clinical staff, to es, certified medication g aides, and any other of professionals will respond mouncement and go to the assistance. Licensed nurse in including assessing, and a change in condition, sness of a change in condition, sness of a change in condition, sness of a change in condition with the sof practice, the on-centered care plan, and	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C <b>)9/12/2024</b>
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F 684	completed by the D Director of Nursing, #2). The emphasis of thi limited to:  1. The importance to include insulin, gl medications per phy 2. The importance assigned to a licens care including provi monitoring, address identifying the serio condition, and recogemergency medical professional standar comprehensive persthe residents' choice 3. The importance be aware of their as beginning of their sl that will indicate the oversee them)  4. The use of "coordinate the oversee them)  5. The implement for unresponsive residents and recheck minutes and notifyir orders.  7. The importance emergencies that reacute care center. (	sing employees will be irector of Nursing, Assistant and/or Unit Coordinators (#1, as education includes but not e of administering medication ucagon, and other ysician order. e of ensuring each resident is sed nurse to oversee his/her sion for assessing, sing a change in condition, usness of a change in gnizing the need to initiate services in accordance with rds of practice, the son-centered care plan, and	F 6	84		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		ATE SURVEY OMPLETED
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(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 SHORT CROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	with a resident until et (EMS) arrived.  9. The importance glucose findings in red.  10. For medication accovered the importannurse immediately at than 60, greater than physician order.  This education will be Any licensed nurses educated by 09/08/2 until educated. Director of Nursing, affective will monitor and the education and will conewly hired licensed aides during the new Alleged immediate jeto 09/09/2024.  On 9/12/24 the follow facility's immediate jeto 09/09/2024.  On 9/12/24 the follow facility's immediate jeto 09/09/2024.  A review of records reconfirming the completaining per the facility A review of staffing second murse was a designation or licensed nurse was a Medication Aide.  Beginning at 9:45 All members were intervationing the facility has to report details of the	en licensed nurse to remain emergency medical services of documenting blood esident's medical records. Asides, the education also note to report to the charge my blood glucose level less a 200 or based on the ecompleted by 9/8/2024. And/or medication aide not 4 will not be allowed to work tor of Nursing, Assistant and/or Unit Coordinators (#1, track the completion of this emplete this education for any nurses and/or medication of hire orientation.	F 6	84		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 684	without medical care failure of assessment physician of changes lack of medical care rather than the medical care rather than the medication and the medication are continuously than the medication are designed on the event of an emication are designed on the event of an emication are designed on the event of an emication of the medication are designed on the event of an emication of the medication are designed on the event of the event of an emication of the event of	nessed any resident go during the past week for and notification of the . There were no reports of a reported for any residents. Who was working on the which nurse was to help rese was observed checking le to ensure the Medication of any assistance on a ware where to find time of an emergency. Staff how they would obtain help regency situation.  The as conducted on 9/12/24 at and oriented diabetic regency situation.  The resident with her diabetic care and regency careful to keep a regency situation.  The additional of the facility on the way and the situation of any assistance on the angle of the situation of any assistance on the second of the situation.  The second of the facility of the situation of any assistance on the situation of any	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		COMPLETED		
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F 684	Set assessment, diresident as moderal Review of physicia an order was given electronic medical labs to be completed a CBC (complete be metabolic panel). Twere to be completed diagnosis of esoph There were no lab 7/29/24.  On 7/29/24 the sar CBC, and basic meagain into the electrompleted was not There were no lab 7/30/24.  On 7/30/24 at 9:22 the following inform record. The resident tremors and congeneasily aroused. His heartrate was elevations.	ity admission Minimum Data ated 6/20/24, coded the ately cognitively impaired.  In orders revealed on 7/28/24 and entered into the record system for the following ed: an Fe panel (an iron panel), clood count), and a BMP (basic the lab order noted the labs ated on 7/29/24 due to the agitis.  In orders for the Fe panel, etabolic panel were entered ronic record. The date to be	F 6	,			
	was again ordered the resident was or (comprehensive matriuretic peptide)	n orders revealed the resident to have a CBC. Additionally, dered to have a CMP etabolic panel), BNP (brain test (a test that measures for ne analysis and culture, and a					

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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
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F 684	Continued From page	e 150	F 6	584			
	chest x-ray These of	rders were placed in the					
		cord system to be completed					
		16's lab results revealed					
		ed since labs were ordered					
		ones completed on 7/31/24.					
		had been ordered due to					
		of esophagitis, was still not					
		t date for the CBC was At that time the resident's					
	· · · · · · · · · · · · · · · · · · ·	s normal. (An elevated					
		can at times indicate					
		date for the CMP, BNP, and					
		mented as reported on					
	-	result reported on 8/1/24					
	showed a preliminary						
	100,000 colonies of g						
		which was drawn in relation					
		t failure, was elevated. A					
		Iture result, reported on					
	8/3/24, revealed there	e were two bacterial					
		w from the culture. A review					
	of Resident # 16's ch	est x-ray revealed on					
	7/31/24 the chest x-ra	· ·					
	showed a pulmonary	infiltrate consistent with					
	pneumonia.						
		which were dated 8/1/24,					
		dered to have Cefuroime					
	, , ,	ams) two times a day for a					
	diagnosis of urinary tr	act infection.					
	   Nurse # 6 was intervi	ewed on 9/4/24 at 2:09 PM					
		wing information. She					
		had some congestion but he					
		7/30/24 when the provider					
	was not in distress of was contacted. She c						
		ed by her, and labs were					
		She did not recall anything in					

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F 684	nursing report about for him or why they h would have found it h on 7/29/24 when she some trouble breathin recall any urinary syr 7/31/24 she called th they were coming. T distress at that time.  Review of nursing no 7/30/24 to 8/2/24 the notes documenting the Review of hospital rerevealed Resident # ED (Emergency Dep ED physician noted thad reportedly not be two days and also reconfused than usual. episode of vomiting of family reported to the resident had being excough with mucous. distress. The resident documented to be blown to be blown to be two days and also recough with mucous. distress. The resident documented to be blown to b	labs already being ordered and not been done. She helpful if they had been done in noticed that he was having and on 7/30/24. She did not imptoms at the time. On e x-ray company to ensure the resident was still not in one the resident was seen in the hospital artment) for evaluation. The he following. The resident had one on the day of 8/2/24, and the ended the properties of the the properties of the the the properties of the	F	84				
	7/31/24 she called the they were coming. To distress at that time.  Review of nursing not 7/30/24 to 8/2/24 the notes documenting the notes documenting the Review of hospital reserve aled Resident #ED (Emergency Dep ED physician noted the had reportedly not be two days and also reconfused than usual episode of vomiting of family reported to the resident had being excough with mucous distress. The resident documented to be blown to be	e x-ray company to ensure the resident was still not in ottes revealed between re were no more nursing the resident's status.  cords, dated 8/2/24, 16 was seen in the hospital partment of the following. The resident en feeling well for the last portedly appeared more. The resident had one on the day of 8/2/24, and the experiencing a productive. The resident was not in t's vital signs in the ED were conducted by the production of the product						

AND DUAN OF CORRECTION IDENTIFICATION NUMBER.		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 09/12/2024
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	I	03/12/2024
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	documentation the facility with a diagnormal diagnormal facility with a dia	M a nursing note included resident had returned to the osis of a urinary tract infection.  The iron panel, which had been was completed was on the riew of the lab result revealed (9 (normal 59-159)). According ters the resident was receiving the resident was receiving the resident was continued.  The second of the lab result revealed (9 (normal 59-159)) according ters the resident was receiving the resident was continued.  The second of the lab resident gwell for a couple days before had been told by the facility teumonia and then the resident and the RP was told he had a sign. Prior to the resident going work had been ordered and it alab work completed. There proor communication between is that needed to be done for	F 6	<u> </u>		
	hospital and so they evaluation. She was not been done for the on 7/28/24. Routine	y sent the resident for s not aware why lab work had ne resident after being ordered ely, the order would be placed t the phlebotomist, who came				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING				C <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	0.0020		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 09/	12/2024
TO WILL OF TH	TO VIDER OR GOLF EIER				1 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		LEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 153	F	684			
		arly AM hours, would know to ing orders on 7/28/24, labs mpleted on 7/29/24.					
	dated 7/3/24, that the daily and the physicia weight gain over a tin nights. On 7/16/24 ar	an orders revealed an order, resident was to be weighed an notified for a three pound ne period of two consecutive order was entered into the in for daily weights to be					
	revealed weights wer ordered. July 2024 ar results documented in record and on the MA 7/5/24-128.8 pounds 7/6/24-131.2 pounds 7/8/24-127 pounds 7/9/24-128 pounds 7/11/24-128.6 pounds 7/14/24-127.8 pounds 7/15/24-127.4 pounds 7/18/24-127.8 pounds 7/19/24-128.4 pounds 7/19/24-128.9 pounds 7/23/24-128 pounds 7/27/24-129.8 pounds 7/28/24-131.2 pounds 8/2/24-131.4 pounds 8/5/24-135 pounds 8/6/24-136 pounds 8/10/24-131 pounds 8/15/24-131.6 pounds 8/15/24-132.4 pounds 8/15/24-132.4 pounds 8/15/24-133.1 pounds 8/16/24-133.1 pounds 8/16/24-133.1 pounds 8/16/24-133.1 pounds						
	8/17/24-133.1 pounds 8/20/24-132.4 pounds	S					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			l	C <b>12/2024</b>
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	'H RALEIGH		,	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	<u> </u>	TEIEUET
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 8/25/24-127.4 pounds 8/26/24-127.2 pounds 8-29-24-127.2 pounds	S S S	F	684			
	on 8/28/24 at 3:29 PM concerned that the fa the resident's weights reported the resident	had a diagnosis of heart ogist wanted the weights ne if the resident was					
F 690 SS=D	corporate Nurse Cons	inence, Catheter, UTI	F	690			10/14/24
	admission receives so maintain continence u	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is					
	ensure that- (i) A resident who ent indwelling catheter is resident's clinical con catheterization was n	on the resident's assment, the facility must ers the facility without an not catheterized unless the dition demonstrates that					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  S	COMPLETED	
		345529	B. WING		C 09/12/2024
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	03/12/2024
(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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 690	is assessed for remoral as possible unless the demonstrates that call and (iii) A resident who is receives appropriate prevent urinary tract is continence to the extension of t	subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary;  incontinent of bladder treatment and services to infections and to restore ent possible.  esident with fecal on the resident's esment, the facility must to who is incontinent of bowel treatment and services to hall bowel function as  is not met as evidenced  in, record review, and and physicians the facility is for the care of a resident's heter. This was for one ee sampled residents with heters. The findings  dimitted to the facility on esident's diagnoses included a discharge summary also do an indwelling urinary ge orders included the atheter should be changed a notation in the discharge at due date for catheter	F 69	F690 Corrective actions accomplished for residents found to be affected by the deficient practice: Resident #16 no longer in the facility other actions taken for resident #16 Identification of other residents havi potential to be affected by the same deficient practice: 100% audit of all current residents vindwelling catheters in the facility completed on 10/02/2024 by the Dir of Nursing, Assistant Director of Nur and/or unit coordinator (#1 or #2) to identify any other resident with an indwelling catheter without an order and/or proper indication for use. no admission orders. No other resident identified without appropriate orders the use of indwelling catheter. Finding	e, v, no ing the with ector sing, was for

PRINTED: 10/22/2024 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	
			A. BUILDII	NG _			
		345529	B. WING _				C / <b>12/2024</b>
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2024
					201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH			RALEIGH, NC 27616		
				- 1	TALEIGH, NC 27010		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 690	Continued From page	e 156	F 6	390			
	the resident had an ir	ndwelling urinary catheter.			this audit are documented on the		
		.a.v.ag aa.y aaaa.a.			indwelling catheter audit tool located in	1	
	Review of the resider	nt's care plan, dated 8/9/24,			the facility compliance binder.		
		of the urinary catheter.			Measures/systemic changes will be pu	t	
		o			into place to ensure that the deficient	•	
	A review of physician	orders for Resident # 16			practice does not recur:		
		r the care of the urinary			F. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3.		
	catheter or when it wa				Effective 10/07/2024, an admitting		
		3			licensed nurse on duty will review hosp	oital	
	On 7/30/24 at 9:22 Al	M Nurse # 6 documented			discharge summary and transcribe all		
	the following informat	ion in Resident # 16's			orders to resident □s medical records to	0	
	record. The resident was noted to have some				include orders for indwelling catheters	and	
	tremors and congesti	on that morning. He was			other orders that are necessary for		
	easily aroused. His vi	tal signs were stable and his			resident care in the facility. Any resider	nt	
	heartrate was elevate	ed. The physician was			admitted with an indwelling catheter		
	notified and ordered I	abs and a chest x-ray to be			without proper indication, the attending	l	
	completed. One of the	e labs ordered was for a			physician will be informed immediately	for	
		ulture. Another lab, which			clarification.		
	was ordered, was for	a complete blood count.					
					Effective 10/07/2024, the Clinical team	,	
		16's lab results revealed			which consists of the DON, ADON,		
		eported on 8/1/24 showed a			Minimum Data set (MDS), and/or Unit		
	preliminary result of g				coordinators (#1, #2, will incorporate the		
		ative rods (bacteria). A			process of discussing residents admitte	ed	
		lture result, reported on			with, or with new orders for indwelling		
	8/3/24, revealed there				catheters to validate each has a prope		
		w from the culture. A review			indication of the use, and physician ord	der	
	of Resident # 16's ch	,			is transcribed correctly in facility□s		
		ay was completed and			electronic medical records. This system		
		infiltrate consistent with			process will take place Monday throug	n	
	pneumonia.				Friday. Any identified issues will be	ha	
	According to and and	which were dated 0/4/04			addressed promptly. This process will		
		which were dated 8/1/24,			incorporated into the daily clinical mee	ung	
		dered to have Cefuroxime			that takes place Mondays to Fridays.		
	times a day for a diag	250 mg (milligrams) two			DON ADON and/or Stoff dayslander	+	
	infection.	prosis or urmary tract			DON, ADON, and/or Staff developmen coordinator will complete 100% of	ı	
	IIIIGUIUII.				education for all licensed nurses to		
	Nurse # 6 was intorvi	ewed on 9/4/24 at 2:09 PM			include full time, part time, and as need	hah	
	THAT SO THE WAS THE CIVI	OHOG OH SITILT AL L.US I WI			I morado fun umo, part umo, and as fiect	40 <b>u</b>	1

Facility ID: 20040007

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 / <b>12/2024</b>
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2024
	101.02.1 011.00.1 2.2.1				201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH					
					RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	Continued From pag	ge 157	F 6	590			
	and reported the foll	owing information. She			employees (PRN). The emphasis of the	ıis	
		t had some congestion but he			education will be the importance of		
		on 7/30/24 when the provider			ensuring each resident with an indwelli	ng	
	was contacted and s	she did not recall any urinary			catheter has a physician order in place		
	symptoms.				that include the type of indwelling		
					catheter, size, and indication of the		
	Review of nursing no	otes revealed between			catheter use. The education also		
	7/30/24 to 8/2/24 the	ere were no more nursing			emphasized that resident who enters the	ne	
	notes documenting t	the resident's status.			facility without an indwelling catheter		
					should not be catheterized unless the		
	•	ecords, dated 8/2/24,			resident□s clinical condition demonstra		
		16 was seen in the hospital			that catheterization was necessary, an		
		partment) for evaluation. The			ordered by a physician, resident with a	n	
		the following. The resident			indwelling catheter is assessed for		
		een feeling well for the last		removal of the catheter as soon as			
	_	eportedly appeared more			possible unless the resident ☐s clinical		
		. The resident had one			condition demonstrates that		
	-	on the day of 8/2/24, and the			catheterization is necessary; and a		
		e ED physician that the			resident who is incontinent of bladder		
	_	experiencing a productive			receives appropriate treatment and		
	_	The resident was not in nt's vital signs in the ED were			services to prevent urinary tract infection and to restore continence to the extent		
		lood pressure 139/63; pulse			possible. This education will be complete		
		9, and respirations 26 with an			by 10/14/2024. Any licensed nurses no		
		f 93%. The resident's chest			educated by 10/14/2024 will be taken of		
		nary edema which was likely			the schedule until educated. This	<b>711</b>	
		ure with small bilateral pleural			education will also be implemented in i	าคพ	
	•	of fluid between the tissues			hire orientation for licensed nurses.		
	` .	gs and the chest) developing.					
		so noted the resident had an			Monitoring of corrective actions to ensu	ure	
		and had "bacteriuria" for which			that the deficient practice is being		
	•	ic. (Bacteriuria is when there			corrected and will not recur:		
	• •	ne). The resident was			Effective 10/07/2024, DON and/or ADO	N	
	prescribed to receive	e Levofloxacin 750 mg every			will monitor compliance with indwelling		
	other day and discha	arged from the ED back to the			catheter orders by reviewing the daily		
	facility.				clinical meeting reports to ensure		
					completion and validate that the clinica	ıl	
		M a nursing note included			team validated each resident with n		
	documentation Resi	dent # 16 had returned to the			indwelling catheter had a proper indica	tion	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345529	B. WING	<del> </del>	09	/12/2024	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO			
				5201 CLARKS FORK DRIVE NW			
UNIVERS	AL HEALTH CARE/NO	ORTH RALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 690	Continued From p	age 158 nosis of a urinary tract infection.	F 69	and a physician order in the	-		
	interviewed on 8/2 the following. The a urologist and his to be changed mo efforts to obtain ur times when the RF the urologist and t catheter as the urocatheter was not of 8/2/24. When the hospital staff of he had a urinary thad told the RP th before the resident shown pneumonia. The ADON (Assist interviewed on 8/2 record was review validated there we urinary catheter. Sthe physician shown the resident was a included how ofter changed. Another 9/5/24 at 1:19 PM been no orders, she were providing catheter had not be Resident # 16's physiciant's abnormal resident's abnormal reside	esponsible Party was 18/24 at 3:29 PM and reported resident was routinely seen by indwelling urinary catheter was nthly. The facility had made no clogy consult notes from the P would take the resident to visit hey would not change the clogist wanted. The urinary changed from 6/17/24 through resident went to the hospital, hanged the catheter and said fact infection. The facility staff at the resident's chest x-ray to went to the hospital had and the resident's chest x-ray to went to the hospital had and the resident's chest x-ray to went to the hospital had and the resident's chest x-ray to went to the hospital had and the resident's chest x-ray to went to the hospital had and the red with her. The ADON are no orders for Resident # 16's the further reported orders from all have been obtained when dmitted and should have in the catheter was to be interview with the ADON on revealed although there had no felt as if the nursing staff theter care although the urinary een changed by them.		electronic health records. The process will be completed disthrough Friday) for two weeks two more weeks, then month months, or until the pattern of is established. Any negative be addressed by the Director promptly. This monitoring product documented on a Foley order monitoring tool located in the compliance binder.  Effective 10/14/2024, Director will report findings of this may process to the facility Quality and Performance Improvem Committee for any additional or modification of this plan in three months, or until a patter compliance is maintained. To committee can modify this put the facility remains in substate compliance.  Compliance date 10/14/2024	aily (Monday ks, weekly for hly for three of compliance findings will or of nursing rocess will be ers review e facility  or of Nursing onitoring y Assurance ent al monitoring nonthly for ern of The QAPI llan to ensure antial		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		SURVEY PLETED
		345529	B. WING _		l	C 1 <b>2/2024</b>
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	TH 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	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 690	on 7/31/24. The physichanging the residen month's time had not infection. He often reurologist want the uridifferent schedules.		F 6			10/14/24
SS=D	S 483.25(i) Respirato tracheostomy care ar The facility must ensure and tracheal succare, consistent with practice, the comprescare plan, the resider and 483.65 of this su This REQUIREMENT by:	ry care, including and tracheal suctioning. Use that a resident who e, including tracheostomy estioning, is provided such professional standards of mensive person-centered and preferences,		F695		
	Services (EMS) record the facility failed to proservices for one (Respective for respirate for respi	rd, staff and family interviews ovide respiratory care ident #4) of three residents ory care. Findings included:  entation in the electronic sident #4 other than the mmary dated as uploaded /2024. The hospital for the 7/3/2024 to ay, revealed Resident #4 ignoses of generalized ironic lymphocytic leukemia,		Corrective actions accomplished residents found to be affected by deficient practice: Resident #4 no longer in the facil other actions taken for resident # Identification of other residents h potential to be affected by the sa deficient practice: 100% audit of all current resident are on oxygen supplement theral completed on 10/03/2024 by the of Nursing, Assistant Director of I unit coordinator (#1 or #2) and/or records coordinator to identify an resident with oxygen therapy with	the lity, no 44 aving the me ts who py Director Nursing, r medical ny other	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(	0
		345529	B. WING _			09/	12/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				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 PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE CO			(X5) COMPLETION DATE
F 695	discharge summary l	itus, and a history of ack (stroke). The hospital	F	695	order. No other resident identified. Findings of this audit are documented of the oxygen therapy audit tool located in the facility compliance binder.		
	There was no docum admission documenta medical record to ind obtained for Resident	n. entation of any orders or any			Measures/systemic changes will be pure into place to ensure that the deficient practice does not recur:  Effective 10/07/2024, an admitting licensed nurse on duty will review hosp discharge summary and transcribe all orders to resident smedical records to include orders for Oxygen therapy and	ital	
	PM. The family memlinformation about the facility. Resident #4 at the facility on 7/10/20 was paralyzed and w	#4 on 8/28/2024 at 12:53 ber provided the following stay of Resident #4 in the arrived from the hospital at 124 at 5:30 PM. Resident #4 as unable to move on his			other orders that are necessary for resident care in the facility. Any resident admitted with an Oxygen therapy without an order, the attending physician will be informed immediately for clarification.		
	oxygen concentrator engine and was very #4 asked a nurse aid oxygen concentrator was too loud and the broken. The nurse aid	s receiving oxygen from an that sounded like a jet loud. The family of Resident e to help them find another because the one in the room re was a concern it might be de told the family they would	n from an a jet bif Resident d another in the room it might be  Effective 10/07/2024, t which consists of the E Minimum Data set (ME coordinators (#1, #2, w process of discussing with, or with new oxyge		Effective 10/07/2024, the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), and/or Unit coordinators (#1, #2, will incorporate th process of discussing residents admitted with, or with new oxygen therapy and ensure they have a physician order for	e ed	
	the oxygen concentration never came down to member went to the of the nurse at the design Resident #4, she would help them in a minute at that moment. Anot came to the room and	all know of the concern for ator. The nurse for the hall the room so the family desk to seek her assistance. It told the family member of all be down to the room to be and that she was very busy her nursing staff member distance.			use of oxygen supplement in facility selectronic medical records. This system process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meet that takes place Mondays to Fridays.  DON, ADON, and/or Staff development	n pe ing	
	oxygen concentrator either because it nee nursing staff member	entrator. When another was brought, it did not work ded to have water per . The family stated at that d been in the facility for			coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as need employees (PRN). The emphasis of th education will be the importance of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			l	C
NAME OF D		343323	3:		TREET ARRESC CITY STATE ZIR CORE	09/	12/2024
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH			201 CLARKS FORK DRIVE NW		
				R	ALEIGH, NC 27616		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 695	Continued From page	e 161	F	695			
F 695	several hours and not him or make sure he oxygen. The family of emergency medical shack to the hospital and an interview was conwas assigned to care 7/10/2024 upon admiremembered on 7/10/receiving a lot of new revealed she was not admission paperwork was a licensed practic registered nurse (RN) she did not do any as initial documentation RN came over to the admissions. Nurse #2 to the room to see Rebusy, but did recall the her assistance with the because it was too look Nurse Aide (NA #5) wat 4:14 PM. NA #5 renurse aide who was a Resident #4. NA #5 salready in bed when she did not know when the facility. NA #5 stated the room for Resident rumbling noise and work NA #5 stated she was went looking for anothe located one in another	body had come to assess was receiving adequate for Resident #4 called for ervices to take Resident #4 to approximately 7:00 PM.  ducted with Nurse #2 who for Resident #4 on ssion. Nurse #2 stated she for Resident #4 on state of the second of the for Resident #4, and that an hallway to assist her with the state of the second of the secon	F	695	ensuring each resident who receives oxygen supplement has a physician or in place that include the amount (liters) and frequency (continuous or as needed. This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken of the schedule until educated. This education will also be implemented in reference in the orientation for licensed nurses.  Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:  Effective 10/07/2024, DON and/or ADC will monitor compliance with oxygen therapy orders by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team validated each resident had the admission orders in resident selectron medical records, including oxygen supplement orders if any. This monitoring process will be completed daily (Mondathrough Friday) for two weeks, weekly two more weeks, then monthly for three months, or until the pattern of compliar is established. Any negative findings we addressed by the Director of nursing promptly. This monitoring process will indocumented on a orders review monitoring tool located in the facility compliance binder.  Effective 10/14/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance.	off  new  I  nic  ing  for  e  nice  ill  g  oe	
	concentrators, so she	ow anything about oxygen went to ask the nurse at or assistance. Nurse #2 said			process to the facility Quality Assuranc and Performance Improvement Committee for any additional monitorin		

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
NAME OF D	ROVIDER OR SUPPLIER	343323	1 2:		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	12/2024
NAIVIE OF F	NOVIDER OR SUFFLIER						
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH			201 CLARKS FORK DRIVE NW		
				F	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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695			F 6	195			
	revealed she asked hall for assistance.	come to the room, so NA #5 a Medication Aide on another aducted with Med Aide # on			or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensu the facility remains in substantial	ıre	
	9/3/2024 at 12:13 PM following information medication aide on a which Resident #4 re the room of Residen requested assistance concentrator becaus was too loud. Med A	M. Med Aide #3 revealed the . Med Aide #3 was a an adjoining hall to the hall for esided. Med Aide #3 went to t #4 because NA #5			compliance. Compliance date 10/14/2024.		
	called into the facility #3 stated she tried to bottle on another oxy Resident #4 was stru	umed those were the orders from the hospital. Med Aide hook up the humidifier gen concentrator, but uggling a little to breathe. The MS before she could get an incentrator to work.					
	dated 7/10/2024 revine Resident #4 at 7:40 provided the following was laying down upon coherently, in no pail advised EMS they wat the facility and was the hospital. Resident minute (LPM) of oxyoby the facility. Resident #4's oxygen assessed as being 8	n, or distress. The family ere not happy with the care nted him transported back to nt #4 was on 2.5 liters per gen via nasal cannula started ent #4 denied any shortness arted on 3 LPM of oxygen. n saturation level was 9 % so the oxygen was after which his oxygen					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C 09/12/2024	
	ROVIDER OR SUPPLIER	H RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		03/12/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 695 F 725 SS=D	An interview was con on 8/30/2024 at 3:20 revealed it was very con 7/10/2024 becaus transition from one manother. Unit Manage informed of Resident oxygen concentrator leave with the resider indicated the oxygen was working but it was Manager #2 stated R distress when he left as EMS took him awas An interview was conconsultant on 8/31/20 nurse consultant acknowled problems with the adiabeginning of July 202 unable to locate any a information regarding #4.  Sufficient Nursing States	ducted with Unit Manager #2 PM. Unit Manager #2 lifficult admitting residents the the facility was trying to edical record database to the #2 stated she was only #4 and an issue with an the state family was ready to the the Unit Manager #2 concentrator for Resident #2 to slouder than normal. Unit the building and was calmed to the building and was calmed to the was the facility nurse the building and was calmed to the was the facility had the sident #2 was not in the building and was calmed to the was the facility had the sident was the facility had the was the was the was the was the facility had the was the was the facility had the was the was the was the facility had the was the was the facility had the was th	F 6			10/14/24	
	the appropriate comp provide nursing and r resident safety and at practicable physical, well-being of each res resident assessments and considering the r diagnoses of the facil	e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING		C 09/12/2024		
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	1 03/12/2024		
(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 SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 725	by sufficient number types of personnel of nursing care to all refresident care plans: (i) Except when waithis section, license (ii) Other nursing personnel of the personnel of	acility must provide services as of each of the following on a 24-hour basis to provide esidents in accordance with wed under paragraph (e) of d nurses; and resonnel, including but not es.  It when waived under a section, the facility must d nurse to serve as a charge of duty.  It is not met as evidenced view and interviews with family the facility failed to as in place to manage call outs nent care and showers could was for one of four residents in staff to meet residents' esident #2). The findings  alled Resident # 2 was a ty on 10/27/23. The resident's in part a history of congestive ry of spinal stenosis and a also had a diagnosis of omatosis (a genetic condition	F 72	,	a were d to the		
	Resident # 2's signi Set assessment, da resident as moderat resident was also as	ficant change Minium Data ted 8/22/24, coded the ely cognitively impaired. The essessed to be totally for bed mobility, hygiene		next 2 weeks of staffing schedules to ensure that there is an appropriate amount of staffing, this audit will be do by the administrator on 10/2/2024.  What measures will be put into place of	one		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI		(X3) DATE SURVEY COMPLETED		
			A. BUILDIN			l ,	c
		345529	B. WING _			l	) 12/2024
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2024
					1 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	ΓH RALEIGH			LEIGH, NC 27616		
()(1) ID	CLIMMADV CT	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 725	Continued From page	e 165	F 7	25			
	was assessed to be f bowel and bladder.	s, and bathing needs. He frequently incontinent of			what systemic changes will you make t ensure that the deficient practice does recur? Before clinical, the DON and the		
		‡ 2's care plan revealed it n 7/18/24 to include that the			Administrator will review the staffing schedule for the following day with the		
	•	istance with his activities of			scheduler to ensure that adequate staff	fina	
		ngestive heart failure and			are scheduled to work the next day. If	9	
	chronic medical cond	litions. The care plan also			there is not adequate staffing, the		
		as incontinent of bladder and			scheduler will work to fill the openings		
	bowel, and staff were directed on the care plan to				PRN staff and agency. If there are call		
	assist the resident wi	th care.			during the weekend, then PRN staff an agency staff will be utilized. If neither o		
	Resident # 2 was inte	erviewed on 8/28/24 at 3:50			these options are available, a bonus wi		
		following information. He		be offered to staff to pick up and if still			
	-	e changed when he was		there is a vacancy, then one of the nurs			
		nd been a recent incident			managers will cover the shift.		
	during which he waite	ed for hours and had soiled			•		
	himself with both urin	e and stool.			How will the facility monitor its corrective actions to ensure that the deficient	⁄e	
		nsible party was interviewed nd reported the following			practice is being corrected and will not recur?		
		t # 2 often had to wait to be			The assistant administrator will audit th	е	
	changed. He would c	all her about the situation,			daily schedule to ensure that there are	no	
	and she would take r	notes. There had been an			unfilled openings on the schedule. This	S	
		hen he had called her			will be done daily Monday through Frid	-	
		ng her know he was waiting			for two weeks, weekly for two weeks, the		
	· ·	ad soiled himself. He called			monthly for three months or until a patt		
	_	4:00 PM letting her know			of compliance is maintained. Results of	)Ť	
		anged him at 3:00 PM. They staff to change him. The RP			the audit will be presented in QAPI for review and recommendation.		
	_	nt # 2 had special skin			review and recommendation.		
	-	rofibromatosis. Areas on his					
		was supposed to get			Compliance date: 10/14/2024		
		tend but those had not been					
		igh of staff members to do					
	the showers.						
	A review of assignme	ent sheets and time cards					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		TE SURVEY MPLETED
		345529	B. WING			C 9/12/2024
NAME OF P	ROVIDER OR SUPPLIER	0.0020		STREET ADDRESS, CITY, STATE, ZIP COD		19/12/2024
				5201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		RALEIGH, NC 27616		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	Continued From pag	ue 166	F 7	25		
		there were six Nurse Aides orking hours for the day shift tire facility.				
	Consultant reported	If the facility corporate Nurse that the census on the on the date of 8/18/24.				
	PM and reported the 8/18/24 there were of day shift for the 300 been one of those N assigned to Residen regarding not received. The Nurse Aide # 8 many residents for wwas just not possible sooner than she did. for hygiene and inco Aides had to pass of the breakfast and lurasked the surveyor the amount of minute afford each of her residents.	interviewed on 9/3/24 at 7:20 e following information. On only two Nurse Aides for the hall and 400 hall. She had urse Aides and had been at # 2. What he reported ing incontinent care was true. The reported that there were so whom they had to care that it is to get to Resident # 2. In addition to making rounds antinent care, the two Nurse out trays and feed residents for each meal. The Nurse Aide on "do the math" and calculate it is she had been able to sidents in a eight hour shift. Give showers. Showers for ake a great deal of time and anough time to do so.				
	PM and reported the weekend staffing. M to work from home of sometimes she had find anyone. She was from agency workers various reasons suc general. She (the sc	nterviewed on 8/30/24 at 3:55 e following information about ost of the time she was able falling for staff and to come in if she could not as aware there were call outs on the weekend due to the as sick children or life in heduler) kept in contact with isor regarding weekend				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
			7 50.25.			(		
		345529	B. WING			09/	12/2024	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT	H RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE  5201 CLARKS FORK DRIVE NW  RALEIGH, NC 27616		201 CLARKS FORK DRIVE NW			
(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 725	on 8/29/24 at 8:05 PN information. She spec weekend of 8/17/24 at multiple agency Nurse scheduled but did not notice. That left them scheduled, and there that came to assist. interviewed about the change residents and make rounds, but the to make about two ronumber of residents to Supervisor was intervithere had been enough residents on that week was not enough time. Nursing Supervisor restaffing over the past and attributed it to ag coming to work or call difficult to provide car Supervisor reported scheduler would community working on squality employees aft multiple employees in were working to hire to utilizing an agency humander.	ekend Nursing Supervisor If revealed the following cifically recalled the and 8/18/24. There were e Aides who had been it show up or call to give with fewer Nurse Aides than had been no replacements The Nursing Supervisor was e timeliness of rounds to if responded that the staff did if Nurse Aides were only able unds per shift due to the hey had. The Nursing viewed regarding whether gh time to give showers to ekend and she reported there to do so. The weekend eported overall the weekend month had not been good ency Nurse Aides not ling. It had made it very e. The weekend Nursing once in a while" the	F	725				
F 755		cedures/Pharmacist/Records	F	755			10/14/24	

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 <b>09/12/2024</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	09/12/2024	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 755	drugs and biologicals them under an agreet §483.70(f). The facili personnel to administ permits, but only under a licensed nurse.  §483.45(a) Procedure pharmaceutical service that assure the accurdispensing, and administ biologicals) to meet the service of the provision that the service of the serv	ervices ide routine and emergency to its residents, or obtain ment described in ty may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide tes (including procedures ate acquiring, receiving, nistering of all drugs and the needs of each resident.  Onsultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of n of all controlled drugs in able an accurate	F 75	F755 Corrective actions accomplished for the	nose	
	-	sure an accurate accounting		residents found to be affected by the deficient practice:		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3)	) DATE SURVEY COMPLETED	
			7. BOILBIN			С	
		345529	B. WING			09/12/2024	
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP (	CODE		
				5201 CLARKS FORK DRIVE NW			
UNIVERS	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	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 755	Continued From p	page 169	F 75	55			
F 755	(Residents # 26, a residents whose of were reviewed and facility was account working under a resident were available and (Resident # 10) or reviewed for pharmincluded:  1a. Resident # 27 8/20/24. One of the osteomyelitis.  Review of orders for Oxycodone 5 as needed (PRN)  Resident # 27's of was reviewed on through 9/12/24. The cord is a form was a controlled substitute from the pharmace date, and time the resident's supply is maintained in dadministering the resident). Resident record for Oxycodone has controlled drug redocumentation of September 2024 record).	#27, and #28) of three sampled controlled substance records d during a time in which the ntable for overseeing a nurse estricted nursing license related and and 2) ensure medications d administered for one is seven sampled residents macy services. The findings  was admitted to the facility on the resident's diagnoses included revealed an order dated 9/4/24 mg (milligrams) every six hours	F 75	1. Resident #10 no longer no other actions taken for 2. Resident #26 no longer no other actions taken for 3. Resident #27 no longer no other actions taken for 4. Resident #28 no longer no other actions taken for Identification of other reside potential to be affected by deficient practice: 100% audit of current reside orders for Clonazepam and antianxiety medication combirector of Nursing, Assist Nursing, Unit coordinator #2 on 10/07/20 any other resident who didentification and the facility compliance bine 100% audit of the controller receipt/record/disposition for sidents with orders for comedication completed by Interest with orders for comedication were removed per physician order. This at the documented on the correceipt/record/disposition for as documented on the correceipt/record/disposition for as documented on the correceipt/record/disposition for documentation of medication documentation of medication documentation of medication and this audit are documented on the correceipt/record/disposition for last 14 documentation of medication and this audit are documented	resident #10 er in the facility, resident #26 er in the facility, resident #27 er in the facility, resident #28 dents having the the same  dents with d other mpleted by cant Director of #1, and/or Unit 024 to identify d not receive physician ks. Findings of on an dit tool located in der. ed drug form for current ontrolled Director of r of Nursing, r Unit 024 to identify if from the card audit compared oved medication introlled drug form to the ion days. Findings of		

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 / <b>12/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	l		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2024
					201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH			RALEIGH, NC 27616		
(X4) ID		ATEMENT OF DEFICIENCIES	ID				(X5)
PREFIX TAG	,	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 755	Continued From page	F	755				
		oorate Nurse Consultant, it			compliance binder.		
		es were failing to document			100% audit of records of controlled dru	-	
		tion of the Oxycodone every			substances delivered to the facility in the	ıe	
	time it was needed a	nd administered.			last 14 days completed by Director of		
					Nursing, Assistant Director of Nursing,		
		ent # 27 on 9/12/24 at 1:40			Unit coordinator #1, and/or Unit		
		experience pain, and the			coordinator #2 on 10/07/2024 to identif	У	
		viding her with her PRN (as			validate the record of the controlled		
	needed) Oxycodone	when she requested it.			substance delivery, removal per documentation on		
	1h Posidont # 26 wa	s admitted to the facility on			receipt/record/disposition form, and ret	urn	
					to pharmacy. Findings of this audit are	ипп	
	8/20/24 after having a new knee prosthesis (knee joint replacement).				documented on Narcotic records		
					validation tool located in the facility		
	Review of physician of	orders revealed orders,			compliance binder.		
		ycodone 2.5 mg every four			Address what measures will be put into	)	
		pain. On 9/3/24 the resident			place or systemic changes made to		
	had an order for Oxy	codone 2.5 mg every four			ensure that the deficient practice will no	ot	
	hours as needed for	mild to moderate pain and 5			recur:		
	mg for severe pain.				Effective 10/07/2024, facility employee	s	
					will administer medication based on		
		rolled drug receipt record for			physician orders to treat a specific		
	Oxycodone for 9/1/24				condition as diagnosed, and document		
		ycodone had been signed			the administration of such medication in	n	
		drug receipt record without			each resident □s clinical record.		
	MAR (medication ad	f the administration on the			On 09/16/2024, Regional Director of		
	WAR (medication add	ninistration record).			Clinical services revised the change of shift narcotic count sheet to include the		
	The above was confi	rmed with the corporate			provision for two nurses to validate the		
	Nurse Consultant on	•			change in count every shift. The revise		
		porate Nurse Consultant, it			form is used effective 09/17/2024.	u	
		es were failing to document			Effective 10/07/2024, the facility clinica	d.	
		tion of the Oxycodone every			team to include the Director of Nursing		
		nd removed from drug			assistant director of Nursing, Unit	,	
	storage.	3			coordinator #1 or #2 revised the shift		
					change process to include the revised		
	Interview with Reside	ent # 26 on 9/12/24 at 1:35			change of shift narcotic count sheet that	at	
	PM revealed she did	experience pain, and the			includes provision for validating the		
	nurses had been providing her with her PRN (as				accuracy of controlled drug including		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
				_		(	С
		345529	B. WING _			09/	12/2024
NAME OF P	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		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 755	55 Continued From page 171		F 7	'55			
	needed) Oxycodone	when she requested it.			oxycodone and clonazepam. This proc	ess	
	, .	·			will ensure medication is removed from		
	1c Resident # 28 res	sided at the facility from			the card based on the physician orders	;	
	2/27/20 until her deat	h on 8/19/24 while under			and, if otherwise, proper documentatio	n	
	hospice care at the fa	acility.			will be included on the disposition of ar	าy	
					medication removed/not removed from		
		28's orders revealed an			the card. Finding of this systemic chan	ge	
	order, dated 8/6/24, for morphine sulfate 100				is documented on the narcotic count		
	milligrams/5 milliliters (ml) give .25 ml (5 mg) four				sheets located in the narcotic count		
		onally, the resident could			binders on each medication cart.		
	have .25 ml every two hours as needed for break				Effective 10/07/2024, the facility s		
	though pain.				nursing administrative team, which includes the DON, ADON, Unit		
	A review of Resident	#28's August 2024 MAR			coordinators (#1, #2), and/or wound		
		ration record) revealed			nurse, incorporated the process for		
	,	2 (who was working as a			reviewing medication not administered		
		4) signed as administering			report from the facility electronic health		
		3/24 at 9:00 AM; 12:00 PM;			record for the last 24 hours, or from the		
	-	MAR's scheduled times.			last clinical meeting to ensure resident		
	·				receive medication based on physician		
	Review of hospice no	otes, dated 8/18/24, revealed			orders. This systemic process will take		
	hospice received a ca	all at 5:13 PM from Resident			place Monday through Friday. Any		
	` .	le party) that the resident's			identified issues will be addressed		
	_	er and faster and the RP was			promptly. This process will be		
		ne resident was receiving her			incorporated into the clinical meeting		
	Morphine due to the	resident sleeping.			taking place Mondays to Fridays. Any		
					identified issues will be addressed		
		nospice notes revealed			promptly by the DON, ADON and/or U	nit	
	8/18/24 at 6:55 PM a	ne hospice nurse arrived on nd documented the following			Coordinators #1 or #2.		
		reported to the hospice			100% education of all Licensed nurses		
		d increased secretions all			and Medication aides to include full time	ie,	
		was also concerned the			part time, and as needed nursing		
		eiving her Morphine as			employees will be completed by the	of	
	-	nurse noted the resident			Director of Nursing, Assistant Director	UI	
		had reportedly had no intake ad both an elevated heart			Nursing, and/or Unit Coordinators (#1,		
	•	She (the hospice nurse)			#2). The emphasis of this education includes but not limited to, the important	200	
		e Nurse # 2 and Nurse # 4			of administering medication to include	IC <del>C</del>	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			l	C / <b>12/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00	712/2024
					201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH			ALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 755	Continued From pag	je 172	F 7	<b>'</b> 55			
F 755	and was advised by the resident had record PM. An additional do administered while the facility per the PRN of the hospice nurse with 5:00 PM and reported When she arrived or appear uncomfortable elevated" and her record elevated. She spoke who showed her on morphine had been hospice nurse) had at the RP did not recall room to administer in is why the RP had conot sure if she could restroom. While the facility and after talking and Nurse # 4, a Progiven to Resident # 28's RP given to Resident # 28's RP sident #	Wound Care Nurse # 2 that eived the Morphine at 5:00 ose of Morphine was he hospice nurse was at the (as needed) order.  Was interviewed on 9/11/24 at ed the following information. In 8/18/24 the resident did le. Her heart rate was "quite spirations were also to Wound Care Nurse # 2 the electronic MAR that the given at 5:00 PM. She (the elso spoken to the RP and any nurse coming into the morphine that afternoon. That ealled hospice. The RP was have stepped out to the hospice nurse was at the fing to Wound Care Nurse # 2 RN dose of Morphine was 28. The hospice nurse orphine dose was beneficial int more comfortable.  Was interviewed on 9/11/24 at ed the following information. If acility from 12:00 PM all # 28 was not able to report incomfortable. The resident's chest was the reshoulders were moving	F 7	755	anti-anxiety medication, and other medications per physician order. Staff education also focused on the revised process for shift changes that include validating the count and ensuring medication was removed from cards per physician orders, and process to reord medication from pharmacy in a timely manner. This education will be completed by 10/14/24. Any Licensed nurse and/ormedication aide not educated by 10/14 will not be allowed to work until educated This education will be provided annually and will be added to the new hire orientation for all new Licensed nurses and medication aides effective 10/14/2 Indicate how the facility plans to monitority plans to monitority performance to make sure that solutions are sustained:  Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication monitoring process. This monitoring process will be accomplished by reviewing medication administration records for all residents with orders for pain medication, and other medication to ensure Licensed nurses and medication aides are administering such medication per physician orders. This monitoring process will be completed aily (Monday through Friday) for two weeks, weekly for two more weeks, the monthly for three months, or until the	er ted or //24 ed. y  024 or e	
	coming into the room the resident and the nurse around 5:00 P	She did not recall any nurse in to administer Morphine to refore she called the hospice PM. She did not recall going to ternoon or leaving the # 28.			monthly for three months, or until the pattern of compliance is established. A negative findings will be addressed by Director of nursing promptly. This monitoring process will be documented a medication review monitoring tool	the	

PRINTED: 10/22/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		345529	B. WING			C 9/12/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		5/12/2024	
TO UNE OF TH	TO VIDER OIL OIL OIL I EIER			5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH					
				RALEIGH, NC 27616			
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F 755	Continued From pag	ge 173	F 75	55			
F 795	Wound Care Nurse in 9/12/24 at 1:08 PM at information. She did to any concerns about had administered the resident's breathing she had recalled priorisiting.  The Corporate Nurse on 9/11/24 at 11:52 of following. Resident is had been sent back destruction on 8/21/2 death on 8/19/24. The records and were uncontrolled drug receit to show when the Mand by whom and or undergone a change months and recently packed and removed Resident # 28's Augiaccounting records were pronsibility while undergone it was though packed and sent away showing when the Mand from storage for administration of the Mand Sential Country and the Ma	# 2 was interviewed on and reported the following not recall the RP alerting her out Resident # 28, and she is Morphine as ordered. The had not been labored that for to the hospice nurse.  Be Consultant was interviewed AM and reported the if 28's remaining morphine to the pharmacy for 24 following the resident's the facility had searched their hable to find Resident # 28's intercords for the Morphine orphine had been signed out in which date. The facility had seen in ownership in recent it items/paperwork had been defrom the facility. Although	F 75	located in the facility compliance Effective 10/07/2024, the Direct Nursing, Assistant Director of N and/or Unit Coordinators (#1, # complete the controlled medicat monitoring process. This monit process will be accomplished be the controlled drug receipt/record/disposition form residents with orders for narcot medication orders to ensure me was removed from the card per order. This monitoring process completed daily (Monday throut for two weeks, weekly for two in weeks, then monthly for three in until the pattern of compliance established. Any negative finding addressed by the Director of in promptly. This monitoring proced documented on a Narcotic cout monitoring tool located in the factompliance binder. Effective 10/07/2024, the Direct Nursing, Assistant Director of N and/or Unit Coordinators (#1, # complete medication availability monitoring process. This monit process will be accomplished be five randomly selected resident and validating the availability of medication in the medication cat monitoring process will be com (Monday through Friday) for tw weekly for two more weeks, the for three months, or until the pat compliance is established. Any	tor of Nursing, 12) will ation oring by reviewing  for all tic edication r physician will be gh Friday) more months, or is ngs will be ursing ess will be ursing tor of Nursing, 12) will y oring by reviewing ts orders f art. This pleted daily to weeks, en monthly attern of		
	Carolina Board of Nu where she was found	ursing for prior incidents d to have removed multiple es without consistently		weekly for two more weeks, the for three months, or until the pa	en monthly attern of negative ne Director		

Facility ID: 20040007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345529	B. WING		C <b>09/12/2024</b>	
NAME OF PE	ROVIDER OR SUPPLIER	0.0020	<del>                                     </del>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/12/2024	
TVAINE OF T	TO VIDER OR OUT FIER					
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH		5201 CLARKS FORK DRIVE NW		
				RALEIGH, NC 27616		
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F 755	Continued From page	e 174	F 75	55		
F 755	Interview with a facilit 12:17 PM revealed fato keep all controlled three years and that it they keep them for five there should be some Resident # 28's morp did not have.  On 9/12/24 at 1:15 PM interviewed nurse) was accounting of controll medication cart locate observations were made controlled substances locked storage reveal cards with controlled 16 controlled drug recorresponding to each card had an acconumber of medication substance bubble car correct according to the receipt records. There count sheet was revisheet included signate going nurses to sign to controlled substances change.) On the sheet about how many individent controlled substance the rehab medication's shift change. On 9/12 sheet showed there we therefore 16 controlled According to the sheet notation if they remove	y pharmacist on 9/12/24 at cilities were required by law drug receipt records for he pharmacy recommended e. The pharmacist validated e sort of accounting for hine sulfate which the facility  M Nurse # 2 (a randomly as interviewed about the ed substances on her ed on the rehab unit and ade. A review of the sin Nurse # 2's double ed there were 16 bubble substances and there were excipt records that he bubble card (indicating counting sheet). The las on each controlled drug in the "controlled substance ewed with Nurse # 2. (This las on comming and off hat the accounting of swas correct at each shift et, there was a notation widual sheets/individual bubble cards should be in solocked drawer at each 2/24 at 1:15 PM this count were 16 sheets on hand and disubstance bubble cards. et, nurses were to make a led a sheet/controlled	F 75	process will be documented on a Medication availability monitoring too located in the facility compliance bine Effective 10/14/2024, the Director of Nursing, Assistant Director of Nursing and/or Unit Coordinators (#1, #2) wil complete the medication administrati monitoring process. This monitoring process will be accomplished by revimedication administration audit repoensure no resident is listed with missimedication administration. This monitoring process will be completed (Monday through Friday) for two weekly for two more weeks, then more for three months, or until the pattern compliance is established. Any negating findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Medication administration monitoring located in the facility compliance bine Effective 10/14/2024, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quanches and Performance Improvement Committee (QAPI), for recommendations and/or modification monthly for three months, or until the pattern of compliance is archived.  Compliance Date: 10/14/2024	der. g, l con ewing rt sing d daily eks, nthly of tive ector g tool der.	
	notation if they remove substance or added a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345529	B. WING				12/2024
NAME OF P	ROVIDER OR SUPPLIER		I	,	STREET ADDRESS, CITY, STATE, ZIP CODE		
HMIVEDS	AL HEALTH CARE/NOR	TU DAI EICU			5201 CLARKS FORK DRIVE NW		
UNIVERS	AL HEALIH CARE/NOR	IN RALEIGH		1	RALEIGH, NC 27616		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	reviewing with Nurse sheet showing the nuclear due to unclear controlled substance added on previous daviewed by Nurse # 2 the date of 9/9/24. Or individual sheets at 7 between the dates of 9/12/24 there had be with controlled substacontrolled drug receip card added or deduc without it always bein added/deducted, by were added/deducted, one resident Lyrica hand appeared to be a Nurse # 2 was unclear removals and addition controlled substance cart's locked storage more or less. The net Nursing) also reviewe 9/12/24 at 2:00 PM at clear. She reported the was supposed to be sheet which was part records, and which mand and addition substances for better. The Corporate Nurse Administrator were in PM and also reported clear. According to the sheet which was part records.	and note on which date. In # 2, she validated the count umber was 16 total was not documentation about s being removed and or ays. The count sheet being and the surveyor started on in that date there were 21 AM. The count sheet noted 9/9/24 at 7:00 AM and en multiple bubble cards ances and the accompanying pt records for each bubble ted to the total count sheet ing clear when they were whom and at what time they d. Also, it was noted that for ad been removed on 9/10/24 added back on 9/11/24. ar when looking at all the ins if there should be 16 bubble cards in the rehab or whether there should be we interim DON (Director of ed the count sheet on and also reported it was not hat she thought the facility utilizing a different count of the new corporation's hade it easier to note the in of new controlled reclarify.  E Consultant and current interviewed on 9/12/24 at 2:45 did the count sheet was not	F	755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345529	B. WING			09/	12/2024
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERSA	AL HEALTH CARE/NO	RTH RALEIGH		5	201 CLARKS FORK DRIVE NW		
				F	RALEIGH, NC 27616		
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F 755	Continued From pa	age 176	F	755			
F 750	subtraction and ad substances to the oreported the follow signing and dating substances were a sheet. This had no resident left, then a Director of Nursing medications should by the DON prior to pharmacy for destrict should be one which the receipt, the accounting and the time a controlle from the pharmacy doses returned to the discharge. Accord Consultant he had working on a syste the accounting. The suspicion that any being diverted. Acconsultant the Wohave been allowed had felt there was a diversion on her part by the facility.  2a. Resident # 10 or 7/22/24 with diagnor osteoarthritis and a admitted to the hos readmitted to the face.	dition of sheets/controlled count sheet. He further ing. Two nurses should be when new controlled dded or removed to the count to been happening. When a counting should go to the land any left- over controlled do be kept under locked storage to being picked up by the ruction. The accounting system challowed the facility to track counting of stored controlled administration of doses from the daubstance was received and any extrathe pharmacy or resident upon ing to the Corporate Nurse identified the problem and was im to ensure the accuracy of the evere no reports or controlled substances were cording to the Corporate Nurse und Care Nurse would not at to work if the Board of Nursing definitive evidence of any cart, and that was not suspected was admitted to the facility on oneses that included anxiety disorder. Resident was spital on 8/17/24 and accility on 8/27/24.		755			
		nission Minimum Data Set t dated 7/24/24 revealed he act.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
		345529	B. WING			C <b>09/12/2024</b>	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		03/12/2024	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 755	Continued From pag	e 177	F 75	55			
	for Clonazepam .5 m hours as needed (PF Oxycodone 5 mg (mi needed (PRN) for pa						
	8/28/24 at 9:55 AM v some of his doses of	· -					
	at 10:37 AM he state medication as reques anxiety medication.	vith Resident #10 on 8/30/24 d he had received his pain sted but had not received his He reported he had been ome in from the pharmacy.					
	10:41 AM she stated any Clonazepam on Resident #10. She s determine if his Clon	vith Nurse #1 on 8/30/24 at she was unable to locate the medication cart for tated she was unable to azepam had been is return from the hospital on					
	on 8/30/24 at 1:10 Pl	vas conducted with Nurse #1 M and she stated Resident nould be delivered the					
	Manager at the facilit 8/30/23 at 1:16 PM. stated Resident #10' on 8/21/24. He repo	nducted with the Pharmacy cy's contracted pharmacy on The Pharmacy Manager s Clonazepam was returned orted the medication would nacy to the facility on 8/30/24.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		E SURVEY PLETED
		345529	B. WING_			C / <b>12/2024</b>
	ROVIDER OR SUPPLIER	H RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	1 03	712/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 755	Corporate Nurse Con controlled substance	ducted with the facility's sultant who stated the	F 7	55		
F 757 SS=E	should have ensured available.	e from Unnecessary Drugs	F 7	57		10/14/24
	•	ary Drugs-General. regimen must be free from An unnecessary drug is any				
	§483.45(d)(1) In exce duplicate drug therapy					
	§483.45(d)(2) For exc	essive duration; or				
	§483.45(d)(3) Withou	t adequate monitoring; or				
	§483.45(d)(4) Without use; or	t adequate indications for its				
	§483.45(d)(5) In the p consequences which reduced or discontinu	indicate the dose should be				
	stated in paragraphs section. This REQUIREMENT by:	mbinations of the reasons (d)(1) through (5) of this is not met as evidenced				
	interview, pharmacist	ew, resident interview, staff interview, and physician iiled to ensure Protimes/		F757 Corrective actions accomplished f residents found to be affected by the second sec		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345529	B. WING			l	C 1 <b>12/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2024
					201 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 PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 757	Continued From page	e 179	F	757			
F /3/	International normalize completed per orders. Coumadin. This was one sampled residen. The findings included. Resident # 2 was adr. 10/27/23. One of the included atrial fibrillatheart arrhythmia and pumping by the heart subsequently lead to chambers and thereb. Review of July 2024 order transcribed onto administration record. Coumadin 2.5 milligra. Tuesday, Wednesday. Saturday, and Sunda. Fibrillation. According was not to receive the (Coumadin is an antiblood clots).  On 7/1/24 there was electronic system on and INRs (internation done weekly on Monoreflect how long it tak and are typically draw an anticoagulant. The determine therapeutic According to the electrotime/INR was to be supported to the support of the electrotime/INR was to be supported to the support of the electrotime/INR was to be supported to the electrotime/INR was to be supported to the supported to the electrotime/INR was to be supported to the electrotime/INR was to be supported to the supported to the electrotime/INR was to be supported to the electrotime in the electronic supported in the electronic suppo	red ratios (INRs) were for a resident receiving for one (Resident # 2) of t receiving Coumadin.  mitted to the facility on resident's diagnoses ion. (Atrial fibrillation is a can lead to ineffective blood which then can blood pooling in the heart by forming clots.)  physician orders revealed an or the MAR (medication ), dated 7/1/24, for ams one time daily on y, Thursday, Friday, y for the diagnosis of Atrial to the order the resident to Coumadin on Mondays. Coagulant and helps prevent  also an order created in the 7/1/24 for weekly Protimes that normalized ratios) to be days. (These lab values the sal normalized ratios of the county for individuals receiving they can help the physician to Coumadin dosage). The drawn on 7/8/24.		15/	deficient practice: Resident #2 was assessed by the attending physician on 09/13/2024. No negative outcomes were identified following missing monitoring of medication. Attending physician discontinued Coumadin for resident #2 9/13/2024. Identification of other residents having potential to be affected by the same deficient practice: All residents with orders for Coumadin/Warfarin have the potential to be affected. 100% audit of all current residents with current orders for coumadin/Warfarin (medication that can break down existing clots or prevent clots from forming in body), completed by the DON, ADON, and/or unit coordinator (#1 or #2) to ensure adequate monitoring of those medication took place per manufacture recommendations. The audit was completed on 10/07/2024. Any identified discrepancies were addressed by DON ADON, and/or unit coordinator (#1 or # Findings of this audit are documented of the anticoagulant order audit tool locate in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur:  On 09/13/2024, Regional Director of Clinical services implemented the Warfarin/Coumadin tracking form, the time of the services implemented the warfarin/Coumadin tracking form, the time of the services implemented the warfarin/Coumadin tracking form, the time of the services implemented the warfarin/Coumadin tracking form, the time of the services implemented the warfarin/Coumadin tracking form, the time of the services implemented the warfarin/Coumadin tracking form, the time of the services implemented the warfarin/Coumadin tracking form, the time of the services implemented the warfarin/Coumadin tracking form, the time of the services implemented the warfarin/Coumadin tracking form, the time of the services implemented the warfarin/Coumadin tracking form.	on the to ng er ed I, 2). on ed t	
	Administration Recor	# 2's July MAR (Medication d) revealed between the day) to 7/7/24 (Sunday)			is utilized to track each resident on Coumadin/Warfarin order, to include resident name, dose of coumadin		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	201/1252 02 01/221/152	345529	D. WING _		D.F.	09/	12/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
UNIVERSA	AL HEALTH CARE/NORT	H RALEIGH		5201 CLARKS FORK DRIVE NW			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 757	Continued From page	∋ 180	F 7	57			
	ordered Coumadin or 7/5/24; 7/6/24; and 7/Review of labs revea 7/8/24 (Monday) as of Review of Resident # between the dates of 7/14/24 (Sunday) Redocumented as received on 7/15/24 the first P done. The Protime rewas 6.75. The lab reptherapeutic range for thrombosis (clots) was also noted Resident #	led no Protime/INR done on ordered for Resident # 2.  2's July 2024 MAR revealed 7/9/24 (Tuesday) and sident # 2 was not ving any Coumadin.  Protime/INR in July 2024 was sult was 58.1 and the INR port noted the INR prevention of deep vein as 2.0 to 3.0. The lab report # 2's 7/18/24 value was a result was called to a facility		ordered, current PT/INR result ordered, and next date for Procumadin tracking sheet is et 09/13/2024.  Effective 10/07/2024, the fact nursing administrative team, includes the DON, ADON, Ulcoordinators (#1, #2), and/or nurse, incorporated the procureviewing coumadin tracking validate each resident has a monitoring per physician ord systemic process will take plus through Friday. This process incorporated into the clinical taking place Mondays to Frici identified issues will be address promptly by the DON, ADON Coordinators #1 or #2.	T/INR. The affective from the af	e m	
	Manager # 2 docume notified regarding Re and orders received to repeat the INR the net according to Resider Coumadin was not according to Resider Reside	at # 2's July 2024 the dministered on 7/16/24  ed no Protime/INR was the Unit Manager had an wanted in the nursing  was placed in the electronic		100% education of all Licens and Medication aides to inclupart time, and as needed nuremployees will be completed Director of Nursing, Assistan Nursing, and/or Unit Coordin #2). The emphasis of this edincludes but is not limited to, importance of ensuring resid coumadin has proper monito by reviewing the last INR be administering coumadin per order. Staff education also fouse of the Coumadin/Warfartool and its importance to en monitoring per physician ord manufacturer recommendatied education will be completed	ude full timersing If by the states (#1, ucation the lents on botton or tracking sure propers and ons. This	e, of ce the	
	On 7/17/24 a revision	order was placed in the		Any Licensed nurse and/or n		-	

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 <b>09/12/202</b> 4	4
NAME OF PR	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP	CODE		
LINID/EDO/		TU DAI 51011		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 ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		ETION
F 757	Continued From page electronic record for repeat critical lab val revision date of 7/17/ According to the July documented as received of 2.5 mg on 7/17/24 Review of lab results Protime/INR was corcompletion of the 7/17/18/24 the resident's 7.99. This 7/18/24 lawere again critical.  On 7/18/24 Resident Vitamin K 5 mg (milli subcutaneously (SQ) supratherapeutic INF Vitamin K helps normal According to the July the Vitamin K on 7/18/24 at 8:31 Adocumentation there Resident # 2's Coum	e 181 PT/INR one time only for ue. (This order showed as a /24)  MAR Resident # 2 was iving his Coumadin dosage  revealed on 7/18/24 the first impleted following the 5/24 critical lab result. On is PT was 67.6 and INR was in report noted these values  # 2 was ordered to receive grams) stat (right away) one time for a receive distribution of imalize elevated INR values).  # 2024 Resident # 2 received in a nursing entry included was an order to hold inadin until further notice, were to be completed, and to SQ that day.	F 7	DEFICIEN	4/24 will not lated. This annually and ire orientation is and 10/14/2024 ctions to ensure being an validate the tracking log obtained per be done daily rewo weeks, in monthly for tern of Results of the QAPI for revisional monitoring lity Assurancement and monitoring monthly for the monitoring lity Assurancement mal monitoring monthly for the monitoring lity Assurancement monitoring monthly for the monitoring lity Assurancement monitoring monthly for the monitoring lity Assurancement monitoring lity Assurancement monitoring monthly for the monitoring lity Assurancement monitoring lity Assurancemen	pe In re N of Ind Ine If we were general sections and Indianate sect	
	electronic record for PT/INR. On /19/24 at 10:00 A Nursing (ADON) doc	Resident # 2 to have a  M the Assistant Director of umented in the nursing red the Vitamin K as ordered.		compliance is maintained. committee can modify this the facility remains in subscompliance. Compliance date: 10/14/26	The QAPI plan to ensustantial	re	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C <b>9/12/2024</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		311212024		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 757	Resident # 2's Proting greater than 9.75. To values were critical.  According to hospital sent to the hospital of PM that evening. The Department of Department of PM that evening is resident was sent to supratherapeutic INI been held in previous any active bleeding, of bleeding upon as repeated in the ED aresident would be dis Coumadin and for the next 24 to 48 howas discharged from 7:27 AM on 7/20/24.  According to the July was documented to 7/21/24.  Review of lab results	se revealed on 7/19/24 me was 87.9 and his INR was his lab report noted the  al records the resident was on 7/19/24 and arrived at 6:10 the ED (Emergency an noted the following. The standard the following of his R and his Coumadin had as days. Resident # 2 denied. There were no obvious signs sessment. The INR was and found to be 4.5. The scharged with a plan to hold for the INR to be rechecked in the ED back to the facility at	F 7	,				
	was a PT of 12.2 ar According to Reside did not receive any 0 7/23/24. On 7/24/24 documented to rece On 7/24/24 at 8:03 F provider was notified 1.19. (This was the	nd an INR of 1.19. ent # 2's July 2024 MAR he Coumadin on 7/22/24 or						

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 09/12/2024
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	03/12/2024
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 757	Continued From pare noted there was an Coumadin 1 mg even Review of orders refor Coumadin 1 mg Review of Resident the dates of 7/25/24 Resident # 1 received dates excluding 7/2 no documentation in the Anursing note, date included documentation and the INF was notified. This was notified. This was notified in the Review of orders rethe Nurse Practition PT/INR to be done On 7/31/24 at 6:38 documented the resident in the Review of orders rethe Nurse Practition PT/INR to be done	ge 183 order at that time to start ery day on 7/25/24.  vealed an order dated 7/24/24 every day.  # 2's July 2024 MAR between It through 7/30/24 revealed ed Coumadin 1 mg on all the 6/24, on which date there was he received Coumadin.  ed 7/30/24 at 11:39 PM ation that Resident # 2's PT It was 1.17 and the physician halue indicated the resident's heutic and it did not show on a he resident's record.  Evealed on 7/31/24 an order by her was given for a Stat	F 7:	DEFICIENCY)	
	to check the resider On 7/31/24 an orde mg through 8/3/24. Review of lab result result of 14.1 and a According to Reside 2024 MAR, the resi from 7/31/23 throug	es three days and to continue nt's PT/INR on a weekly basis.  It was given for Coumadin 3  Its revealed on 8/1/24 a PT in INR result of 1.27.  Lent # 2's July 2024 and August dent received Coumadin 3 mg in 8/3/24.  It wealed an order dated 8/2/24			

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		LETED
		345529	B. WING _			C 12/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	<u> </u>	12/2024
(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 CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 757	drawn on 8/8/24 which to the weekly draw the PT/INR of 8/1/24.  Review of labs reveal a result of PT 16.9 and Review of orders revito give a one time exist In the directions of the was to be given "ton According to Resider was documented as from 8/3/24 through 8/6/24 and 8/7/24 there was documented to receive additional dose of the dates of 8/6/24 and documented to receive according to the MAI on the MAR separate on the dates of 8/6/2 documented under the was administered.  Review of lab results Resident # 2's PT/IN it was drawn earlier the was due on 8/16/24 and Results Resu	revealed no PT/INR was ch would have corresponded me from the resident's last led a PT/INR on 8/9/24 with and INR 1.71 ealed an order dated 8/10/24 tra dose of 1 mg coumadin. The order the one time dose norrow".  Int # 2's August 2024 MAR he receiving Coumadin 1.5 mg 8/13/24 excluding the dates and 8/10/24. On 8/10/24 ation the resident received f 1 mg with his 1.5 mg. On and 8/7/24 the resident was we only .5 mg rather than 1.5. R, the nurses documented by for the 1 mg dose and the the total dose of 1.5 mg and 4 and 8/7/24 the staff only he Coumadin .5 mg that it  revealed on 8/12/24 R was drawn which indicated than the weekly draw which after being drawn on 8/9/24. of 16 and an INR of 1.61.	F 7	757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			1	C <b>12/2024</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	TH RALEIGH		520	EET ADDRESS, CITY, STATE, ZIP CODE  1 CLARKS FORK DRIVE NW  LEIGH, NC 27616	1 00,	TATAVAT	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE		
F 757	the resident received between the dates of excluding the two dates of excluding the two dates of the documented to receive the recheck a PT/INR in Review of lab results completed early on 8 of 15.1 and an INR of 15.1 and a	at # 2's August 2024 MAR I this Coumadin 2 mg dosage If 8/14/24 and 8/20/24 Ites of 8/14/24 and 8/17/24. Ites of 8/14/24 and 8/17/24. Ite resident was not I we Coumadin.  I ealed an order on 8/14/24 to I one week on 8/21/24. I revealed the PT/INR was Is/16/24. The result was a PT If 1.51. I ealed on 8/20/24 an order I ealed on 8/20/24 an order I ealed on 8/20/24 and I was not checked off as I method the report was 18.2 and the I revealed on 8/19/24 I revealed on 8/21/24 Resident # I eive Coumadin 4 mg daily I ealed on 8/21/24 Resident # I eive Coumadin 4 mg daily I ealed on 8/22/24 through	F	757				
	_	and the August 2024 MAR 1 8/30/24 there was no 1ed as ordered or						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C <b>09/12/2024</b>	
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		00/12/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 757	Review of lab result PT/INR was completed to have a PR Review of lab result PT/INR was completed to the problem of the facility pharmacon 8/30/24 at 2:55 Finformation. During resident's weekly Problem. She had refollowing month (Au labs to the physician Coumadin was for the problem. She had refollowing month (Au labs to the physician Coumadin was for the physician of the physic	vealed Resident # 2 was T/INR repeated on 8/26/24. s revealed on 8/26/24 the ted and was 13.5 and 1.34. t # 3's Coumadin was	F7	757			
	and now he was abl see the results. This keep better track of weekly PT/INRs wo sure why they had b	e to look in the record and made it easier for him to the levels. For Resident # 2 ald be sufficient. He was not seen drawing them more often that one of his fellow					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345529	B. WING		C <b>09/12/2024</b>	
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE/NORTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE  5201 CLARKS FORK DRIVE NW  RALEIGH, NC 27616	03/12/2024	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE.	
Continued From page 187 collegues visited, the nurse made his collegue aware of the result, and the collegue ordered a PT/INR while not being apprasied by the facility nurse that the resident was already on weekly PT/INR orders.  Interview with the facility Corporate Nurse Consultant on 8/30/24 at 3:20 PM revealed the following information. The documentation on the MAR indicating the days and dosages of Coumadin given may not be reflective of the actual administration. This was because the facility had transitioned to a new medical electronic record system, and they had identified documentation issues on the MARs. Administration was working to correct the documentation issue and develop a better tracking system for Protime lab results to be tracked.  F 806 Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)  §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(Food that accommodates resident allergies, intolerances, and preferences;  §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with residents and staff the facility failed to ensure a system where residents who preferred and requested larger portions received	F 757		10/14/24 Dise	

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 D		343323	B: *******	0.	TDEET ADDRESS SITV STATE 71D SODE		09/12/2024	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERS	AL HEALTH CARE/NO	RTH RALEIGH		52	201 CLARKS FORK DRIVE NW			
				R	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		3E	(X5) COMPLETION DATE	
F 806	Continued From pa	age 188	F	306				
	1	eir preference without having to			Resident #9 no longer in the facility, no	0		
		epartment and ask for more			other actions taken for resident #9	,		
		two (Residents # 9 and # 11) of			Resident #11 registered dietician			
		nts reviewed for dietary			recommendation for double portion			
	· ·	neir preferences and needs.			implemented on 8/31/2024.			
	The findings includ	•			Identification of other residents having	the		
					potential to be affected by the same			
	1. Resident # 9 wa	s admitted to the facility on			deficient practice:			
I		e diagnoses which in part			100% of all registered dietician			
	included congestiv	e heart failure and diabetes.			recommendation for current residents			
					given in the last 30 days were audited	on		
	Review of Residen	t # 9's admission Minimum			10/07/2024 by the Director of Nursing,	ı		
		ent, dated 8/21/24, revealed			Assistant Director of Nursing, and/or u			
	the resident had m	oderate cognitive impairment.			coordinator (#1 or #2) to identify any corecommendations that were not	ther		
	A review of Reside	nt # 9's diet orders revealed an			transcribed/implemented correctly in tl	ne		
	order, dated 8/15/2	24, for a diabetic regular diet.			facility. Findings of this audit are			
	The order did not r	note any preferences for larger			documented on the F806 audit tool			
	portions.				located in the facility compliance binde			
					The dietary manager has interviewed			
		nt # 9's care plan, dated			residents listing double portions to ens			
		he resident's dietary			that they are receiving double portion			
	the resident.	o be reviewed as needed for			indicated. This audit was complete on 10/2/2024.			
					The dietary manager completed 100%	)		
	Review of the facili	ity's RD (registered dietician)			interview for all current residents to			
		4, revealed the resident's			determine their likes and dislikes to			
	weight was 171 po	unds and he was 68 inches			include the preference of double portion	on of		
	tall. The RD noted	the resident had complained of			meals and updated the dietary tickets	to		
		ff and she (the RD)			reflect each resident⊡s preferences. T	his		
		ble portions of protein and			audit was complete on 10/7/2024.			
	_	ls and snacks if the resident			Measures/systemic changes will be pu	ıt		
	1 '	continued to complain of			into place to ensure that the deficient			
	hunger between m	eals.			practice does not recur			
	Resident # 9 was i	nitially interviewed on 8/28/24			Effective 10/7/2024, the registered			
	at 9:50 AM and rep	oorted he was supposed to get			dietician and/or Dietary manager will			
	· ·	food and the staff did not			interview the new admission to determ	iine		
	always sarve him t	he double portions			each resident s food preferences to			

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	0.0020		STREET ADDRESS, CITY, STATE, ZIP CO	•	09/12/2024	
TVAIVIL OF T	TOVIDER OR OUT FEEL				DE		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE NW			
				RALEIGH, NC 27616			
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F 806	Continued From pag	e 189	F 80	06			
F 806	On 8/29/24 at 9:00 A observed to have reg food items. His tray of preference for double Interview with the RE revealed she had red because of the reside She sent the recommadministrative staff in members who receive recommendation was:  The DM was intervie and reported he had knew the resident proportions. He (the DM registered dietician to confirm changing his portions. The DM did recommendation of the Interview with the Co. 8/31/24 at 11:00 AM been giving Residen hungry. The resident kitchen and asking for the facility had now unote that he should a extra food without has	M Resident # 9 was gular portions of breakfast card made no mention of his exportions.  O on 9/4/24 at 10:12 AM commended double portions cent's complaints of hunger. In the dietary complaints of hunger. In the dietary center of the staff ed the dietary center of the staff ed the dietary manager).  Wed on 8/30/24 at 8:34 AM spoken to the resident and deferred to have double of the evaluate the resident to diet orders to include larger of the he RD from 8/19/24.  Interporate Nurse Consultant on revealed the facility had to the additional portions and updated his preferences to nutomatically receive the	F 8	include the preference for do of meals. The registered diet dietary manager will update tickets and implement reside preferences as indicated. Effective 10/7/2024 the Clinic which consists of the DON, A Minimum Data set (MDS), ar coordinators (#1, #2), revised for reviewing Registered diet recommendations written in hours or from the last held of to ensure such recommendation portions, are transcribed confacility electronic medical recresident stray card. This sy process will take place Mono Friday. Any identified issues addressed promptly. This proincorporated into the daily climeeting. Any findings will be on the daily clinical meeting maintained in the daily clinical binder.  On 10/07/2024, the facility D Manager established a proce review of tray cards during the ensure resident spreference for double portion reviewed and implemented, include one staff member will tray card to include whether a double portion or not for the	tician and/or the meal ent  cal team, ADON, ad/or Unit d the process tician the last 24 linical meeting ations, on for double rectly in cords and vstemic day through will be ocess will be inical documented form and al meeting ess for detail and the tray line to ces to include as are this process ll read the resident need		
		th 11's quarterly Minimum t, dated 5/29/24, revealed nitively intact.		a double portion or not for the staff member to serve mention the plate, that will be verified person before placed on the 100% education of all currents.	oned food to by the third cart.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	MULTIPLE CONSTRUCTION  IILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			l	C <b>12/2024</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NOR	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE  5201 CLARKS FORK DRIVE NW  RALEIGH, NC 27616			12/2027	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 806	Continued From page A review of Resident an order, dated 7/2/2 diet with thinned liqui portions.  Resident # 9 was inte AM and reported he was portions of food, and serve him the double  On 8/30/24 at 12:45 to observed to have reg There was one fish s tray card specified do  During an interview w 8/30/24 at 12:50 PM Resident #11's tray w  An interview and obs with the Dietary Mana He stated Resident #	# 11's diet orders revealed 4, for a heart healthy regular ds. The order noted double  erviewed on 8/28/24 at 10:09 was supposed to get double the staff did not always portions.  PM Resident # 11 was ular portions of food items. andwich on his tray. His		806		rill es, that will ill y on t ded is		
					The education also emphasized the importance of following registered dietician recommendation timely. This education will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken of the schedule until educated. This education will also be implemented in rhire orientation for licensed nurses.			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345529	B. WING _				C 12/2024
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE  5201 CLARKS FORK DRIVE NW  RALEIGH, NC 27616			
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F 806	Continued From pag	e 191	F	306	Monitoring of corrective actions to ensuthat the deficient practice is being corrected and will not recur:  Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all registered dietician recommendations during weekly meeting to ensure the recommendations were carried out. Any negative findings will be corrected promptly. This monitoring process will be completed weekly for forweeks, then monthly for three months of until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the RD recommendation monitoring tool for new residents located in the facility compliant binder.  Effective 10/07/2023, the Dietary Manager, kitchen manager or designed will complete food serving monitoring process by observing tray line on one meal a day to ensure; residents food preferences including double portion and served per tray card. This monitoring process will be completed daily (Mondathrough Fridays) for two weeks, weekly two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on Food serving monitoring tool located in the facility compliance binder.  Effective 10/14/2024, Director of Nursing Dietary Manager and/or Kitchen management of the facility compliance binder.	ngs e our or w nce e ay for e ce ng	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
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		345529	B. WING _			09/12/2024	
	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE	
F 806	Continued From page	÷ 192	F 8	process to the facility Quality As and Performance Improvement Committee for any additional moor modification of this plan mont three months, or until a pattern compliance is maintained. The committee can modify this plan the facility remains in substantia compliance.  Compliance date: 10/14/2024.	onitoring hly for of QAPI to ensure		
F 825 SS=D	S483.65 Specialized in S483.65 Specialized in S483.65 Specialized rehability not limited to physical pathology, occupation therapy, and rehability illness and intellectual lesser intensity as set required in the reside	rehabilitative services. of services. tative services such as but I therapy, speech-language nal therapy, respiratory ative services for mental I disability or services of a t forth at §483.120(c), are int's comprehensive plan of	F 8	825		10/14/24	
	§483.65(a)(2) In according obtain the required seresource that is a proper rehabilitative services participating in any ferograms pursuant to the Act.  This REQUIREMENT by:	e the required services; or ordance with §483.70(f), ervices from an outside vider of specialized and is not excluded from ederal or state health care o section 1128 and 1156 of is not met as evidenced iew, family interview, and		F825 What corrective actions will be			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	1 ' '			( - /	LETED
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		345529	B. WING				12/2024
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UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH			ALEIGH, NC 27616		
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE
					DEFICIENCY)		
'							
F 825	Continued From page	e 193	F	825			
	rehabilitation services	s per the resident's plan of			accomplished for those residents found	d to	
		e (Resident # 16) of three			be affected by the deficient practice?		
		viewed for therapy services.			Resident #16 is no longer in the facility		
	The findings included	l:			Identification of other residents having	the	
					potential to be affected by the same		
		dmitted to the facility on			deficient practice:		
	6/17/24 following a fo			100% audit of all current residents who			
	According to a hospit			receive therapy services completed on			
	6/17/24 the resident v			10/07/2024, by the Director of			
	acute ulcerative esop	- · · · · · · · · · · · · · · · · · · ·			Rehabilitation to identify any other		
		ling, and a urinary tract alized. Additionally, the			resident who missed therapy services porder/plan of care in the last 30 days. A		
		es in part which included a			resident(s) identified with missing thera	-	
		retention, congestive heart			per plan of care will be reassessed to	ру	
	-	uctive pulmonary disease,			ensure no negative outcomes resulted		
		hypertension. According to			from missing rehab.		
		e summary Resident # 16			3		
	was to have physical	therapy upon discharge.			Measures/systemic changes will be pu	t	
					into place to ensure that the deficient		
		num Data Set assessment,			practice does not recur:		
		4, coded the resident as					
	moderately cognitivel	• •			Effective 10/07/2024, facility rehabilitat		
	was assessed to nee				employees will ensure residents receiv	es	
	assistance with his hy	ygiene and bathing needs.			specialized rehabilitative services as	_	
	Dovious of thorons: de	ecumentation revealed			determined by their comprehensive pla		
		cumentation revealed itially evaluated by physical			of care to assist them to attain, maintai or restore their highest practicable leve		
	therapy on 6/19/24 ar				physical, mental, functional and	i Oi	
		sions for five times per week			psycho-social well-being. This systemic	_	
		erapy certification was from			modification will be accomplished by	-	
		herapy goals set for the			implementing the following measures:		
		rking on transfers, walking,			Effective 10/07/2024, the Clinical team	,	
	and navigating steps.	-			which consists of the DON, ADON, MD		
					Rehab Director, and social worker will		
	Review of physical th	erapy June 2024 service			review 100% of new admissions to ens	ure	
	logs revealed physica	al therapy staff members			that each resident is screened by thera	ру	
		physical therapy treatment			staff to determine the need for		
		welve days between 6/19/24			rehabilitation services, and if so ensure		
	to 6/30/24. This was	on 6/19/24; 6/20/24; 6/24/24;			that the plan of care for such services i	s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345529	B. WING _	B. WING		09/12/2024		
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LININGERO	AL LIEALTH CARE/AL	ODTU DAL FIOLI		52	201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/N	ORTH RALEIGH		R	ALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 825	Continued From p	page 194	F	825				
	· ·	ween the dates of 7/1/24 to	, ,	020	developed and implemented timely.			
	7/18/24 physical t			Additionally, if there are recommendate	ions			
		therapy hours on ten days of			on the discharge summary pertaining			
		period. These were 7/1/24 to			therapy services, the therapy director			
		10/24 to 7/12/24; and 7/16/24.			share these recommendations with he			
	, , , , , , , , , , , , , , , , , , , ,				therapists who evaluate residents on	•		
	On 7/22/24 an up	dated physical therapy plan was			admissions.			
	devised and the the			100% education of all therapy staff, to	)			
	approval/certificat			include full time, part time, and as nee	ded			
	physical therapy f			therapy employees will be completed	by			
		atment plan again included			the Director of Rehabilitation services			
	' '	services for five times per week			The emphasis of this education includ	es		
	for four weeks.				but not limited to the importance of;			
					screening all new admission for the ne			
		al therapy July 2024 service logs			of specialized rehabilitation services,			
		therapy staff members logged			ensuring each resident who need ther			
		sical therapy treatment hours the time of 7/22/24 through			services, receives such services base individual plan of care. This education			
	7/31/24. This was				be completed by 10/14/2024. Any the			
	7/51/24. Tills was	OH 1/22/24.			employee not educated by 10/14/24 w			
	Review of physica	al therapy August 2024 service			not be allowed to work until educated.			
		sical therapy staff members			This education will be provided for any			
		ded physical therapy treatment			newly hired therapy employees during			
		it of nineteen days from 8/1/24			new hire orientation, and annually.			
	to 8/19/24. These	were on 8/6/24 through 8/9/24;			Monitoring of corrective actions to ens	ure		
	8/12/24 through 8	/16/24; and on 8/19/24.			that the deficient practice is being corrected and will not recur:			
	Interview with Res	sident # 16's RP (Responsible						
		at 3:29 PM revealed Resident #			Effective 10/7/2024, the Administrator	,		
	16 had not always	s received physical therapy per			and/or Director of Rehabilitation servi	es		
		he RP had asked about this			will complete the monitoring process t			
		d the therapy department had			ensure residents received necessary	care		
		apists. The RP was concerned			to include specialized rehabilitation			
		goal was for the resident to			services based on plan of care. This			
		ne with assistance after			monitoring process will be accomplish			
	rehabilitation.				by implementing the following measur			
	The Debahilitetie	Director was intensioned as			Effective 10/7/2024, during the clinical	ı		
		n Director was interviewed on M and again on 8/31/24 at 8:10			meeting, the rehab director will cross reference discharge summary orders			
	0/00/24 at 0.10 Al	vi anu ayani on 0/3 1/24 at 0.10	1	- 1	i reference discriarge suffilliary didels		1	

PRINTED: 10/22/2024 FORM APPROVED OMB NO. 0938-0391

OLIVILIY	OT OIL MEDIO, ILL A	WEDIO/ ND CEITTIOEC				<u> </u>	. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
							3
		345529	B. WING				12/2024
NAME OF P	ROVIDER OR SUPPLIER	•	<b>I</b>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				52	201 CLARKS FORK DRIVE NW		
UNIVERSA	AL HEALTH CARE/NOR	IH RALEIGH		R	ALEIGH, NC 27616		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	•	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG	REGULATORT OR	EGG IDENTIL TING IN GRANATION)	IAG		DEFICIENCY)	-	
F 825	Continued From pag		F	825			
	AM and reported the	following information. She			pertaining to therapy recommendations	in	
		ent # 16 had not received			the facility electronic health record syste		
		of care which was based on			to ensure they are accurate and correct		
		evaluation of his needs.			This will be done daily Monday through		
	,	on Manager) had returned to			Friday for two weeks, weekly for two	_	
		r an extended leave of			weeks, then monthly for three months o	r	
	absence. During her time away from the facility, a				until a pattern of compliance is		
	therapist from a sister facility was supposed to be handling problems related to staffing issues that				maintained. Effective 10/07/2024, the Director of		
	might arise. When she (the Rehabilitation				Rehabilitation services will review		
	Manager) returned she immediately recognized				resident⊟s therapy schedule for service	76	
		re staff. There had been			provided in the last 24 hours or from the		
	· ·	rs out of work due to illness			last clinical meeting to ensure each		
		y positions. She made her			resident receive such care per the plan	of	
		re of the problem and met			care. This monitoring process will be		
	with her. They immed	diately devised a plan and			completed daily (Monday through Friday	y)	
	had worked on filling	the open positions and			for two weeks, weekly for two more		
		ositions also to ensure			weeks, then monthly for three months, or	or	
	residents were receive	ing therapy per their plan of			until the pattern of compliance is		
	care.				established. Any negative findings will be	е	
					addressed by the Director of		
		rporate Nurse Consultant on			Rehabilitation services promptly. This		
		revealed that there had been			monitoring process will be documented		
	_	therapy through the facility's			a service log matrix located in the facilit	У	
		nce program to ensure the ectified although the rehab			compliance binder. Effective 10/07/2024, Director of		
		oactive steps to resolve the			Rehabilitation services will report finding	ns	
	· ·	t that all residents were			of this monitoring process to the facility	- 1	
	again receiving thera				Quality Assurance and Performance		
	J	1.7			Improvement Committee for any		
	A review of Resident	# 16's physical therapy			additional monitoring or modification of		
		esident had again been			this plan monthly for three months, or u		
		nysical therapy services from			a pattern of compliance is maintained.		
		as receiving therapy as his			The QAPI committee can modify this pla	an	
	evaluation indicated,	and had made progress			to ensure the facility remains in		
	towards his goals.	• •			substantial compliance.		
					Compliance date: 10/14/2024		
F 842	Resident Records - I	dentifiable Information	F	842			10/14/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C <b>09/12/2024</b>	
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	•	03/12/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	(i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use of except to the extent to do so.  §483.70(h) Medical §483.70(h)(1) In acc professional standa must maintain medithat are- (i) Complete; (ii) Accurately docur (iii) Readily accessil (iv) Systematically of §483.70(h)(2) The fall information contaregardless of the for records, except when (i) To the individual, representative wher (ii) Required by Law (iii) For treatment, poperations, as permit with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial an law enforcement pupurposes, research	ent-identifiable information. release information that is to the public. release information that is to an agent only in contract under which the agent of disclose the information the facility itself is permitted  records. cordance with accepted ords and practices, the facility cal records on each resident  mented; ole; and organized  accility must keep confidential ained in the resident's records, or storage method of the en release isor their resident e permitted by applicable law; or, ayment, or health care itted by and in compliance	F8	42			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		345529	B. WING		C 09/12/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	09/12/2024	
(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)	ILD BE COMPLETION	ON
F 842	by and in compliance §483.70(h)(3) The farecord information a unauthorized use.  §483.70(h)(4) Medic for- (i) The period of time (ii) Five years from the series in the se	ealth or safety as permitted e with 45 CFR 164.512.  acility must safeguard medical gainst loss, destruction, or  al records must be retained  e required by State law; or the date of discharge when ent in State law; or the ears after a resident reaches the law.  The edical record must containtain to identify the resident; the sident's assessments; this plan of care and services by preadmission screening evaluations and ucted by the State; the's, and other licensed the ess notes; and blogy and other diagnostic the equired under §483.50.  This not met as evidenced the rately and consistently the resident lay of three residents by of medical record.	F8	F842 Corrective actions accomplished f those residents found to be affecte the deficient practice: Resident #13 no longer in the facili other actions taken for resident #13 Resident #22 no longer in the facili	d by ty, no 3	
		physician order dated Resident #22 was ordered to		other actions taken for resident #2: Identification of other residents ha the potential to be affected by the s	ving	

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 09/12/2024	
NAME OF PE	ROVIDER OR SUPPLIER	0.0020		STREET ADDRESS, CITY, STATE, ZIP COD		9/12/2024	
TAPAWIE OF TH	TO VIDER OR GOLT EIER				=		
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		5201 CLARKS FORK DRIVE NW			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	Continued From page	e 198	F 8	42			
F 842	receive Novolog insusubcutaneously (und at 8:00 AM, 12:00 PM following sliding scale was 201 milligrams pmg/dL administer 4 umg/dL administer 6 umg/dL administer 8 umg/dL administer 10 mg/dL call the physic insulin used to treat hwith diabetes.  Documentation on the Administration Recorrevealed on 7/9/2024 399 mg/dL and Medicadministered ten unit Med Aide #5, an againterviewed on 9/5/20 the following informationshe did take the bloomg/dL on 7/9/2024 and administer insulin to 1 did not recall who the was assigned to help administration tasks on 7/9/2024. Med Aidput the blood glucose MAR, the administration incorrectly go under hindicated she had to to whom she reporter	lin solution to be injected er the skin) three times day M, and 4:00 PM per the e: If the blood glucose level er deciliter (mg/dL) to 250 nits; 251 mg/dL to 300 nits; 351 mg/dL to 400 units; 351 mg/dL to 400 units; greater than 400 ian. Novolog is a fast-acting high blood glucose for people e. July Medication d (MAR) for Resident #22 the blood glucose level was eation Aide (Med Aide) #5 is of insulin at 6:22 PM.  Incy employee, was 124 at 1:08 PM and revealed the did glucose reading of 399 ind that she did not resident #22. Med Aide #5 incensed nurse was who her perform medication but of her scope of practice le #5 explained when she is reading into the electronic ion of the insulin would also her name. Med Aide #5 trust that the licensed nurse, did the blood glucose level of	F 8	deficient practice: 100% audit of all current resid glucose reading documented 6/28/2024 to 09/07/2024 com 09/07/2024 and 09/08/2024, b Director of Nursing, Assistant Nursing, and/or Unit Coordina #2) to identify any other docur a high blood glucose documer appropriate intervention to incadministration of ordered insuresident(s) identified with miss documentation of administratias ordered, the Director of nurinform the physician for appromeasures and or interventions implement the interventions at 100% audit of current resident orders for levothyroxine was of the DON, ADON, and unit coor #2) to ensure ordered mediadministered per physician or last fourteen days. The audit is completed on 10/7/2024 & 10. Findings of this audit is documented in the facility compliant Measures/systemic changes with the place to ensure that the diagractice does not recur.	from pleted on by the Director of otor (#1 or mentation of inted with no clude lin. Any sing on of insulin rsing will priate s and s ordered.  Its with completed by ordinator (#1 ication were ders in the was /08/2024. mented on audit tool ince binder. will be put deficient		
	dose and document t name.	administer the correct insulin he administration under their entation on the July MAR		discharge summary and transcribe/document all orders resident⊡s medical records to orders for levothyroxine and in	include		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C <b>09/12/2024</b>		
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2024	
					201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NOI	RTH RALEIGH			ALEIGH, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From pa	ge 199	F 8	342				
	Resident #22 had a	blood glucose level taken or sulin as ordered at 8:00 AM			Effective 10/07/2024, the Clinical leadership team, which consists of the DON, ADON, Minimum Data set (MDS Unit coordinators (#1, #2), and/or wour			
	Aide #4 took a bloo	he July MAR revealed Med d glucose level of 400 mg/dL 0 units of Novolog insulin on M to Resident #22.			nurse, resumed the process for review new admissions/readmission to ensure that the medication orders and other orders on the discharge summary, mat the orders that are entered into the fac	ing e ch		
	There was no document Resident #22 had a was administered N 4:00 PM on 7/10/20			Electronic Health Records (EHR). Additionally, if there are recommendati on the discharge summary that are not reflected in the discharge orders, the	ons			
	9/6/2024 at 1:54 PM was assigned to the resided on 7/10/202 shift. Med Aide #4 r Nurse #4 that she h medications to Resi7:00AM shift ending stated she expected the MAR the medical	onducted with Med Aide #4 on M. Med Aide #4 confirmed she hallway which Resident #22 24 for the 7:00 AM to 7:00 PM evealed she was told by ad already administered dent #22 on the 7:00 PM to g on 7/10/2024. Med Aide #4 d Nurse #4 to document on ations she was told had			clinical team will ensure the clarification obtained from the discharging facility and/or resident sattending physician. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daclinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder.	s aily ng		
	why there was no dinsulin for Resident Med Aide #4 explair remember which licher on 7/10/2024 at administer Novolog 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass Manager #2. On 7/10/2024 at 1:43 Flicensed nurse, ass M	istered as an explanation for ocumentation of the Novolog #22 at 8:00 AM on 7/10/2024. The distance of the second not ensed nurse was assisting and confirmed she did not insulin to Resident #22 on IM. Med Aide #4 thought the isting her on 7/10/24, was Unit 10/2024 the blood glucose 22 read as "HI" or above 400 see monitor. (A reading of "HI" eans the reading is above the e glucometer.) The licensed at #4 the physician ordered 12			Effective 10/07/2024, facility employee will document the administration of medication based on physician orders treat a specific condition as diagnosed and document the administration of sumedication in each resident sclinical record.  Effective 10/07/2024, the facility clinical team to include the Director of Nursing assistant director of Nursing, Unit coordinator #1 or #2 revised the shift change process to provision for validat the administration of all medication including insulin and levothyroxine by	to , ch ,		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	EICATION NI IMBED:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(	
		345529	B. WING _			09/	12/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				52	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 CY 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 842	Resident #22 and to glucose level every he checking the blood greported to the licens still registering as ab thought the licensed document everything PM scheduled Novol 7/10/2024 because of that were over 400 m to be involved. Med did not allow Novolog administered unless entered into the MAF reading. Med Aide #4 mg/dL although the major was 8:21 AM. Unit Manager #2 was 8:21 AM. Unit Manager #10 mg/dL.  Unit Manager #2 was 8:21 AM. Unit Manager #2 information. Unit Manager #2 information which resident #22 informing glucose levels on 7/1 revealed she kept a swhich residents she documentation on as #2 thought perhaps is blood glucose levels but she forgot to go is 1. There was no documentation on documentation documentation on documentation on documentation on documentation documentatio	alin to be administered to keep checking the blood hour. Med Aide #4 kept lucose level every hour and sed nurse the reading was ove 400 mg/dL. Med Aide #4 nurse was going to and take care of the 4:00 log insulin administration on of the blood glucose readings mg/dL, requiring a physician Aide #4 revealed the MAR glinsulin to be checked off as an actual number was an actual number was an actual number was as for the blood glucose 4 stated she had to put in 400 leading may have been over so interviewed on 9/10/2024 at ger #2 revealed the following mager #2 revealed the following mager #2 revealed she ext to the physician for mg him of the elevated blood 10/2024. Unit Manager #2 small notebook with notes on had to go back and complete as a late entry. Unit Manager Resident #22 having elevated was one of those residents, back and document.  The entation on the July MAR of I taken or Novolog insulin ordered at 8:00 AM on ant #22.  Chedule dated 7/11/2024	F	842	ensuring no omission are on the Medication administration Records. DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as need employees (PRN). The emphasis of the education will be the importance of ensuring medication and other orders in discharge summaries are transcribed a administered per physician order for earesident. The education also emphasize on the shift change process that include the importance of validating no omission on medication administration records a the beginning of each shift. This educate will be completed by 10/14/2024. Any licensed nurses not educated by 10/14/2024 will be taken off the scheduluntil educated. This education will also implemented in new hire orientation for licensed nurses.  Monitoring of corrective actions to ensurthat the deficient practice is being corrected and will not recur:  Effective 10/07/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication monitoring process. This monitoring process will be accomplished by reviewing medication administration records for all residents with orders for insulin, levothyroxine, and other medications to ensure Licensed nurses and medication aides are administering such medication per	ded is n ind inch ied ie in it	
		as assigned to the hallway			physician orders. This monitoring proce	ess	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING			С	
		345529	B. WING _		•	9/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		5201 CLARKS FORK DRIVE NW			
				RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page	e 201	F 84	42			
	"day shift (7:00 AM to	,		will be completed daily (Mo Friday) for two weeks, week more weeks, then monthly	kly for two for three		
		ewed on 9/5/2024 at 2:37		months, or until the pattern	•		
		she was an agency nurse		is established. Any negative	-		
	_	ne facility on one occasion		be addressed by the Direct promptly. This monitoring p			
		24. Nurse #7 stated she did ne was assigned to. Nurse		documented on a medication			
	#7 stated when she a	•		monitoring tool located in the			
		uler handed her a stack of		compliance binder.	ic raciity		
		her to go to the hall to begin		Effective 10/07/2024, the D	irector of		
		Nurse #7 explained she was		Nursing, Assistant Director			
	•	ive access to the electronic		and/or Unit Coordinators (#	-		
	medical record syste	m. Nurse #7 revealed it was		complete the medication ac			
		ed. Nurse #7 revealed she		monitoring process. This m			
	_	mation for the electronic		process will be accomplished	-		
	medical record syste	m until approximately 2:30		medication administration a	audit report		
	PM.			ensure no resident is listed medication administration.	•		
	An interview with the	medical records supervisor		monitoring process will be	completed daily		
		30/2024 at 12:10 PM. The		(Monday through Friday) fo			
		ervisor confirmed the paper		weekly for two more weeks	-		
		by the facility in July 2024		for three months, or until th			
		medications administered to		compliance is established.			
	residents were lost a	nd never located.		findings will be addressed by	•		
	D			of nursing promptly. This m			
		e July MAR revealed Med		process will be documented			
		glucose level of 400 mg/dL		Medication administration r	-		
	7/11/2024 at 11:47AN	units of Novolog insulin on		located in the facility compl Effective 10/07/2024, Direc			
	7/11/2024 at 11.47At	ito Resident #22.		will report findings of this m	•		
	Documentation on th	e July MAR revealed Med		process to the facility Quali	-		
		glucose level of 400 mg/dL		and Performance Improven	•		
		units of Novolog insulin on		Committee for any addition			
	7/11/2024 at 4:51 PM	<del>-</del>		or modification of this plan	•		
	.,, 202   Gt 1.0   1   1	<del>.</del>		three months, or until a pat	•		
	During the interview	conducted with Med Aide #4		compliance is maintained.			
	•	PM she stated she was		committee can modify this			
		24 for the 7:00 AM to 7:00		the facility remains in subst			

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	
NAME OF D	20VIDED OD CLIDDLIED	343323	5: 1110		TREET ADDRESS CITY STATE ZID CODE	09/	12/2024	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
UNIVERSA	AL HEALTH CARE/NOR	TH RALEIGH		5	201 CLARKS FORK DRIVE NW			
				R	RALEIGH, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From pag	e 202	F	342				
		all next to the hall which			compliance.			
		d. Med Aide #4 revealed			Compliance date: 10/14/2024.			
		ess" on the hallway which			Compliance date: 10/14/2024.			
		d because there was an						
		e #7) who was trying to figure				ĺ		
		and she was not giving de #4 revealed the agency				ĺ		
		0 ,						
		and was put on the do not #4 confirmed she took the						
		gs for Resident #22 on						
	_	•						
		M and 4:51 PM. Med Aide #4 of the blood glucose readings						
		re actually registering as HI						
		hile at least one of the						
		ented on the MAR on						
		lly 400 mg/dL. Med Aide #4						
		ed nurses were going into the						
	-	nented the blood glucose						
	reading and using he	•						
		istration of insulin, so it was						
		e licensed nurse was who						
	administered insulin							
	auministereu msuim	to Resident #22.						
	Documentation in the	e physician orders revealed						
		2024 at 7:00 PM for Resident				ĺ		
	#22 to be administer	ed ten units of Humalog						
		injected subcutaneously one				ĺ		
		glucose exceeding 400 and						
		n in two hours. Humalog						
		g insulin which is absorbed						
		orking in about 15 minutes						
		er blood glucose levels.						
	There was no docum	nentation on the July MAR						
	that the order for Hur	•				ĺ		
		dent #22 on 7/11/2024 after				ĺ		
	7:00 PM.							
	Documentation in the	e physician orders revealed						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345529	B. WING _			C 09/12/2024	
	ROVIDER OR SUPPLIER	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	<b>'</b>	03/12/2024	
(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 842	#22 to be administer insulin solution suborglucose exceeding a physician in two hour that the one-time one ever administered to after 7:00 PM.  There was no other electronic medical resolution of Resident #22 on Documentation in the #22 dated 7/12/2024 revealed, "Physician glucose exceeding a received from physical Humalog or Novologhours. After 2 hours reading still exceeded made aware of resulting still exceeded made aware of resulting still exceeded and the suborglucose exceeding still exceeded made aware of resulting still exceeded and the suborglucose exceeding still exceeded made aware of resulting still exceeded and the suborglucose exceeding still exceeded and suborglucose exceeding still	documentation in the ecord of Novilog	F 8	42			
	order received to se room]. DON made at An interview was co 9/5/2024 at 6:04 PM her 7:00 PM to 7:00 7/11/2024. Nurse #4 nursing report from glucose level of Resmg/dL on the 4:00 F stated she assessed vital signs at the sta	. Physician made aware and nd resident to [emergency ware."  nducted with Nurse #4 on 1. Nurse #4 stated she started AM shift at 7:00 PM on 1. received the information in a 1. Med Aide #4 that the blood 1. Sident #22 was above 400 PM medication pass. Nurse #4 dt Resident #22 and took her ret of her shift. Nurse #4 glucose level of Resident #22					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345529	B. WING		C 09/12/2024
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NO	RTH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	00/12/2027
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY 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 APPROVIDENCY)	D BE COMPLETION
F 842	was registering as I glucometer, a device levels. Nurse #4 revents acting insulin to Rephysician back in twent back to checked 9:00 PM and all here Resident #22 did not elevated blood preserate. Nurse #4 states still registering as Inglucometer. Nurse the facility and requested hospital via ements when the medical record residents, but docus sometimes staying indicated she may be the details of the viareadings, and insulimated in the medical record for a facility and requested the medical record residents. The following blood documented in the medical record for a facility and requested the medical record residents.	High or over 400 mg/dL on the be to measure blood glucose wealed the vital signs of fine, so she called the on-call 4 stated she received an order to administer 10 units of fast sident #22 and call the wo hours. Nurse #4 stated she on Resident #22 again at rivital signs were fine. To thave a temperature, soure, or an elevated heart ed her blood glucose level was fill or above 400 mg/dL on the fill of th	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345529	B. WING _			C <b>09/12</b> /2	2024
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	CODE	00.12.2	
UNIVERSA	AL HEALTH CARE/NORT	'H RAI FIGH		5201 CLARKS FORK DRIVE NW			
ONIVERO	RETIEAETH OAKE/NOKT	TITALLION		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	-	(X5) DMPLETION DATE
F 842	F 842 Continued From page 205		F 8	342			
	On 7/3/2024 a readin	g of 400.0 mg/dL					
	vital signs taken for th	ocumentation of any other ne month of July 2024 for ital signs section of the cord.					
	physician for Residen PM. MD #2 stated whof his residents, he diwhat the blood glucos but looked at the vital electronic medical rewhen he looked at the #22, he saw no concelevels because there 7/10/2024 that was 4 stated he did not see signs in July for Resident have concluded the emergency for that rewhen the properties was concorporate Nursing Council 2:38 PM. The nursing the facility had probles	cord. MD #2 stated that e vital signs for Resident erns with the blood glucose was only one reading on 00 mg/dL. MD #2 further any other concerning vital dent #22 therefore, he would here was any medical esident or concerns.  ducted with the facility onsultant on 8/30/2024 at g consultant acknowledged ems with documentation in					
	2. Resident #13 was 12/29/23 with diagnoshypothyroidism. Resident #13's quarte	admitted to the facility on ses that included erly Minimum Data Set ated 7/10/24 revealed she					

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 _				C 1 <b>12/2024</b>
	ROVIDER OR SUPPLIER	TH RALEIGH		5201	EET ADDRESS, CITY, STATE, ZIP CODE  CLARKS FORK DRIVE NW  LEIGH, NC 27616	1 00/	12/2027
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Review of orders for order dated 8/20/24 tablet 125 (micrograstomach for low thyr Review of Resident Administration Recosodium tablet was not 8/20-8/25/24, 8/27/2 During an interview 8:33 AM who review #13's levothyroxine she could not tell whomissed. Nurse #3 doses had been mis never administered #13.  An interview was consultant or stated he felt the meadministered and it will the facility switched.	Resident #13 revealed an for levothyroxine sodium ms) mcg daily on an empty oid hormone.  #13's August Medication rd revealed the levothyroxine ot documented as given on 4, and 8/28/24.  with Nurse #3 on 8/31/24 at red the MAR and Resident sodium tablet card and stated nich doses may have been stated it appeared some sed. She clarified she had this medication to Resident and with the Corporate of 8/31/24 at 8:40 AM who	F	342			
	9:52 AM. She repo Resident #13's medi stated she believed Nurse #4 stated son down and she was r given. She stated sh an issue with interne An interview was co Corporate Nurse Co	with Nurse #4 on 8/31/24 at rted she administered ication as ordered. She the MAR was incorrect. netimes the internet goes not able to record medications are had not advised any one					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  IG		COMPLETED	
		345529	B. WING _			09/12/2024
	ROVIDER OR SUPPLIER	TH RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		03/12/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 842	-	ge 207 ernet service not working	F 8	42		
F 925 SS=G		Pest Control Program	F 9	25		10/14/24
	program so that the rodents. This REQUIREMEN by: Based on observati interviews with resid control technician th maintained routine a services for the entil twenty-seven sampl flies. Resident # 24 while four flies kept # 1 was found by ston her and in her be which the facility wa and during which tin and family were obsfacility. (Resident # unable to express his would express if the located on them whith Therefore, the reason applied in determining the findings included 1. Resident # 1 was 3/1/17 and had diag a degenerative neur bipolar disorder with Resident # 1's quart	ed residents were affected by was observed trying to eat landing on her food. Resident aff to have multiple maggots d during the timeframe during swithout a service contract ne staff members, residents, erving multiple flies in the 1 had mental illness and was arm a reasonable person y had multiple maggots le relying on others for care. In the serving multiple maggots le relying on others for care. In the serving multiple maggots le relying on others for care. In the serving multiple maggots le relying on others for care. In the serving multiple maggots le relying on others for care. In the serving multiple maggots le relying on others for care. In the serving magging m		F925 Corrective actions accomplished residents found to be affected by deficient practice: Resident #1 head to toes skin ins was conducted by the Unit Coord on 10/7/2024. No new skin altera and/or Maggots identified on resino other actions taken for resider Resident #24 is no longer in the fon 09/06/2024, facility Administrate secured a new contract with a lice pest control company to provide in the facility to include controlling Pest control company provide an service on 09/06/2024.  Identification of other residents he the potential to be affected by the deficient practice: 100% of skin inspection for all curesidents in the facility conducted 09/19/2024, by Director of Nursin coordinator #1, and/or Unit coord #2, to identify any other resident maggot(s) in their wounds or any their body. No other resident ider have maggots on their body. Find this audit are documented on a service.	spection dinator #1 ditions dent #1, nt #1 facility. ator ensed services g flies. onsite naving e same arrent d between ng, Unit linator with parts of ntified to dings of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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		345529	B. WING _			09/12/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
HMIVEDS:	AL HEALTH CARE/NO	DETH BALEIGH		5201 CLARKS FORK DRIVE N	IW		
UNIVERSA	AL HEALTH CARE/NO	OKTH KALEIGH		RALEIGH, NC 27616			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE COMP		(X5) COMPLETION DATE	
F 925	1 3		F 9				
		ct and as being totally f for bathing, dressing, hygiene,		inspection tool locate compliance binder.  100% inspection for a in the facility conducte	all current residents		
	she was seeing the	Practitioner # 1 documented e resident, who was bedbound, rae had been identified on the ved.		Director of Nursing, U Unit coordinator #2, a identify any other resi landing on their body No other resident ide	Unit coordinator #1, and/or scheduler to ident with flies while in the facility.		
	9/5/24 at 8:55 AM information. She h told Resident had her, which facility sassessed the residuals of inflammatimaggots. From he	# 1 (NP#1) was interviewed on and reported the following ad been called on 8/12/24 and approximately 26 maggots on staff removed. On 8/13/24 she dent and found she had some ion in her hand because of the rassessment, she could tell and been in the resident's		landing on their body. audit are documented inspection tool locate compliance binder. Measures/systemic cl into place to ensure the practice does not recompliance.  Effective 10/07/2024,	. Findings of this d on a Flies d in the facility hanges will be put hat the deficient ur:		
	to talk to the reside had mental illness people at the time resident had not be been in her hand be 8/12/24. Due to the the resident did no	neath her fingernails. She tried ent on 8/13/24 but the resident and was talking to nonexistent of her assessment. The een aware the maggots had before they were identified on the resident's medical diagnoses, at have the sensation in the		control service to erac	ree of pests and mic changes will be lementing the a licensed pest provide effective post dicate and contain		
	and she did not hat from flies. The resiner room. If she hat hand without adeq have landed on he take long for a fly to the weekend treat 8/31/24 at 9:30 AM information. On 8/1 told her Resident #	they had been in her hand, we the mobility to move away dent tended to keep snacks in ad gotten some food in her uate hygiene, then flies could by hand and laid eggs. It did not so do this.  It ment nurse was interviewed on M and reported the following 11/24 MA (Medication Aide) # 1 # 1 had some dried blood on ekend treatment nurse also		common household p lice, roaches, ants, m mice, and rats). The c routine services mont Effective 10/07/2024, report any pests or fli- facility to the mainten through maintenance Maintenance director control vendor as nee request of staff. Effective 10/07/2024, which consists of the	company will provide thly and as needed. a facility staff will es identified in the ance director request platform. will contact the Pest eded following the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345529	B. WING _		n	9/12/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	07.12/2021	
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NO	ORTH RALEIGH		RALEIGH, NC 27616			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	THE APPROPRIATE	COMPLETION DATE	
F 925	Continued From page	age 209	F9	25			
	knew that on 8/10/	24 (Saturday) Nurse # 1 said		Assistant Director of Nursir	ng, DON,		
	that therapy had b	een working with the resident		ADON, Minimum Data set	(MDS), and/or		
	and her hand was	bleeding. On Saturday, Nurse		Unit coordinators (#1, #2, v			
	# 1 took care of the	e resident's hand because she		the process for reviewing of	•		
		tment nurse) had been busy.		skin inspection to ensure the			
		ekend treatment nurse) saw		resident has a completed s			
		d on 8/11/24 (Sunday) there		weekly and assure no mag	-		
		ding. In her right contracted		identified in resident skin.	•		
		had fragile skin where she had		process will take place Mor			
	1 '	kdown. Within the fragile skin		Friday. Any identified issue			
		red as if she had a very small		addressed promptly. This p			
		om her fingernails being		incorporated into the daily	ciinicai		
		f her skin. She (the weekend		meeting.			
		sed a cotton tipped swab to nd she applied a dressing. At		DON ADON and/or Stoff	dovolonment		
				DON, ADON, and/or Staff of coordinator will complete 1	•		
		ot see any signs of maggots in d or wound. She had seen flies		education for all licensed n			
		oom and she had also seen		include full time, part time,			
		of the facility landing on		employees (PRN). The em			
	people.	or the facility fariding on		education will be the impor			
	роорю.			maintaining effective pest of			
	MA#1 was intervi	ewed on 8/29/24 at 2:38 PM		and maintaining resident			
		ollowing information. She had		treating each resident with			
		# 1 both on 8/10/24 (Saturday)		respect including ensuring	• •		
		ay). On 8/10/24 (Saturday)		is free from maggots. The			
		rse Aide (NA) had told her that it		emphasized the importance			
		dent # 1's hand was bleeding.		skin inspection weekly, rep			
		. On 8/10/24 (Saturday) there		to the maintenance directo			
	were a lot of flies i	n Resident # 1's room. MA # 1		maintenance request platfo	orm. This		
	estimated there we	ere about 12 or so flies in the		education will be completed	d by		
		She (MA # 1) was "swishing,		10/14/2024. Any licensed r	nurses not		
		" trying to get them away from		educated by 10/14/2024 w			
		ut of her room to the best of her		the schedule until educated			
		l land on the resident, who		education will also be imple			
		od items resting on her chest as		hire orientation for licensed	l nurses.		
		MA # 1 also was aware blood					
		hand might attract the flies to		Monitoring of corrective act			
		nce director was aware flies		that the deficient practice is	•		
	were in the facility.	It was her understanding that		corrected and will not recu	r:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NITIMBED:		PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
						С	
		345529	B. WING _		09	9/12/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				5201 CLARKS FORK DRIVE NW			
UNIVERSA	AL HEALTH CARE/NORT	TH RALEIGH		RALEIGH, NC 27616			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD BE	COMPLETION DATE	
F 925	F 925 Continued From page 210		F 92	25			
	the problem with flies	had been added to the					
	maintenance log and	he had been told multiple		Effective 10/07/2024, facility Ad	dministrator		
	times. She (MA #1) of	could not go to the nursing		and/or Assistant administrator	will observe		
	desk and sit down wit	thout flies following her. On		five randomly selected residen	ts to ensure		
	Sunday 8/11/24, she	knew the weekend		no flies are landing on their boo	dy. Any		
	treatment nurse had	cared for Resident # 1's		negative findings will be addres	ssed		
		vell. She (MA # 1) never saw		promptly by the Administrator,			
	maggots on Resident	t # 1 during the weekend.		Administrator, and/or Maintena			
				Director. This monitoring proce			
		red on 8/29/24 at 3:21 PM		done daily Monday through Fri	•		
		owing information. She had		weeks, weekly for two weeks, t			
	been assigned to care			monthly for three months or un	til a pattern		
	, -,	en the maggots were found		of compliance is maintained.			
		had started her medication		Effective 10/07/2024 DON and			
		# 1's Nurse Aide came to		will monitor compliance with co	•		
		sident # 1 had maggots on		skin inspection by reviewing th	•		
	, ,	erted a nurse who also		clinical meeting reports to ensu			
		ON (Director of Nursing). On		completion and validate that th			
	room.	seen a fly in Resident # 1's		team cross referenced skin ins schedule to assure completion	•		
	TOOTII.			identification of any new altera			
	Nurse Aide # 2 who	had been assigned to care		include maggots. Any negative			
		/12/24 (Monday), was		will be addressed promptly by			
		24 at 7:47 PM and reported		and/or ADON. This will be done			
		ots on Resident # 1 while		Monday through Friday for two	-		
	she was providing ca			weekly for two weeks, then mo			
		acility and had seen them at		three months or until a pattern	•		
	times land on residen			compliance is maintained. Res			
				audit will be presented in QAP			
	Nurse Aide # 1 was ir	nterviewed on 8/29/24 at		and recommendation.			
		d the following information.		Effective 10/14/2024, Maintena	ance		
	·	g on 8/12/24 and had helped		Director and/or Administrator w			
		Resident # 1. She (NA # 2)		findings of this monitoring proc	•		
		s on the resident and in her		facility Quality Assurance and			
		ng care for the resident. It		Performance Improvement Cor	mmittee for		
	was her understandir	ng the maggots had crawled		any additional monitoring or me	odification		
	out from the resident'	's hand. The "higher ups"		of this plan monthly for three m	onths, or		
	(including the former	DON) had been present in		until a pattern of compliance is			
	the room to deal with	the maggots. Flies had		maintained. The QAPI commit	tee can		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION IILDING			(X3) DATE SURVEY COMPLETED	
		345529	B. WING _				C <b>12/2024</b>	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	,	
LINIVEDS:	NI HEALTH CARE/NOR	TH DAI EICH		52	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 PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 925	F 925 Continued From page 211		F 9	925				
		e facility. She (NA # 1) saw would at times land on			modify this plan to ensure the facility remains in substantial compliance. Compliance date: 10/14/2024			
	interviewed on 8/29/2 the following information witnessed maggots of flies "all the time" in the aware residents come.  The facility's weekdate interviewed on 8/30/2 the following information treatment nurse) had maggots in her hand had not personally seen not witnessed flies la	on Resident # 1. She saw he facility and she was						
	AM. At the time she we hand contracture. Where are in general, the rup the maggots during to wander in her consumption will be talking about somentioned she had mone time had maggot went off topic again at the former DON, where maggots, was not during the survey.  On 8/29/24 at 1:10 Proconducted with a rank.	erviewed on 8/29/24 at 8:20 was observed to have a right nen interviewed about her esident did not initially bring ng conversation. She tended versation from topic to topic. omething else, she abruptly neuropathy in her hand and at ts in her hand. She then and did not expound further.  o had reportedly removed t available for interview						

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 <b>12/2024</b>
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	12/2024
				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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 925	# 1 resided. The famili visited often and saw further commented the resident and on the reconstantly fanning the them away.  During a random obscunit (Station 2) other them away.  During a random obscunit (Station 2) other them away.  During a random obscunit (Station 2) other them away.  Resident # 1 resided, at 8:10 AM that a fly with them away carts waiting to be hall.  Interview with the Mailian them away carts waiting to be hall.  Interview with the Mailian them aware there specific resident having related to flies in their were flies in the facility control company, and had not visited that me Maintenance Director had called and indicated them away from doors which there doors. The main accompanied as the cobserved. There was a working fly curtain leading them are the saw and the s	on the unit where Resident by member reported she flies "all the time." She ey would land on the esident's food and she was e resident's food to keep ervation made on a different than the unit on which it was observed on 8/31/24 was hovering over the meal e served to residents on the estate that the unit on which it was observed on 8/31/24 was hovering over the meal e served to residents on the estate the had been a problem with a ng any medical issues from. He was aware there y and he had called a pest the company's technician onth as of 8/29/24. The enamed the company he ted they would be out the enance Director was rent strategies to keep flies reported he thought there evy duty fans that blast air ch lead outside) on two to intenance director was exit doors in the facility were one door observed to have eading to the exit. There	F 9			
	inner courtyard or on	n exit doors leading to the the front door of the facility. e Nurse Consultant was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION  NG	, ,	ATE SURVEY DMPLETED	
		345529	B. WING _			C <b>09/12/2024</b>
	ROVIDER OR SUPPLIER	TH RALEIGH		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616		03/12/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 925	the Corporate Nurse had not informed the employees of any properties of the employees of any properties of the employees of any properties of the most important flies in the facilities. Given he the problem might be when he did go to facilities.	ge 213 224 at 6:00 PM. According to a Consultant the former DON and Administrator or corporate oblems with the resident er bed and on her. If the end eso, the issue of flies in the been addressed and a plan arm from reoccurring would. He had learned that day that are a pest control contract eler. When the facility recently ership, there had been with the pest control company that had not been extended. In additional pest control services facility. They had called that services up again. The ensultant reported the for may have called someone not have a contract with gnizing that the contract with the previous company.  Pest control company, which the facility up until May 2024, 19/4/24 at 1:50 PM. The the following information. One are things to do in controlling as to inspect where flies were to eliminate a source of part of his job when he went are had not been to the facility are was not aware from where the originating. In general, incilities, in addition to finding source, he tried to install fly	FS	025		
	lights and glue board flies that might make	ds which might bait and trap e their way into the facility. kinds of flies, and at times				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345529	B. WING_			C <b>09/12/2024</b>	
	ROVIDER OR SUPPLIER  AL HEALTH CARE/NORT			STREET ADDRESS, CITY, STATE, ZIP COD 5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616	I IE	09/12/2024	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		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 925	Continued From page he also considered ta differentiate what kind problems.	king a sample to	FS	025			
	7/5/2024 with multiple included mild cognitive.  Documentation on a state documentation form of Resident #24 was assets.	skilled daily nursing lated 8/28/2024 revealed					
	conducted with Resid 1:18 PM. Resident #2 up in bed with her lun container in front of h Resident #24 stated, here 24 hours a day, #24 was observed att food into her mouth a and flying around her attempted to brush th	ation and interview were ent #24 on 8/28/2024 at e4 was observed to be sitting ch meal in a Styrofoam er on her bedside table. "There are always flies in 7 days a week." Resident empting to put a fork full of s four flies were landing on lunch meal. Resident #24 e flies off her food with her intinued to land on her food					